

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2016
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NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383
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W 0000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00188285.</p> <p>Complaint #IN00188285: SUBSTANTIATED, Federal and State deficiencies related to the allegation are cited at W149, W154, and W331.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: 3/23, 3/24, 3/28, 3/29, 3/30, 3/31, and 4/1/2016.</p> <p>Provider Number: 15G364 Facility Number: 000878 AIM Number: 100249230</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/7/16.</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 3 sample clients</p>	W 0104	<p>W104 Governing Body</p> <p>The governing body must exercise general policy, budget, and operating</p>	05/01/2016

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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	<p>(clients A, B, and C) and 5 additional clients (clients D, E, F, G, and H), the governing body failed to exercise operating direction over the facility to ensure maintenance and repairs were completed at the group home for clients A, B, C, D, E, F, G, and H.</p> <p>Findings include:</p> <p>Observations and interviews were conducted at the group home on 3/23/16 from 3:00pm until 6:00pm. Clients A, B, C, D, E, F, G, and H were observed at the group home. During the observation period the following needed repairs were observed with the Residential Manager (RM):</p> <p>-The RM stated four of four (4 of 4) tiled hallways had "worn and stained" floor tiles. The RM indicated the group home was in the process of obtaining bids for the floor tiles to be replaced. The RM stated the tile finish was "discolored," worn, the edges on the hallway tiles in "some" areas were damaged, and the edges of the tiles were a hazard.</p> <p>-The RM indicated the wooden door casing to clients A and E's shared bedroom was damaged and had splintered wood around the bedroom door.</p> <p>-The RM indicated client D's bedroom</p>		<p>direction over the facility.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The maintenance needs for the home will be addressed. · An estimate has been received from the contractor to address the following maintenance concerns: tiled hallways to be repaired/replaced, wooden door casing in clients A and E's bedroom to be repaired/replaced, tile in clients F and G's room will be repaired/replaced and the tile in the kitchen/dining room will be repaired/replaced. · The contractor indicated that the work for the repairs should start around May 16th, 2016. · Client D's bedroom dresser handles will be replaced. · The maintenance needs for the home in the future will be addressed by outside contractors. · The process for reporting maintenance concerns will be reviewed with the Program Coordinator and Program Director. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · The maintenance needs for the home in the future will be addressed by outside contractors. 				

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	<p>dresser was missing four of five hand grips which were to be used to open the dresser drawers.</p> <p>-The RM indicated clients F and G's shared bedroom tile was stained and needed to be replaced.</p> <p>-The RM indicated the dining room and kitchen tile was worn, stained, and needed to be replaced.</p> <p>On 3/24/16 at 9:25am, an interview with Area Director (AD) #1 was conducted. AD #1 indicated clients A, B, C, D, E, F, and G lived at the group home. AD #1 indicated the group home was to undergo a remodel in the next year. AD #1 indicated no further information was available for review.</p> <p>On 4/1/2016 at 1:00pm, an interview with AD #2 was conducted. AD #2 indicated the group home was to be scheduled for a remodel in the next year. No further information was available for review.</p> <p>9-3-1(a)</p>		<ul style="list-style-type: none"> · The process for reporting maintenance concerns will be reviewed with the Program Coordinator and Program Director. · The maintenance needs for the home will be addressed. · An estimate has been received from the contractor to address the following maintenance concerns: tiled hallways to be repaired/replaced, wooden door casing in clients A and E's bedroom to be repaired/replaced, tile in clients F and G's room will be repaired/replaced and the tile in the kitchen/dining room will be repaired/replaced. · The contractor indicated that the work for the repairs should start around May 16th, 2016. · The Program Coordinator will address and report maintenance concerns as they arise. · The Program Director will review the maintenance needs of the home during their supervisory visits. <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · The maintenance needs for the home in the future will be addressed by outside contractors. · The process for reporting maintenance concerns will be reviewed with the Program Coordinator and Program Director. · The maintenance needs for the home will be addressed. · An estimate has been received 		

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			<p>from the contractor to address the following maintenance concerns: tiled hallways to be repaired/replaced, wooden door casing in clients A and E's bedroom to be repaired/replaced, tile in clients F and G's room will be repaired/replaced and the tile in the kitchen/dining room will be repaired/replaced.</p> <ul style="list-style-type: none"> · The contractor indicated that the work for the repairs should start around May 16th, 2016. · The Program Coordinator will address and report maintenance concerns as they arise. · The Program Director will review the maintenance needs of the home during their supervisory visits. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Program Coordinator will address and report maintenance concerns as they arise. · The Program Director will review the maintenance needs of the home during their supervisory visits. These are completed at least monthly. · The Area Director will review the Program Director's supervisory visit information. · Quarterly Health and Safety reviews will be completed on the site and forwarded to the Quality Improvement Specialist for review. <p>1.What is the date by which the systemic changes will be</p>	

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W 0125 Bldg. 00	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review, and interview, for 3 of 3 sampled clients (clients A, B, and C) and 5 additional clients (clients D, E, F, G, and H), the facility failed to ensure clients A, B, C, D, E, F, G, and H had unimpeded access to secured snack items and failed to ensure the restriction had been assessed.</p> <p>Findings include:</p> <p>Observations and interviews were conducted at the group home on 3/23/16 from 3:00pm until 6:00pm. Clients A, B, C, D, E, F, G, and H were observed at the group home. During the observation period the snack items of crackers, granola bars, pudding cups, apple sauce, and chips were observed kept inside the medication area. At 4:25pm, the Residential Manager (RM) entered the medication room, asked GHS (Group Home Staff) #1 for the cracker container, GHS #1 located a container kept under</p>	W 0125	<p>completed?</p> <ul style="list-style-type: none"> May 1st, 2016 <p>W125 Protection of Clients Rights The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> The snacks have been removed from the medication room and they are no longer secured. Resident rights including restricting access to desired snacks will be reviewed with staff at their team meeting on 4-25-16. Resident rights, including restricting access to desired snacks and appropriate behavior interventions (least to more restrictive) will be reviewed with the Program Director and Program Coordinator by 5-1-16. The team will meet to determine how affected individuals want to keep their personal snacks 	05/01/2016			

