STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G384	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA LUTHERAN COMMUNITIES INC	1601 STURDY RD VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	This visit was for an annual fundamental recertification and state licensure survey. Dates of Survey: July 16, 17, and 18, 2012. Facility number: 000898 Provider number: 15G384 AIM number: 100235150 Surveyor: Tracy Brumbaugh, Medical Surveyor III These deficiencies also reflect state findings under 460 IAC 9. Quality Review was completed on 7/23/12 by Tim Shebel, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W0136	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. Based on record review and interview the facility failed to ensure for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) who lived in the home by not developing a documentation system to verify all clients had opportunity to participate in grocery shopping. Findings include: On 7-17-12 at 11:30 a.m. a record review for client #3 was conducted. The Qualified Mental Retardation Professional's (QMRP) quarterly review dated 6-30-12, 3-31-12, 12-31-12 and 9-30-11 failed to indicate client #3 had participated in buying the groceries for her home. A list of community inclusions for the months of January 2012 through June 2012 did not include participation in grocery shopping. On 7-17-12 at 10: 30 a.m. a record review for client #2 was conducted. The QMRP'S quarterly review dated 6-30-12, 3-31-12, 12-31-11, and 9-30-11 failed to indicate client #2 had participated in buying groceries for her home. A list of	W0136	Individuals at this group home have been going grocery shopping and some DSPs have logged the data in the daily event notes in CASPer (the computerized program used by Bethesda). A two and a half month review of event notes (May, June and July) indicate that Client #1 went grocery shopping on 5/19 and 7/12; client #2 did not go due to medical concerns ; client #3 went 5/2/12, 6/7/12; client #4 went 5/10/12, 5/26/12, 6/7/12, and 7/3/12; client #5 went 5/2/12, 5/26/12, 6/1/12 and 7/14/12; client #6 went on 6/19/12. Staff will be retrained on the importance of documenting the individuals' community activities. Staff will now document all community activities and turned down opportunities on the Community Opportunities form. The QMRP will address community activities on the monthly progress note. The QMRP will be responsible for addressing any concerns in this area at the monthly staff meetings.	08/08/2012

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	community inclusions for the months of January 2012 through June 2012 did not include participation in grocery shopping. On 7-17-12 at 8:30 a.m. a record review for client #1 was conducted. The QMRP's quarterly review dated 6-30-12, 3-31-12, 12-31-11, and 9-30-11 failed to indicate client #1 had participated in buying groceries for her home. A list of community inclusion for the months of January 2012 through June 2012 did not include participation in grocery shopping. On 7-16-12 at 4:45 p.m. an interview with client #1 was conducted. Client #1 indicated she did not go to the grocery store. On 7-16-12 at 5:15 p.m. an interview with client #2 was conducted. Client #2 indicated direct care staff took care of buying the groceries for her home but she would be willing to go and help if they needed her to. On 7-16-12 at 5:30 p.m. an interview with client #3 was conducted. Client #3 stated her staff went to the grocery store but she would go and pick out some "good food" if she got to go. On 7-16-12 at 5:45 p.m. an interview with client #4 was conducted. Client #4			

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	indicated direct care staff went to the grocery but she liked to go shopping and would go and help. On 7-16-12 at 5:30 p.m. an interview with direct care staff #1 indicated direct care staff #1, #5 and #6 did the grocery shopping for clients #1, #2, #3, #4, #5, and #6's home. On 7-17-12 at 12:40 p.m. an interview with the Qualified Mental Retardation Professional indicated clients #1, #2, #3, #4, #5 and #6 should be going to the grocery store and buying the groceries for their own home. 9-3-2(a)			

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W0149	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 record review and interview, the facility neglected to ensure the facility's Abuse/Neglect policy was implemented in regard to one of one reviewed abuse allegation for 2 of 6 clients (clients #2 and #6) who lived in the home. Findings include: On 7-16-12 at 11:45 a.m. the facility's BDDS (Bureau of Developmental Disabilities Services) reports for the period from 8-11 through 7-12 indicated the following: -A BDDS report, dated 6-19-12 indicated client #2 was hit on the top right side of her back and her arm by client #6. No injuries were noted. On 7-16-12 at 12:15 p.m. a review of the facility's Abuse/Neglect policy dated 6-11-12 indicated clients would be free from abuse/neglect and an investigation would begin within 24 hours. The Qualified Mental Retardation Professional (QMRP) was interviewed on 7-17-12 at 12:40 p.m. The QMRP indicated the facility's Abuse/Neglect	W0149	The Abuse, Neglect Policy will be followed as written. Staff will be retrained on the importance of reporting any allegation of abuse, neglect, exploitation as soon as possible and the necessity of having an investigation. All allegations of abuse, neglect, exploitation will be investigated and documented using Investigation Report, Addendum C. At the Monthly Risk Management Meeting, in addition to reviewing incident reports, the team will now review the investigation report to ensure that an investigation was completed and if an allegation was substantiated, that a plan is in place to prevent any further concerns in this area. The minutes of the Monthly Risk Management Meeting will reflect that this has been done. The QMRP will be responsible for ensuring that this is done.	08/01/2012

