STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G724	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IN-PACT INC	9321 SULLIVAN LN CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
W000000	This visit was for the investigation of Complaint #IN00158472. Complaint #IN00158472: Substantiated, federal/state deficiencies related to the allegation are cited at W104, W122, W148, W149, W153, W154, W157, W186, W189, W218 and W331. Dates of Survey: November 5, 6, 7, 12, 13 and 14, 2014 Facility number: 004837 Provider number: 15G724 AIM number: 200803700 Surveyor: Christine Colon, QIDP The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/2/14 by Ruth Shackelford, QIDP.	W000000		

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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W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review, for 1 of 3 sampled clients and 1 additional client (clients A and F), the governing body failed to exercise general policy and operating direction over the facility to ensure it developed and implemented a policy and procedure to give group home staff and the outside day program staff guidance on when to contact the facility's nursing services in regards to clients' health concerns. The governing body failed to ensure client A's legally appointed decision makers/health care representatives/parents were notified of injuries of unknown origin and falls with injury. The governing body failed to exercise general policy and operating direction to ensure the facility implemented its written policies and procedures to prevent neglect and/or potential harm in regard to client A's injuries of unknown origin and a pattern of falls with injury. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility specifically addressed the use of head gear to prevent injury in	W000104	All incidents of unknown origin or falls with injuries will be reported to the family within 24 hours. The family will be notified promptly, if it is a more serious injury/illness (ER visit). Responsible person: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. We will be requesting that all verbal communication is followed up in writing. Responsible person: Sheila O'Dell, Group Home Director. Documentation of contact with the family will be noted on the BDDS state incident reports and will be noted on internal incident report, a parent contact log &/or by e-mail. Responsible person: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. When to contact the family is added to his high risk seizure protocol on 11/3/14. Responsible person: Traci Hardesty, QIDP & Sherri DiMarco, RN. All management staff will be retrained on promptly notifying client's parents/guardian of any significant incident(s) and that contact needs to be documented. Responsible person: Sheila O'Dell, Group Home Director. All staff will be	12/14/2014

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	the client's risk plan. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility staff reported client A's lack of bowel movements to the physician as outlined by the client's physician's order and/or program plan. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted investigations in regard to an allegation of abuse, falls with injury and injuries of unknown origin. Findings include: 1. Please refer to W148: The governing body failed for 1 of 3 sampled clients (client A), to promptly notify client A's legally appointed decision makers/health care representatives/family members of falls which resulted in injury and injuries of unknown injury. 2. Please refer to W149: The governing body neglected for 1 of 3 sampled clients and 1 additional client (clients A and F), to implement written policy and procedures to prevent abuse/neglect of a client who had a history of falls with injuries and a pattern of injuries of unknown origin. The governing body neglected to put in place measures to prevent potential harm and/or recurrence		retrained on promptly notifying client's parents/guardian of any significant incident(s) and that contacts needs to be documented. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, at least monthly when internal IRs are being reviewed by upper management; they will check to see if there has been documented contact with the family that is corresponding with the dates of the IRs. BDDS reportable incident reports would be reviewed and noted contacted with family within 24 hours of the incident. Responsible person: Sheila O'Dell, Group Home Director & Traci Hardesty, QIDP. All management staff will be re-trained on the abuse/neglect policy, which includes implementation of policy, reporting and thorough investigation. Responsible person: Sheila O'Dell, Group Home Director. All staff will be re-trained on the abuse/neglect policy. Responsible person: Traci Hardesty, QIDP. A reliability will be completed with each staff to ensure competency. Responsible person: Airielle Rogers, Group Home Manager. To ensure future compliance, the Manager will review all internal incident reports daily when present for injury of unknown origin, falls and significant injuries &/or allegations. Responsible person: Airielle Rogers, Group	