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	<p>the medication shelf, and gave the container to the RM for clients D and G to select their snack. At 4:25pm, GHS #1 indicated the snacks of pudding cups, granola bars, chips, crackers, and apple sauce were kept inside the medication area because of client G's behavior of eating all the snacks. GHS #1 stated "the door was kept closed, clients have to ask staff for snacks" before entering the room, and the medication room was not kept locked. At 4:35pm, the RM stated "we discourage clients from coming in on their own" to obtain snacks and indicated the door to the snacks was not kept locked.</p> <p>On 3/24/16 at 9:25am, an interview with Area Director (AD) #1 was conducted. AD #1 indicated clients A, B, C, D, E, F, G, and H lived at the group home. AD #1 indicated clients A, B, C, D, E, F, and H did not have an identified need for snacks to be kept secured. AD #1 indicated clients A, B, C, D, E, F, and H had not given consent for the locked items. AD #1 indicated staff were to supervise client G around food.</p> <p>On 4/1/2016 at 1:00pm, an interview with AD #2 was conducted. AD #2 indicated clients A, B, C, D, E, F, and H did not have an identified need for snacks</p>		<p>secured by 5-1-16.</p> <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · The snacks have been removed from the medication room and they are no longer secured. · Resident rights including restricting access to desired snacks will be reviewed with staff at their team meeting on 4-25-16. · Resident rights, including restricting access to desired snacks and appropriate behavior interventions (least to more restrictive) will be reviewed with the Program Director and Program Coordinator by 5-1-16. · The Behavior Clinician will monitor during her monthly observations. · In the event that a restrictive measure needs to be implemented, the IDT will convene to determine what measures need to be addressed. The IDT will outline the guidelines for the restriction. Team member, individual and guardian signatures will be obtained. HRC approval would be obtained for the restriction before it would be implemented. <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p>	

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	<p>to be kept secured. AD #2 indicated clients A, B, C, D, E, F, and H had not given consent for the locked items.</p> <p>Client A's record was reviewed on 3/24/16 at 10:00am. Client A's 5/4/15 ISP (Individual Support Plan) and record did not indicate an identified need to secure snacks. Client A's record did not indicate consent for secured snacks.</p> <p>Client B's record was reviewed on 3/24/16 at 10:45am. Client B's 4/20/15 ISP (Individual Support Plan) and 5/7/15 BSP (Behavior Support Plan) did not indicate the identified need to secure snacks. Client B's record did not indicate consent for secured snacks.</p> <p>Client C's record was reviewed on 3/24/16 at 11:15am. Client C's 6/10/15 ISP (Individual Support Plan) and 1/4/16 Risk Plan did not indicate an identified need to secure snacks. Client C's record did not indicate consent for secured snacks.</p> <p>9-3-2(a)</p>		<ul style="list-style-type: none"> · The snacks have been removed from the medication room and they are no longer secured. · Resident rights including restricting access to desired snacks will be reviewed with staff at their team meeting on 4-25-16. · Resident rights, including restricting access to desired snacks and appropriate behavior interventions (least to more restrictive) will be reviewed with the Program Director and Program Coordinator by 5-1-16. · The Behavior Clinician will monitor during her monthly observations. · In the event that a restrictive measure needs to be implemented, the IDT will convene to determine what measures need to be addressed. The IDT will outline the guidelines for the restriction. Team member, individual and guardian signatures will be obtained. HRC approval would be obtained for the restriction before it would be implemented. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Behavior Clinician will monitor as she is in the home for her monthly observations. · The Program Director will monitor when she is in the home to complete her supervisory visits. · The Program Coordinator will monitor on a daily basis when she is in the home. 				

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W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review, and interview, for 2 of 3 sampled clients (clients A and B) and for 1 additional client (client G), the facility neglected to report and investigate client B's open skin areas from SIB (Self Injurious Behavior), neglected to thoroughly investigate client A's open skin areas caused from pressure, and neglected to ensure client G was supervised according to his identified staff supervision need for his AWOL (Absence Without Leave) behavior from the workshop. The facility neglected to ensure the facility staff implemented clients A, B, and G's plans to protect the clients from the risk of injuries and from their identified risks and behaviors.</p> <p>Findings include:</p> <p>1. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations from 11/2015 through 3/23/2016 were reviewed on 3/24/16 at 7:33am and</p>	W 0149	<p>1. What is the date by which the systemic changes will be completed? · May 1, 2016</p> <p>W149 Staff Treatment of Clients The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>1. What corrective action will be accomplished? · Competency based training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors, skin/wound concerns and injuries of unknown origin). · Competency based training with Program Coordinator and Program Director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors, skin/wound concerns and injuries of unknown origin).</p>	05/01/2016

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	<p>indicated client A's open pressure skin area.</p> <p>-A 12/3/15 BDDS report for an incident on 12/1/15 at 8:00am indicated client A "has quadriplegia and is wheelchair bound. He has very limited communication ability. He was taken to the doctor on 12/1/15 with a level 3 pressure sore under his arm and a level 2 pressure sore on his buttocks. He recently, approximately 2-3 weeks ago, got a new wheelchair that is formed to his body. His (doctor) said the pressure sore under his arm was from the chair rubbing underneath it and the sore on his buttocks is from not being able to adequately reposition him due to the chair being specifically made for his body. (The doctor) prescribed a cream for his wounds and duoderm to cover the area for the next several days...." The report and investigation did not address how client A's open pressure areas went from no areas to level 2 and level 3 pressure sores before the open sores were identified for care and treatment.</p> <p>Client A's record was reviewed on 3/24/16 at 10:00am. Client A's 5/4/15 ISP (Individual Support Plan) and 6/26/15 Risk Plan both indicated client A used a wheel chair because he has a diagnosis of Quadriplegia and was at risk</p>		<ul style="list-style-type: none"> · Training will be completed with the Program Director regarding the components of a thorough investigation. · Area Director and/or Quality Assurance will review investigations for thoroughness. · The Program Director and Nurse will attend risk management assessment and protocol training on May 4th, 2016. · Client A and B's risk plans will be reviewed and revised as needed. · Client B is scheduled to see her psychiatrist on 4-27-16. Her SIB behavior will be addressed to determine if any additional medication changes are needed. · Client B was seen by wound care on 3-24-16. Orders were received to cleanse and dress the wound. She was discharged from their care at that time. · Client B's PCP ordered a new cream on 4-13-16 to help address areas on Client B's right wrist where Client B has been skin picking to help promote healing. · Client A and B will be on the nurses high risk monitoring. · The nurse will monitor Client A and B on a weekly basis or more frequently as the need arises. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · Client G's supervision needs will be reviewed with the day service staff. 				

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	<p>for pressure sores. Client A's records indicated he was "reposition (sic) and changed depends (adult incontinent briefs) every 2 hours and used hand over hand assistance" during dining. Client A's records indicated "total assistance needed. Wears depends and uses a hooyer lift to transfer" from his wheel chair to another location. Client A's risk plan indicated "Impaired skin integrity results in open wounds, pressure sores, infection, and pain. Prevention: The key to keeping the skin intact is keeping it dry and pressure free." Client A's record indicated client A was to be out of his wheelchair one hour a day during day services, changed every two hours, and repositioned every two hours in his wheel chair, bed, recliner, and other locations. Client A's risk plan indicated client A "...requires assistance with bathing daily and staff have the opportunity to visually examine his skin from head to toe daily. [Client A] uses adult incontinent products. Staff assist him with changing every 2 hrs. (hours) while awake and sleeping and any time that he is wet and initial on the MAR (Medication Administration Record) each time. Staff are trained to report anything unusual including injuries to the skin...."</p> <p>-Client A's record indicated the GER on 12/1/15 at 8:00am was the first notation</p>		<ul style="list-style-type: none"> · Client G's behavior plan, IPOP assessments and risk plans that address supervision concerns will be reviewed and revised as needed. · Staff will be retrained on how to complete skin wound assessments at their staff meeting on 4-25-16. · The Program Coordinator will review the skin wound documentation submitted by the staff on a daily basis. Any concerns will be reported to the Program Director and the nurse. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Competency based training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors, skin/wound concerns and injuries of unknown origin). · Competency based training with Program Coordinator and Program Director/QIDP regarding timely review of internal 	