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	policy should be followed at all times. 9-3-2(a)			

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W0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview 1 of 1 BDDS (Bureau of Developmental Disabilities Services) reports which documented client to client aggression, the facility failed to provide evidence of a complete and thorough investigation for clients #2 and #6. Findings include: On 7-16-12 at 11:45 a.m. the facility's BDDS (Bureau of Developmental Disabilities Services) reports for the period from 8-11 through 7-12 indicated the following: -A BDDS report, dated 6-19-12 indicated client #2 was hit on the top right side of her back and her arm by client #6. No injuries were noted. The Qualified Mental Retardation Professional (QMRP) was interviewed on 7-17-12 at 12:40 p.m. The QMRP indicated no investigation was completed for the client to client aggression for client #2 and #6 which happened on 6-19-12. 9-3-2(a)	W0154	Although a formal investigation report was not completed, the incident was reviewed and a determination was made that the allegation was not substantiated. This was documented in the incident report section in CASPer (electronic program used by Bethesda). All allegations of abuse, neglect, exploitation will be investigated and documented using Investigation Report, Addendum C.In additon to reviewing all incident reports at the Risk Management Meeting, the team will now review all investigation reports at the meeting also to ensure that the needed investigations are completed satisfactorily with a written report. The team will ensure that if the allegation is substantiated, that a plan is in place to ensure that the incident does not occur again. The Monthly Risk Managemetn Meeting minutes will reflect this. The QMRP will be responsible for ensuring that this is done.	08/01/2012

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W0249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and interview, for 1 of 3 clients (client #5) observed during medication administration the facility failed to ensure the medication goal was implemented per her Individualized Support Plan (ISP). Findings include: On 7-17-12 at 6:30 a.m. client #5 was observed during her medication administration. Direct care staff (dcs) #1 assisted client #5 with her medications. Client #5 gelled her hands, had her blood pressure taken and agreed with dcs #1 that the date was the 17th. Dcs #1 did not ask client #5 how many pills she received at the medication administration. Client #5 received her Omeprozole 20 milligram (mg) for acid reflux, Fluticasone propionate 50 mcg for breathing, Loratadine 10 mg for allergies, chapstick for dry lips, and Vaseline for her eyelids. On 7-17-12 at 9:00 a.m. a record review for client #5 was conducted. The ISP	W0249	Staff will be retrained on Active Treatment and the importance of working on formal outcomes and taking advantage of teachable moments. The data sheets for the medication related outcomes have been moved to the MAR to make it easier for staff to remember to address and document the outcome during medication administration. The QMRP will be responsible for checking over all data monthly and for addressing any concerns, including failure to train on mediction goals. In addition, during the monthly observation, the Program Manager or designee will document whether or not the medication outcomes were addressed during the medication pass. This will be documented on the Monthly Observation Checklist. Any problems areas from the Monthly Observation Checklist will be reviewed at the next staff meeting.	08/17/2012

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	dated 9-15-11 indicated client #5 had a medication goal to state the correct number of pills at her medication administration. On 7-17-12 at 12:40 p.m. an interview with the Qualified Mental Retardation Professional indicated medication goals she be implemented at all times of opportunity. 9-3-4(a)			

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W0368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed for 4 of 6 clients (clients #1, #2, #5, and #6) to ensure physicians orders were followed during medication administrations. Findings include: On 7-16-12 at 11:45 a.m. a review of the facility's Bureau of Developmental Disability Services (BDDS) reports was conducted. The review indicated the following. -A BDDS report dated 8-11-11 indicated client #2 did not receive her Metoprolol Tartate for her blood pressure which was 144/114. Direct care staff (dcs) #1 made the error. Dcs #1 repeated medication core A on 9-15-11. -A BDDS report dated 8-11-11 indicated client #1 was given her Lisinopril although it should have been held since her blood pressure was in the range to hold the medication. Dcs #1 make the error. Dcs repeated medication core A on 9-15-11. -A BDDS report dated 4-28-12 indicated client #2 was given Carbamazepine 100 milligrams (mg) and it was one of her housemates medications. Dcs #6 made	W0368	All staff will be retrained on Medication Administration. On an ongoing basis, staff will receive some type of medication administration review. A staff person making a medication error will be expected to complete a plan of correction specific to the situation. The Performance Improvement Plan form will be used. The Program Manager or QMRP will review the plan and determine the root cause of the error and if any additional plans need to be put in the place to prevent future errors. These plans will be reviewed by the Risk Management team at the monthly meeting. Any staff making a medication error will receive additional training and if warranted, corrective action. The staff person will be observed adminsitering medication by the nurse or designee at least once monthly for 3 months. The Post Medication Error Observation form will be used. If no problems are noted during the observations for three months, observations will be done periodically thereafter. The QMRP will be responsible for ensuring that this occurs.	08/15/2012