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	<p>by a staff that client A had an open pressure sore on his buttocks and a pressure wound under his right arm. No sizes, descriptions, and/or documented appearance of the wounds were recorded.</p> <p>-Client A's 3/1/16 and 12/29/15 nursing assessments did not indicate the descriptions, sizes, stages, and appearances of client A's wounds. Client A's 12/29/15 nursing entry indicated he was seen by the wound care clinic for his open pressure wounds on his buttocks and right arm.</p> <p>On 3/24/16 at 11:30am, an interview with Area Director (AD) #1 was conducted. AD #1 indicated client A's ISP and risk plans were not implemented correctly by the facility staff when client A had developed open pressure sores on his skin on 12/1/15. AD #1 indicated client A's 12/1/15 BDDS report and investigation did not include how and/or why client A's skin went from no open areas to a level 2 open pressure sore on his buttocks and a level 3 open pressure sore under client A's right arm without staff noting the changes in client A's skin. AD #1 stated client A received a new wheelchair "several" weeks before the open sores were noted. AD #1 indicated the staff were to have recorded client A's skin status each time when they changed him</p>		<p>incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors, skin/wound concerns and injuries of unknown origin).</p> <ul style="list-style-type: none"> · Training will be completed with the Program Director regarding the components of a thorough investigation. · Area Director and/or Quality Assurance will review investigations for thoroughness. · The Program Director and Nurse will attend risk management assessment and protocol training on May 4th, 2016. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · As the client needs change the IDT will meet to address the concerns. Risk plans, IPOP assessment and behavior plans will be revised as needed by the QMRP. · As the client needs change the nurse can increase the frequency that she completes observations with the clients based on the client need. · The Behavior Clinician will observe supervision needs and supports provided by day services during their observations. · The Program Coordinator and Program Director will observe supervision needs and supports provided by day services during their observations. · Staff will be retrained on how 	

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	<p>and/or repositioned him. AD #1 indicated client A's open pressure skin sores were not staged, measured, and the appearance documented by the facility staff and the agency nurse.</p> <p>On 4/1/16 at 1:00pm, an interview with AD #2 was conducted. AD #2 indicated client A was at risk for pressure sores on his skin. AD #2 indicated client A's ISP and risk plans were not implemented correctly by the facility staff when client A had developed open pressure sores on his skin on 12/1/15. AD #2 indicated client A's 12/1/15 BDDS report and investigation did not include how and/or why client A's skin went from no open areas to a level 2 open pressure sore on his buttocks and a level 3 open pressure sore under client A's right arm without staff noting the changes in client A's skin. AD #2 stated client A received a new wheelchair "a few weeks" before client A developed the open sores on his skin. AD #2 indicated the staff were to have recorded client A's skin status each time when they changed him and/or repositioned him. AD #2 indicated client A's opened pressure skin sores were not staged, measured, and the appearance documented by the facility staff and the agency nurse.</p> <p>2. The facility's reportable incidents to</p>		<p>to complete skin wound assessments at their staff meeting on 4-25-16.</p> <ul style="list-style-type: none"> The Program Coordinator will review the skin wound documentation submitted by the staff on a daily basis. Any concerns will be reported to the Program Director and the nurse. The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. <p>1. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> Competency based training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors, skin/wound concerns and injuries of unknown origin). Competency based training with Program Coordinator and Program Director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors, skin/wound concerns and injuries of unknown origin). Training will be completed with the Program Director regarding the components of a thorough 	

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	<p>the Bureau of Developmental Disabilities Services (BDDS) and investigations from 11/2015 through 3/23/2016 were reviewed on 3/24/16 at 7:33am and did not include client B's open skin areas.</p> <p>During observations on 3/23/16 from 3:00pm until 6:00pm, client B was observed to have open skin areas on the top of her head and on her right wrist. At 4:45pm, client B showed her open areas to the top of her head which were a bright red circular area and a circular open area on her right wrist which was a dime sized bright red area. During the observation period client B did not wear a dressing, did not wear a hat, and both wounds were visible uncovered on client B's skin. At 4:45pm, the RM (Residential Manager) stated client B "picks" the areas on her right wrist and the top of her head open. The RM stated "it is from SIB" and indicated client B was scheduled to be seen at the wound clinic on 3/24/16.</p> <p>Client B's record was reviewed on 3/24/16 at 10:45am. Client B's 4/20/15 ISP (Individual Support Plan), 5/7/15 BSP (Behavior Support Plan), and 10/2015 Risk plans identified client B was at risk for open sores caused from her SIB of picking her skin until it is open. Client B's 3/17/16 GER (General Event Report) indicated client B "has a</p>		<p>investigation.</p> <ul style="list-style-type: none"> · Area Director and/or Quality Assurance will review investigations for thoroughness. · The Program Director and Nurse will attend risk management assessment and protocol training on May 4th, 2016. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · As the client needs change the IDT will meet to address the concerns. Risk plans, IPOP assessment and behavior plans will be revised as needed by the QMRP. · As the client needs change the nurse can increase the frequency that she completes observations with the clients based on the client need. · The Behavior Clinician will observe supervision needs and supports provided by day services during their observations. · The Program Coordinator and Program Director will observe supervision needs and supports provided by day services during their observations. · Staff will be retrained on how to complete skin wound assessments at their staff meeting on 4-25-16. · The Program Coordinator will review the skin wound documentation submitted by the staff on a daily basis. Any concerns will be reported to the Program Director and the nurse. · The nurse will review the skin wound documentation submitted by 	

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	sore on right wrist she is continuously picking at...." but did not include the open area on the top of client B's head. Client B's 5/7/15 BSP indicated "...SIB: Self Injurious behavior as identified by skin picking, picking scabs and/or wound on her head...." Client B's Risk plan indicated "Risk for Impaired Skin Integrity...6/5/15 Definition...when opening is created in the skin...[Client B] is currently under the care of the wound care center for treatment of wound on top of her head. She is encouraged to wear a hat to prevent her from picking at areas on top of her head..Complete these steps to treat the ulcer on [client B's] head, per wound care center: Wound care is to be completed daily and anytime [client B] has removed bandage and has picked at her wound. 1. Gently and thoroughly clean area with saline. 2. Cut Prisma dressing in half and lightly moisten Prisma dressing with saline and place on wound. 3. Apply dry gauze pad on top of Prisma dressing. 4. Secure with ACE wrap. 5. Document wound appearance, size, and description in skin/wound module in therap (a computerized client record generated by the facility staff)...." Client B's "Wound/Skin" module and client B's record were reviewed and no record was available for review of the sizes, appearances, and description of client B's open wounds on her head and		<p>the staff on a weekly basis to ensure accuracy.</p> <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Behavior Clinician will observe supervision needs and supports provided by day services during their observations. · The Program Coordinator and Program Director will observe supervision needs and supports provided by day services during their monthly observations and when they are at the facility. · The Program Coordinator will review the skin wound documentation submitted by the staff on a daily basis. Any concerns will be reported to the Program Director and the nurse. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. · The nurse will complete weekly observations on Client A and B. · The Program Director will submit all investigations to the Area Director and/or the Quality Improvement Specialist to review to ensure it is thorough. <p>1.What is the date by which the systemic changes will be completed?</p> <ul style="list-style-type: none"> · May 1st, 2016 	

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	<p>her right wrist.</p> <p>On 3/24/16 at 11:30am, an interview with Area Director (AD) #1 was conducted. AD #1 indicated client B's open skin sores were from SIB and were not reported to BDDS. AD #1 indicated client B was seen by the wound care clinic for the areas to her head and right wrist. AD #1 indicated client B's ISP and risk plans were not implemented correctly by the facility staff when client B had developed open sores on her head and right wrist. AD #1 indicated client B should have been prompted and encouraged to wear a hat or covering over the open sores. AD #1 indicated client B's opened pressure skin sores were not staged, measured, and the appearance documented by the facility staff and the agency nurse.</p> <p>On 4/1/16 at 1:00pm, an interview with AD #2 was conducted. AD #2 indicated client B's ISP and risk plans were not implemented correctly by the facility staff when client B had developed open sores on her skin. AD #2 indicated client B's open sores were not reported to BDDS. AD #2 stated client B was at risk for open sores related to her history of skin picking. AD #2 indicated client B's opened skin sores were not staged, measured, and the appearance</p>			

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	<p>documented by the facility staff and the agency nurse.</p> <p>3. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations from 11/2015 through 3/23/2016 were reviewed on 3/24/16 at 7:33am and did not include a report for client G's AWOL behavior from the workshop.</p> <p>-A 12/14/15 investigation for an incident on 12/9/15 at 12:15pm from the facility operated day services indicated client A "had eloped (AWOL) from the day program and got (sic) a ride from a community member to the Indiana Mentor Office. Reportedly [client G] would leave his residence without staff supervision, therefore, he had a risk plan in place for AWOL. [Client G] did not have recent documented incidents of AWOL, therefore it was not addressed in his BSP (Behavior Support Plan)...The 12/14/15 AWOL was the first AWOL in over 1 year...Conclusion: Evidence supports that [client G] was out of staff supervision approximately somewhere between the times of 12:15pm and 12:30pm on 12/14/15 while he was attending day services. Evidence supports that [client G] has a history of going AWOL...Evidence supports that [client G's] supervision level includes</p>			

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	<p>[client G] can independently travel the day program building. Evidence supports that [client G] supervision level is staff on premises at all times with in the line of sight checks every 15 minutes...Evidence supports that [client G] was taken to the Indiana Mentor office on 12/14/15 by an individual that was not Indiana Mentor Staff...."</p> <p>On 4/1/16 at 12:00noon, client G's record was reviewed. Client G's 4/20/15 BSP, 4/20/15 ISP (Individual Support Plan), and 4/2015 Risk plan indicated client G "required line of sight" staff supervision while in the community. Client G's risk plan indicated he was at risk for AWOL behaviors.</p> <p>On 4/1/16 at 1:00pm, an interview with AD #2 was conducted. AD #2 indicated client G was at risk for AWOL behavior because of his history. AD #2 indicated client G had not gone AWOL for over a year. AD #2 indicated client G should have been supervised by the facility staff with line of sight supervision. AD #2 indicated no BDDS report was available for review for client G's 12/2015 AWOL from the facility owned day services. AD #2 indicated client G was not supervised according to his identified need.</p> <p>The facility's policy and procedures were</p>			

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W 0153	<p>reviewed on 3/24/16 at 9:25am. The facility's 4/2011 Quality and Risk Management policy indicated "Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The 4/2011 Quality and Risk Management Policy indicated failure to provide appropriate supervision, care or training was considered neglect. The 4/2011 Quality and Risk Management Policy indicated, "Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee. (1.) Investigation findings will be submitted to the AD (Area Director) for review and development of further recommendations as needed within 5 days of the incident."</p> <p>This federal tag relates to complaint #IN00188285.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p>			

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Bldg. 00	<p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on observation, record review, and interview, for 1 of 3 sampled clients (client B) and for 1 additional client (client G), the facility failed to report client B's open skin areas from SIB (Self Injurious Behavior) and client G's AWOL (Absence Without Leave) behavior from the workshop to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>1. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations from 11/2015 through 3/23/2016 were reviewed on 3/24/16 at 7:33am and did not include client B's opened skin areas.</p> <p>During observations on 3/23/16 from 3:00pm until 6:00pm, client B was observed to have open areas on the top of her head and on her right wrist. At 4:45pm, client B showed her open areas to the top of her head which were a bright red circular area and a circular open area on her right wrist which was a dime sized bright red area. During the observation</p>	W 0153	<p>W153 Staff Treatment of Clients</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Competency based training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors, skin/wound concerns and injuries of unknown origin). · Competency based training with Program Coordinator and Program Director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors, skin/wound concerns and injuries of unknown origin). · The Program Coordinator will review the skin wound 	05/01/2016

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	<p>period client B did not wear a dressing, did not wear a hat, and both wounds were visible uncovered on client B's skin. At 4:45pm, the RM (Residential Manager) stated client B "picks" the areas on her right wrist and the top of her head open. The RM stated "it is from SIB" and indicated client B was scheduled to be seen at the wound clinic on 3/24/16.</p> <p>Client B's record was reviewed on 3/24/16 at 10:45am. Client B's 4/20/15 ISP (Individual Support Plan), 5/7/15 BSP (Behavior Support Plan), and 10/2015 Risk plans identified client B was at risk for open sores caused from her SIB of picking her skin until it is open. Client B's 3/17/16 GER (General Event Report) indicated client B "has a sore on right wrist she is continuously picking at..." but did not include the open area on the top of client B's head.</p> <p>On 3/24/16 at 11:30am, an interview with Area Director (AD) #1 was conducted. AD #1 indicated client B's open sores were from SIB and were not reported to BDDS. AD #1 indicated client B was seen by the wound care clinic for the areas to her head and right wrist.</p> <p>On 4/1/16 at 1:00pm, an interview with AD #2 was conducted. AD #2 indicated client B's open sores were not reported to</p>		<p>documentation submitted by the staff on a daily basis. Any concerns will be reported to the Program Director and the nurse.</p> <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Training with Program Director/QIDP regarding reporting to the administrator or to other officials in accordance with State law allegations of mistreatment, neglect or abuse, skin/wound concerns as well as injuries of unknown source. · Training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors, skin/wound concerns and injuries of unknown origin). · Training with Program Coordinator and Program Director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors, skin/wound concerns and injuries of unknown origin). <p>1.What measures will be put into</p>	