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	the error. -A BDDS report dated 5-28-12 indicated client #5 was given her Aricept at 6:00 a.m. instead of 6:00 p.m. Dcs #2 made the error. -A BDDS report dated 6-10-12 indicated client #6 did not receive her 4:00 p.m. medications which included her Carbamazephine 100 mg. Dcs #1 made the error. -A BDDS report dated 6-10-12 indicated client #2 did not receive her Oxybutynin or her Prilosec at 4:00 p.m. Dcs #1 made the error. On 7-17-12 at 12:00 p.m. a review of the physicians orders (po) dated 6-11-12 for client #1 was conducted. The order indicated client #1 took Lisinopril 20 mgs. for her blood pressure. On 7-17-12 at 12:00 p.m. a review of the po dated 6-4-12 for client #5 indicated she took Aricept daily. On 7-17-12 at 10:30 a.m. a review of the po (no date available) indicated client #2 took carbamazephine, oxybutynin and prilosec. On 7-17-12 at 12:40 p.m. an interview with the Qualified Mental Retardation Professional indicated physicians orders should be followed at all times.			

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W0369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview, the facility failed for 2 of 3 clients (clients #1 and #5) who were observed during medication administration to ensure medications were administered without error for 2 of 19 medication administrations. Findings include: On 7-17-12 at 6:30 a.m. client #5 was observed during her medication administration. Direct care staff (dcs) #1 assisted client #5 with her medications. Client #5 received her Omeprozole 20 milligram (mg) for acid reflux, Fluticasone propionate 50 mcg for breathing, Loratadine 10 mg for allergies, chapstick for dry lips, and Vaseline for her eyelids. Dcs #1 squirted 2 sprays of the Fluticasone propionate 50 mcg into each of client #5's nostrils. The label on the medication indicated 1 spray into each nostril 1 time daily. On 7-17-12 at 9:00 a.m. a record review for client #5 was conducted. The Medication Administration Record (MAR) dated 7-12 indicated client #5	W0369	The Staff person making the error will be retrained on Medication Administration (Core A). She will also receive corrective action. She will be observed administering medications at least once monthly by the nurse or management staff to ensure that she is following the correct procedure in order to avoid future errors. The Post Medication Error Observation form will be used. Three months without any medication errors and she will be observed periodically. All staff will be retrained on Medication Administration. On an ongoing basis, staff will receive some type of medication administration review. A staff person making a medication error will be expected to complete a plan of correction specific to the situation using the Peformance Improvement Plan form. The Program Manager or QMRP will review the plan and determine the cause of the error and if any additional plans need to be put in the place to prevent future errors. These plans will be reviewed by the Risk Management team at the monthly meeting. The staff person will be observed at least once monthly by the nurse or designee for three months and then periodically. The	08/15/2012

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	was prescribed Fluticasone Propionate Nasal Spray and to give one puff into each nostril. On 7-17-12 at 6:47 a.m. client #1 was observed during her medication administation. Dcs #1 assisted client #1 with her medications. Client #1 recieved her Central-vite tablet for nutrtion, Hydrochlorothiazide 25 mg for allergies, Calcium 600 for bones, Fluticasone Propionate Nasal Spray for clear passages, and Bion tears 1 drop in each eye due to dry eyes. Dcs #1 sprayed 1 spray of the Fluticasone nasal spray into client #1's right nostril and 2 sprays in her left nostril. On 7-17-12 at 11:30 a.m. a record review for client #1 was conducted. The MAR dated 7-12 indicated client #1 was to recieve 2 sprays of Fluticasone Nasal Spray into each nostril. On 7-17-12 at 12:40 p.m. an interview with the Qualified Mental Retardation Professional indicated the medication labels and Mar should be followed by staff when administering medications. 9-3-6(a)		Post Medication Error Observation form will be used. The QMRP will be responsible for ensuring that this happens.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G384	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/18/2012