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	<p>BDDS. AD #2 stated client B was at risk for open sores related to her history of skin picking.</p> <p>2. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations from 11/2015 through 3/23/2016 were reviewed on 3/24/16 at 7:33am and did not include a report for client G's AWOL behavior from the workshop.</p> <p>-A 12/14/15 investigation for an incident on 12/9/15 at 12:15pm from the facility operated day services indicated client A "had eloped (AWOL) from the day program and got (sic) a ride from a community member to the Indiana Mentor Office. Reportedly [client G] would leave his residence without staff supervision, therefore, he had a risk plan in place for AWOL. [Client G] did not have recent documented incidents of AWOL, therefore it was not addressed in his BSP (Behavior Support Plan)...The 12/14/15 AWOL was the first AWOL in over 1 year...Conclusion: Evidence supports that [client G] was out of staff supervision approximately somewhere between the times of 12:15pm and 12:30pm on 12/14/15 while he was attending day services. Evidence supports that [client G] has a history of going AWOL...Evidence supports that</p>		<p>place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Training with Program Director/QIDP regarding reporting to the administrator or to other officials in accordance with State law allegations of mistreatment, neglect or abuse, skin/wound concerns as well as injuries of unknown source. · Training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors, skin/wound concerns and injuries of unknown origin). · Training with Program Coordinator and Program Director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors, skin/wound concerns and injuries of unknown origin). <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Training with Program Director/QIDP regarding reporting to the administrator or to other officials in accordance with State law allegations of mistreatment, neglect or abuse, skin/wound concerns as well as injuries of unknown source. · Training with staff regarding completion of internal incident/injury 		

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	<p>[client G's] supervision level includes [client G] can independently travel the day program building. Evidence supports that [client G] supervision level is staff on premises at all times with in the line of sight checks every 15 minutes...Evidence supports that [client G] was taken to the Indiana Mentor office on 12/14/15 by an individual that was not Indiana Mentor Staff...."</p> <p>On 4/1/16 at 1:00pm, an interview with AD #2 was conducted. AD #2 indicated client G was at risk for AWOL behavior because of his history. AD #2 indicated client G had not gone AWOL for over a year. AD #2 indicated client G should have been supervised by the facility staff with line of sight supervision. AD #2 indicated no BDDS report was available for review for client G's 12/2015 AWOL from the facility owned day services. AD #2 indicated client G was not supervised according to his identified need.</p> <p>9-3-2(a)</p>		<p>reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors, skin/wound concerns and injuries of unknown origin).</p> <ul style="list-style-type: none"> · Training with Program Coordinator and Program Director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors, skin/wound concerns and injuries of unknown origin). · The Area Director will monitor the timeliness of reporting incidents via IN Mentor's internal reporting tracking. · The Program Director, Program Coordinator and nurse will review the internal accident/injury reports submitted by staff to ensure that all incidents requiring BDDS reports are reported in accordance with State law. · The Quality Improvement Specialist will review accident/injury reports submitted by staff as she completes her audits to ensure that all incidents requiring BDDS reports are reported in accordance with State law. <p>1.What is the date by which the systemic changes will be completed?</p> <ul style="list-style-type: none"> · May 1st, 2016 		

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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 observation, record review, and interview, for 2 of 3 sampled clients (clients A and B), the facility failed to investigate client B's open skin areas from SIB (Self Injurious Behavior) and to thoroughly investigate client A's open skin areas caused from pressure.</p> <p>Findings include:</p> <p>1. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations from 11/2015 through 3/23/2016 were reviewed on 3/24/16 at 7:33am and indicated client A's open pressure skin area.</p> <p>-A 12/3/15 BDDS report for an incident on 12/1/15 at 8:00am indicated client A "has quadriplegia and is wheelchair bound. He has very limited communication ability. He was taken to the doctor on 12/1/15 with a level 3 pressure sore under his arm and a level 2 pressure sore on his buttocks. He recently, approximately 2-3 weeks ago, got a new wheelchair that is formed to his body. His (doctor) said the pressure sore under his arm was from the chair rubbing</p>	W 0154	<p>W154 Staff Treatment of Clients The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Competency based training with Program Director/QIDP regarding incidents requiring investigation as well as timely completion of investigations. · Area Director and/or Quality Assurance will review investigations for thoroughness. · Training will be completed with the Program Director regarding the components of a thorough investigation. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Training with Program Director/QIDP regarding incidents requiring investigation as well as timely completion of investigations. · Competency based training with Program Director/QIDP regarding incidents requiring investigation as well as timely 	05/01/2016

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	<p>underneath it and the sore on his buttocks is from not being able to adequately reposition him due to the chair being specifically made for his body. (The doctor) prescribed a cream for his wounds and duoderm to cover the area for the next several days...." The report and investigation did not address how client A's open pressure areas went from no areas to level 2 and level 3 pressure sores before the open sores were identified for care and treatment.</p> <p>Client A's record was reviewed on 3/24/16 at 10:00am. Client A's 5/4/15 ISP (Individual Support Plan) and 6/26/15 Risk Plan both indicated client A used a wheel chair because he has a diagnosis of Quadriplegia and was at risk for pressure sores. Client A's records indicated he was "reposition (sic) and changed depends (adult incontinent briefs) every 2 hours and used hand over hand assistance" during dining. Client A's records indicated "total assistance needed. Wears depends and uses a hooyer lift to transfer" from his wheel chair to another location. Client A's risk plan indicated "Impaired skin integrity results in open wounds, pressure sores, infection, and pain. Prevention: The key to keeping the skin intact is keeping it dry and pressure free." Client A's record indicated client A was to be out of his</p>		<p>completion of investigations.</p> <ul style="list-style-type: none"> · Area Director and/or Quality Assurance will review investigations for thoroughness. · Training will be completed with the Program Director regarding the components of a thorough investigation. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Training with Program Director/QIDP regarding incidents requiring investigation as well as timely completion of investigations. · Competency based training with Program Director/QIDP regarding incidents requiring investigation as well as timely completion of investigations. · Area Director and/or Quality Assurance will review investigations for thoroughness. · Training will be completed with the Program Director regarding the components of a thorough investigation. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Area Director and/or Quality Assurance will review investigations for thoroughness. <p>1.What is the date by which the systemic changes will be completed?</p>		

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	<p>wheelchair one hour a day during day services, changed every two hours, and repositioned every two hours in his wheel chair, bed, recliner, and other locations. Client A's risk plan indicated client A "...requires assistance with bathing daily and staff have the opportunity to visually examine his skin from head to toe daily. [Client A] uses adult incontinent products. Staff assist him with changing every 2 hrs. (hours) while awake and sleeping and any time that he is wet and initial on the MAR (Medication Administration Record) each time. Staff are trained to report anything unusual including injuries to the skin...."</p> <p>-Client A's record indicated the GER on 12/1/15 at 8:00am was the first notation by a staff that client A had an open pressure sore on his buttocks and a pressure wound under his right arm. No sizes, descriptions, and/or documented appearance of the wounds were recorded.</p> <p>-Client A's 3/1/16 and 12/29/15 nursing assessments did not indicate the descriptions, sizes, stages, and appearances of client A's wounds. Client A's 12/29/15 nursing entry indicated he was seen by the wound care clinic for his open pressure wounds on his buttocks and right arm.</p>		May 1st, 2016				

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	<p>On 3/24/16 at 11:30am, an interview with Area Director (AD) #1 was conducted. AD #1 indicated client A's ISP and risk plans were not implemented correctly by the facility staff when client A had developed open pressure sores on his skin on 12/1/15. AD #1 indicated client A's 12/1/15 BDDS report and investigation did not include how and/or why client A's skin went from no open areas to a level 2 open pressure sore on his buttocks and a level 3 open pressure sore under client A's right arm without staff noting the changes in client A's skin. AD #1 stated client A received a new wheelchair "several" weeks before the open sores were noted. AD #1 indicated the staff were to have recorded client A's skin status each time when they changed him and/or repositioned him. AD #1 indicated client A's open pressure skin sores were not staged, measured, and the appearance documented by the facility staff and the agency nurse.</p> <p>On 4/1/16 at 1:00pm, an interview with AD #2 was conducted. AD #2 indicated client A was at risk for pressure sores on his skin. AD #2 indicated client A's ISP and risk plans were not implemented correctly by the facility staff when client A had developed open pressure sores on his skin on 12/1/15. AD #2 indicated client A's 12/1/15 BDDS report and</p>			

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	<p>investigation did not include how and/or why client A's skin went from no open areas to a level 2 open pressure sore on his buttocks and a level 3 open pressure sore under client A's right arm without staff noting the changes in client A's skin. AD #2 stated client A received a new wheelchair "a few weeks" before client A developed the open sores on his skin. AD #2 indicated the staff were to have recorded client A's skin status each time when they changed him and/or repositioned him. AD #2 indicated client A's open pressure skin sores were not staged, measured, and the appearance documented by the facility staff and the agency nurse.</p> <p>2. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations from 11/2015 through 3/23/2016 were reviewed on 3/24/16 at 7:33am and did not include client B's open skin areas.</p> <p>During observations on 3/23/16 from 3:00pm until 6:00pm, client B was observed to have open skin areas on the top of her head and on her right wrist. At 4:45pm, client B showed her open areas to the top of her head which were a bright red circular area and a circular open area on her right wrist which was a dime sized bright red area. During the observation</p>			

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	<p>period client B did not wear a dressing, did not wear a hat, and both wounds were visible uncovered on client B's skin. At 4:45pm, the RM (Residential Manager) stated client B "picks" the areas on her right wrist and the top of her head open. The RM stated "it is from SIB" and indicated client B was scheduled to be seen at the wound clinic on 3/24/16.</p> <p>Client B's record was reviewed on 3/24/16 at 10:45am. Client B's 4/20/15 ISP (Individual Support Plan), 5/7/15 BSP (Behavior Support Plan), and 10/2015 Risk plans identified client B was at risk for open sores caused from her SIB of picking her skin until it is open. Client B's 3/17/16 GER (General Event Report) indicated client B "has a sore on right wrist she is continuously picking at...." but did not include the open area on the top of client B's head. Client B's 5/7/15 BSP indicated "...SIB: Self Injurious behavior as identified by skin picking, picking scabs and/or wound on her head...." Client B's Risk plan indicated "Risk for Impaired Skin Integrity...6/5/15 Definition...when opening is created in the skin...[Client B] is currently under the care of the wound care center for treatment of wound on top of her head. She is encouraged to wear a hat to prevent her from picking at areas on top of her head...Complete these steps</p>			

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	<p>to treat the ulcer on [client B's] head, per wound care center: Wound care is to be completed daily and anytime [client B] has removed bandage and has picked at her wound. 1. Gently and thoroughly clean area with saline. 2. Cut Prisma dressing in half and lightly moisten Prisma dressing with saline and place on wound. 3. Apply dry gauze pad on top of Prisma dressing. 4. Secure with ACE wrap. 5. Document wound appearance, size, and description in skin/wound module in therap (a computerized client record for the staff to make entries)...." Client B's "Wound/Skin" module and client B's record were reviewed and no record was available for review of the sizes, appearances, and description of client B's open wounds on her head and her right wrist.</p> <p>On 3/24/16 at 11:30am, an interview with Area Director (AD) #1 was conducted. AD #1 indicated client B's open skin sores were from SIB and were not investigated. AD #1 indicated client B was seen by the wound care clinic for the areas to her head and right wrist. AD #1 indicated client B's ISP and risk plans were not implemented correctly by the facility staff when client B had developed open sores on her head and right wrist. AD #1 indicated client B should have been prompted and encouraged to wear a</p>			

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W 0331 Bldg. 00	<p>hat or covering over the open sores. AD #1 indicated client B's opened pressure skin sores were not staged, measured, and the appearance documented by the facility staff and the agency nurse.</p> <p>On 4/1/16 at 1:00pm, an interview with AD #2 was conducted. AD #2 indicated client B's ISP and risk plans were not implemented correctly by the facility staff when client B had developed open sores on her skin. AD #2 indicated client B's SIB open sores were not investigated. AD #2 stated client B was at risk for open sores related to her history of skin picking. AD #2 indicated client B's opened skin sores were not staged, measured, and the appearance documented by the facility staff and the agency nurse.</p> <p>This federal tag relates to complaint #IN00188285.</p> <p>9-3-2(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 2 of 3 sampled clients (clients A and B), the facility's nursing staff failed to ensure client's A and B's</p>	W 0331	<p>W331 Nursing Services</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p>	05/01/2016

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	<p>open skin wounds were staged, measured, and the appearance documented by the facility staff and the agency nurse.</p> <p>Findings include:</p> <p>1. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations from 11/2015 through 3/23/2016 were reviewed on 3/24/16 at 7:33am and indicated client A's open pressure skin area.</p> <p>-A 12/3/15 BDDS report for an incident on 12/1/15 at 8:00am indicated client A "has quadriplegia and is wheelchair bound. He has very limited communication ability. He was taken to the doctor on 12/1/15 with a level 3 pressure sore under his arm and a level 2 pressure sore on his buttocks. He recently, approximately 2-3 weeks ago, got a new wheelchair that is formed to his body. His (doctor) said the pressure sore under his arm was from the chair rubbing underneath it and the sore on his buttocks is from not being able to adequately reposition him due to the chair being specifically made for his body. (The doctor) prescribed a cream for his wounds and duoderm to cover the area for the next several days...." The report</p>		<p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The Program Director and Nurse will attend risk management assessment and protocol training on May 4th, 2016. · Client A and B's risk plans will be reviewed and revised as needed. · Client B is scheduled to see her psychiatrist on 4-27-16. Her SIB behavior will be addressed to determine if any additional medication changes are needed. · Client B was seen by wound care on 3-24-16. Orders were received to cleanse and dress the wound. She was discharged from their care at that time. · Client B's PCP ordered a new cream on 4-13-16 to help address areas on Client B's right wrist where Client B has been skin picking to help promote healing. · Client A and B will be on the nurses high risk monitoring. · The nurse will monitor Client A and B on a weekly basis or more frequently as the need arises. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · Staff will be retrained on how to complete skin wound assessments at their staff meeting on 4-25-16. · The Program Coordinator will review the skin wound documentation submitted by the staff on a daily basis. Any concerns will be reported to the Program Director 				