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W0455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview, the facility failed for 1 of 3 clients (client #5) observed during medication administration to ensure gloves were changed between touching the eyes and the lips. Findings include: On 7-17-12 at 6:30 a.m. client #5 was observed during her medication administration. Direct care staff (dcs) #1 assisted client #5 with her medications. Client #5 received her Omeprozole 20 milligram (mg) for acid reflux, Fluticasone propionate 50 mcg for breathing, Loratadine 10 mg for allergies, chapstick for dry lips, and Vaseline for her eyelids. Dcs #1 put on gloves, put Vaseline on client #5's eyelids then used the same gloves to rub Vaseline and chapstick onto client #5's lips. On 7-17-12 at 12:40 p.m. an interview with the Qualified Mental Retardation Professional indicated dcs #1 should have changed her gloves between touching the eyes and the lips of client #5. 9-3-7(a)	W0455	The staff person in question will be retrained on Infection Control by the nurse. She will be observed at least once monthly by the nurse or management staff to ensure that she is following the best infection control practices and using standard precautions. Three months without a problem and observations will be done periodically. This will be documented on the Post Medication Error Observation Form. The QMRP will be responsible for ensuring that this occurs. DSPs receive annual training on Infection Control and Standard Precautions. This will be reviewed as part of the medication administration review training with all staff. A monthly observation will be done by the Program Manager or designee, using the Monthly Observation Checklist. Any concerns will be addressed with the staff person involved and then reviewed at the next staff meeting.	08/15/2012

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W0488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation, record review, and interview, the facility failed for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) to ensure they assisted with the breakfast meal and had the opportunity to assist with the menu preparation. Findings include: 1. On 7-17-12 from 6:00 a.m. until 7:30 a.m. an observation at the home of clients #1, #2, #3, #4, #5, and #6 was conducted. At 7:10 a.m. client #3 asked if bananas could be served with the cereal. Direct care staff (dcs) #2 cut up bananas into a bowl. At 7:10 a.m. dcs #2 placed the bread in the toaster and buttered it as clients #1, #2, #3, and #4 sat at the table. At 7:30 a.m. dcs #2 poured apple juice in cups for clients #1, #2, and #4 as they watched her. On 7-17-12 at 11:30 a.m. a record review for client #1 was conducted. The Comprehensive Functional Assessment dated 6-19-12 indicated client #1 could assist with meal preparation with assistance. On 7-17-12 at 10:30 a.m. a record review	W0488	Staff will be retrained on the importance of taking advantage of teachable moments and teaching the individuals to do for themselves instead of staff doing for them. The Program Manager or designee will complete a monthly observation in which meal preparation will be observed. Any problems relating to the individuals not being involved in meal preparation will be noted on the Monthly Observation Checklist and reviewed at the next staff meeting. A meeting was held on 7-19-12 with the individuals supported. Information was collected to redo menus so that they reflect the individuals favorite foods and that the meals are easier to prepare. The individuals will sign off on the menus showing that they had input. There will be ongoing food discussion to ensure that the menus reflect the food that the individuals like to eat and to prepare. The QMRP will be responsible for ensuring that this happens.	08/15/2012

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	for client #2 was conducted. The Comprehensive Functional Assessment dated 8-5-11 indicated client #2 could assist with meal preparation with assistance. On 7-17-12 at 8:30 a.m. a record review for client #3 was conducted. The Comprehensive Functional Assessment dated 8-9-11 indicated client #3 could assist with meal preparation with assistance. 2. On 7-16-12 at 4:15 p.m. until 6:15 p.m. an observation at the home of clients #1, #2, #3, #4, #5, and #6 was conducted. At 4:30 p.m. a discussion about the posted menu between clients #2 and #3 took place. Clients #2 and #3 indicated they wanted to pick food to put on the menu. Dcs #1, client #2, and client #3 indicated the [QMRP from another home] made the menu. At 4:30 p.m. client #2 indicated she would have scrambled eggs and bacon on the menu and client #3 indicated she would have pizza on the menu. At 5:15 p.m. client #2 indicated she would put pizza, french fries, and milkshakes on the menu if she could. Client #6 indicated she would have pizza, fried chicken, and chocolate pudding for supper. On 7-16-12 at 5:40 p.m. a review of the			

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	posted menu dated 6-30-11 indicated the QMRP planned the menu and the registered dietician approved the menu. The Menu indicated juice, cold cereal, oatmeal, toast, and milk were on the menu for Monday through Friday, Saturday was juice, yogurt, toast, and milk, Sunday was juice, waffles, and milk. Pizza, fried chicken, pudding, french fries and milk shakes were not included on the menu. On 7-17-12 at 11:30 a.m. a record review for client #1 was conducted. The Individualized Support Plan (ISP) dated 6-21-12 indicated client #1 was on a regular diet. On 7-17-12 at 10:30 a.m. a record review for client #2 was conducted. The ISP dated 8-5-11 indicated client #2 was on a regular diet. On 7-17-12 at 8:30 a.m. a record review for client #3 was conducted. The ISP dated 8-11-11 indicated client #3 was on a regular diet. On 7-17-12 at 12:40 p.m. an interview with the Qualified Mental Retardation Professional indicated clients #1, #2, #3, #4, #5, and #6 should fix their own breakfast and should be participating in the making of the menu for their home.			

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	9-3-8(a)			