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	<p>and investigation did not address how client A's open pressure areas went from no skin areas to level 2 and level 3 pressure sores before the open sores were identified for care and treatment.</p> <p>Client A's record was reviewed on 3/24/16 at 10:00am. Client A's 5/4/15 ISP (Individual Support Plan) and 6/26/15 Risk Plan both indicated client A used a wheel chair because he has a diagnosis of Quadriplegia and was at risk for pressure sores. Client A's records indicated he was "reposition (sic) and changed depends (adult incontinent briefs) every 2 hours and used hand over hand assistance" during dining. Client A's records indicated "total assistance needed. Wears depends and uses a hooyer lift to transfer" from his wheel chair to another location. Client A's risk plan indicated "Impaired skin integrity results in open wounds, pressure sores, infection, and pain. Prevention: The key to keeping the skin intact is keeping it dry and pressure free." Client A's record indicated client A was to be out of his wheelchair one hour a day during day services, changed every two hours, and repositioned every two hours in his wheel chair, bed, recliner, and other locations. Client A's risk plan indicated client A "...requires assistance with bathing daily and staff have the opportunity to visually</p>		<p>and the nurse.</p> <ul style="list-style-type: none"> The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. Develop competency based training for wound care and documentation of wound including descriptive terms and any prior pain management to include parameters of time dose, pain scale, when to notify the nurse, documentation and follow up and train staff and verify competency. Competency based training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors, skin/wound concerns and injuries of unknown origin). <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the same deficient practice. Competency based training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors, skin/wound 	
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	<p>examine his skin from head to toe daily. [Client A] uses adult incontinent products. Staff assist him with changing every 2 hrs. (hours) while awake and sleeping and any time that he is wet and initial on the MAR (Medication Administration Record) each time. Staff are trained to report anything unusual including injuries to the skin...."</p> <p>-Client A's record indicated the GER on 12/1/15 at 8:00am was the first notation by a staff that client A had an open pressure sore on his buttocks and a pressure wound under his right arm. No sizes, descriptions, and/or documented appearance of the wounds were recorded.</p> <p>-Client A's 3/1/16 and 12/29/15 nursing assessments did not indicate the descriptions, sizes, stages, and appearances of client A's wounds. Client A's 12/29/15 nursing entry indicated he was seen by the wound care clinic for his open pressure wounds on his buttocks and right arm.</p> <p>On 3/24/16 at 11:30am, an interview with Area Director (AD) #1 was conducted. AD #1 indicated client A's ISP and risk plans were not implemented correctly by the facility staff when client A had developed open pressure sores on his skin on 12/1/15. AD #1 indicated client A's</p>		<p>concerns and injuries of unknown origin).</p> <ul style="list-style-type: none"> · The Program Director and Nurse will attend risk management assessment and protocol training on May 4th, 2016. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · As the client needs change the IDT will meet to address the concerns. Risk plans, IPOP assessment and behavior plans will be revised as needed by the QMRP. · As the client needs change the nurse can increase the frequency that she completes observations with the clients based on the client need. · Staff will be retrained on how to complete skin wound assessments at their staff meeting on 4-25-16. · The Program Coordinator will review the skin wound documentation submitted by the staff on a daily basis. Any concerns will be reported to the Program Director and the nurse. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. · Develop competency based training for wound care and documentation of wound including descriptive terms and any prior pain management to include parameters of time dose, pain scale, when to notify the nurse, documentation and follow up and train staff and verify competency. 	

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NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383
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	<p>12/1/15 BDDS report and investigation did not include how and/or why client A's skin went from no open areas to a level 2 open pressure sore on his buttocks and a level 3 open pressure sore under client A's right arm without staff noting the changes in client A's skin. AD #1 stated client A received a new wheelchair "several" weeks before the open sores were noted. AD #1 indicated the staff were to have recorded client A's skin status each time when they changed him and/or repositioned him. AD #1 indicated client A's open pressure skin sores were not staged, measured, and the appearance documented by the facility staff and the agency nurse.</p> <p>On 4/1/16 at 1:00pm, an interview with AD #2 was conducted. AD #2 indicated client A was at risk for pressure sores on his skin. AD #2 indicated client A's ISP and risk plans were not implemented correctly by the facility staff when client A had developed open pressure sores on his skin on 12/1/15. AD #2 indicated client A's 12/1/15 BDDS report and investigation did not include how and/or why client A's skin went from no open areas to a level 2 open pressure sore on his buttocks and a level 3 open pressure sore under client A's right arm without staff noting the changes in client A's skin. AD #2 stated client A received a new</p>		<p>1. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Competency based training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors, skin/wound concerns and injuries of unknown origin). · The Program Director and Nurse will attend risk management assessment and protocol training on May 4th, 2016. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · As the client needs change the IDT will meet to address the concerns. Risk plans, IPOP assessment and behavior plans will be revised as needed by the QMRP. · As the client needs change the nurse can increase the frequency that she completes observations with the clients based on the client need. · Staff will be retrained on how to complete skin wound assessments at their staff meeting on 4-25-16. · The Program Coordinator will review the skin wound documentation submitted by the staff on a daily basis. Any concerns will be reported to the Program Director and the nurse. 	

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	<p>wheelchair "a few weeks" before client A developed the open sores on his skin. AD #2 indicated the staff were to have recorded client A's skin status each time when they changed him and/or repositioned him. AD #2 indicated client A's opened pressure skin sores were not staged, measured, and the appearance documented by the facility staff and the agency nurse.</p> <p>2. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations from 11/2015 through 3/23/2016 were reviewed on 3/24/16 at 7:33am and did not include client B's open skin areas.</p> <p>During observations on 3/23/16 from 3:00pm until 6:00pm, client B was observed to have open skin areas on the top of her head and on her right wrist. At 4:45pm, client B showed her open areas to the top of her head which were a bright red circular area and a circular open area on her right wrist which was a dime sized bright red area. During the observation period client B did not wear a dressing, did not wear a hat, and both wounds were visible uncovered on client B's skin. At 4:45pm, the RM (Residential Manager) stated client B "picks" the areas on her right wrist and the top of her head open. The RM stated "it is from SIB" and</p>		<ul style="list-style-type: none"> · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. · Develop competency based training for wound care and documentation of wound including descriptive terms and any prior pain management to include parameters of time dose, pain scale, when to notify the nurse, documentation and follow up and train staff and verify competency. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Program Coordinator will review the skin wound documentation submitted by the staff on a daily basis. Any concerns will be reported to the Program Director and the nurse. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. · The nurse will complete weekly observations on Client A and B or more frequently as needed. · The IDT will convene to discuss identified needs as necessary. · The Program Director, Program Coordinator and nurse will review the internal accident/injury reports submitted by staff to ensure that all incidents are being addressed timely and appropriately. · The Quality Improvement Specialist and/or the Area Director will review accident/injury reports 	

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	<p>indicated client B was scheduled to be seen at the wound clinic on 3/24/16.</p> <p>Client B's record was reviewed on 3/24/16 at 10:45am. Client B's 4/20/15 ISP (Individual Support Plan), 5/7/15 BSP (Behavior Support Plan), and 10/2015 Risk plans identified client B was at risk for open sores caused from her SIB of picking her skin until it is open. Client B's 3/17/16 GER (General Event Report) indicated client B "has a sore on right wrist she is continuously picking at...." but did not include the open area on the top of client B's head. Client B's 5/7/15 BSP indicated "...SIB: Self Injurious behavior as identified by skin picking, picking scabs and/or wound on her head...." Client B's Risk plan indicated "Risk for Impaired Skin Integrity...6/5/15 Definition...when opening is created in the skin...[Client B] is currently under the care of the wound care center for treatment of wound on top of her head. She is encouraged to wear a hat to prevent her from picking at areas on top of her head...Complete these steps to treat the ulcer on [client B's] head, per wound care center: Wound care is to be completed daily and anytime [client B] has removed bandage and has picked at her wound. 1. Gently and thoroughly clean area with saline. 2. Cut Prisma dressing in half and lightly moisten</p>		<p>submitted by staff as they complete their audits to ensure that all incidents are being addressed timely and appropriately.</p> <p>1.What is the date by which the systemic changes will be completed? · May 1st, 2016</p>				

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	<p>Prisma dressing with saline and place on wound. 3. Apply dry gauze pad on top of Prisma dressing. 4. Secure with ACE wrap. 5. Document wound appearance, size, and description in skin/wound module in therap (a computerized client record in which the staff documents client specific information)...." Client B's "Wound/Skin" module and client B's record were reviewed and no record was available for review of the sizes, appearances, and description of client B's open wounds on her head and her right wrist.</p> <p>On 3/24/16 at 11:30am, an interview with Area Director (AD) #1 was conducted. AD #1 indicated client B's open skin sores were from SIB. AD #1 indicated client B was seen by the wound care clinic for the areas to her head and right wrist. AD #1 indicated client B's ISP and risk plans were not implemented correctly by the facility staff when client B had developed open sores on her head and right wrist. AD #1 indicated client B should have been prompted and encouraged to wear a hat or covering over the open sores. AD #1 indicated client B's open pressure skin sores were not staged, measured, and the appearance documented by the facility staff and the agency nurse.</p>			

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W 0454 Bldg. 00	<p>On 4/1/16 at 1:00pm, an interview with AD #2 was conducted. AD #2 indicated client B's ISP and risk plans were not implemented correctly by the facility staff when client B had developed open sores on her skin. AD #2 stated client B was at risk for open sores related to her history of skin picking. AD #2 indicated client B's opened skin sores were not staged, measured, and the appearance documented by the facility staff and the agency nurse.</p> <p>This federal tag relates to complaint #IN00188285.</p> <p>9-3-6(a)</p> <p>483.470(l)(1) INFECTION CONTROL</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation, record review, and interview, for 2 of 2 pill crushers used for 2 additional clients who needed their medications crushed (clients D and E), the facility failed to follow Universal Precautions for clients D and E's soiled pill crushers stored as clean.</p> <p>Findings include:</p> <p>On 3/23/16 at 4:18pm, observation and</p>	W 0454	<p>W454 Infection Control</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Pill crushers will be available to each individual client who needs their medications crushed. · Training will be completed with the staff to instruct them to wash the pill crushers out after each med pass to ensure there are no residual 	05/01/2016

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	interviews were completed at the group home and two of two pill crushers were stored as clean in the clean bin on the counter in the medication room. Both pill crushers had a white powdered residue on the inside of each pill crusher. At 4:18pm, GHS (Group Home Staff) #1 asked client D to come to the medication room. GHS #1 selected the purple capped pill crusher on the staff table inside the medication room, uncapped the pill crusher, GHS #1 indicated there was a white colored fine powder residue inside the base container of the pill crusher, GHS #1 inserted client D's oral tablet medication, ground the tablets, and administered the crushed medication to client D. GHS #1 recapped the soiled pill crusher and replaced it inside the clean bin on the staff table. At 4:25am, GHS #1 asked client E to come to the medication room. GHS #1 selected the blue capped pill crusher out of the clean bin on the staff table inside the medication room, uncapped the pill crusher, GHS #1 indicated there was a white colored fine powder residue inside the base container of the pill crusher, GHS #1 inserted client E's oral tablet medications, ground the tablets, and administered the crushed medication to client E. GHS #1 recapped the soiled blue capped pill crusher and replaced it inside the clean bin on the staff table. At 4:35pm, GHS #1 stated		<p>medications left in the pill crusher for the next medication administration.</p> <ul style="list-style-type: none"> Programming will be implemented for Clients D and E to assist with washing their pill crushers. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the same deficient practice. Pill crushers will be available to each individual client who needs their medications crushed. Training will be completed with the staff to instruct them to wash the pill crushers out after each med pass to ensure there are no residual medications left in the pill crusher for the next medication administration. The Program Coordinator will monitor daily when she is in the home to ensure the pill crushers are clean. The nurse will monitor as she is in the home to ensure the pill crushers are clean. <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> Pill crushers will be available to each individual client who needs their medications crushed. 	

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	<p>the pill crushers were washed when they were soiled, "usually daily," and did not wash the pill crushers. At 6:00pm, the purple and blue soiled pill crushers sat inside the clean bin on the staff table inside the medication room stored as clean.</p> <p>On 3/24/16 at 11:30am, an interview and record review with Area Director #1 was conducted. AD #1 indicated facility staff should have followed Core A/Core B medication training manual, dated 2004, for Universal Precautions. On 3/24/16 at 11:30am, the 2004 Core A/Core B Medication Administration training manual page 3 indicated "Universal precautions should also be used when cleaning personal items..." No specific facility policy or procedure was available for review for the care and cleaning of the pill crushers. AD #1 indicated client D and E's pill crushers should have been clean and free of debris.</p> <p>9-3-7(a)</p>		<ul style="list-style-type: none"> · Training will be completed with the staff to instruct them to wash the pill crushers out after each med pass to ensure there are no residual medications left in the pill crusher for the next medication administration. · The Program Coordinator will monitor daily when she is in the home to ensure the pill crushers are clean. · The nurse will monitor as she is in the home to ensure the pill crushers are clean. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Program Coordinator will review with all staff as they complete medication practicums (as new hires and monthly random medication practicums) to ensure that the pill crushers are clean. · The nurse will review will all staff during Core A and B and during medication practicums to ensure that the pill crushers are clean. · The Program Coordinator will monitor daily when she is in the home to ensure the pill crushers are clean. · The nurse will monitor as she is in the home to ensure the pill crushers are clean. <p>1.What is the date by which the systemic changes will be completed?</p> <ul style="list-style-type: none"> · May 1st, 2016 		