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	in regard to client A's falls with injury and a pattern of injuries of unknown origin. The governing body neglected to specifically address/develop a protocol/risk plan for client A's use of protective head wear and the use of a hand held, portable monitoring system. The governing body neglected to deploy sufficient staffing at the group home to supervise client A in regards to the client's falls with injury. The facility neglected to conduct thorough investigations in regard to abuse/neglect and injuries of unknown origin. 3. Please refer to W153: The governing body failed for 1 of 3 sampled clients (client A), to report injuries of unknown origin immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law. 4. Please refer to W154: The governing body failed to exercise general policy and operating direction over the facility for 1 of 3 sampled clients and 1 additional client (clients A and F), to provide written evidence thorough investigations were conducted in regard to injuries of unknown origin and an allegation of staff abuse. 5. Please refer to W157: The governing		Home Manager. To ensure future compliance, the QIDP will review in the home three times a month, all internal incident reports for injury of unknown, origin, falls and significant injuries &/or allegations the first month and then monthly there after. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, all incident reports will be reviewed at least monthly during the program status review and at least monthly by our Nurse to ensure that the facility's abuse and neglect policy has been followed. Responsible person: Traci Hardesty, QIDP, Sheila O'Dell Group Home Director, and Sherri Dimarrco, RN. Appropriate/sufficient corrective measures are put into place to help prevent future incidents from occurring. We continue to put effective measures in place, but due to the increase of seizures and increase of the severity of these seizures, it has been an ongoing process. It should be noted that many falls and injuries to Client A have been prevented, but not eliminated completely due to the nature of his disability. A head buddy (protective headwear) and was purchased in September 2013. We also purchased a skull cap with his favorite theme on it to wear over the head buddy to help encourage him to wear the head buddy for more protection. Client A's mother made a foam bumper	

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	body failed to exercise general policy and operating direction over the facility to ensure the facility took sufficient/effective corrective measures in regard to preventing client A's falls with injury and injuries of unknown origin. 5. Please refer to W331: The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services specifically addressed/developed a protocol for client A's use of protective head wear. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services monitored client A's bowel movement and fluid intake on a more frequent basis and notified the physician as requested by the physician. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services ensured facility staff reported client A's lack of bowel movements to the physician as outlined by the client's physician's order and/or program plan. This federal tag relates to complaint #IN00158472. 9-3-1(a)		for him to wear on top of a hat of his choice. A script was then requested from the doctor to get a seizure helmet and it was ordered and picked up February 2014. A new helmet that fit better was picked up on April 2014. A program was put into place February 2014 to help encourage and lengthen the time Client A wears the seizure helmet. It was revised December 2014 to track refusals, as we are now requiring him to wear only the helmet, per his doctor's orders. Responsible person: Traci Hardesty, QIDP. Protocol was written for taking Client A to ER (due to falls/possible injuries) and when and who to contact per Client A's mother's request on January 2014. Seizure management risk plan was updated February 2014 and again November 2014. Responsible persons: Sherri DiMarco, RN. Video monitoring system was purchased late December 2013 and the protocol for its use implemented 1-2-14. It is used every day when client A is home. Responsible person: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. A fall risk plan was implemented for client A on Oct. 2013, since he had an increase of falls. This protocol was updated on February 2014 to include protective headwear and a video monitoring system. It was updated again on 11-3-14 to include body checks after each	

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			fall and again on 11-17-14 to include the use of the helmet only. Responsible persons: Sherri DiMarco, RN & Traci Hardesty, QIDP. Old bed was covered with padding, was placed directly on the floor and surrounded by body pillows. Current dresser corners covered with foam. Padding placed on both fireplaces. New, bigger bed purchased in October 2014, which is still surrounded by body pillows on the floor. The old bed was removed due to the wood frame/foot board (wood was covered in foam padding), which he had fallen on with his arm. Responsible persons: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. During times of increased seizure activity and whenever staffing hours allowed, Client A does receives 1:1 staffing. Responsible persons: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. Several anticonvulsant medication changes (new med Fycompa 4/2/14) and VNS adjustments (10/22/14) have been made. Responsible persons: Sherri DiMarco, RN & Airielle Rogers, Group Home Manager. Staff training: 12-3-14, Client A is to wear helmet at all time…, program to document refusals, review of all protective measures that are in place, form revisions, revised high risk plans, reporting procedures, reportable incidents, contact/time frames, completing	

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			reports and investigation. 11-6-14, incident reporting and review of Client A's risk plans. 8-27-14, following protocols and who to call when an emergency arises and documentation for Client A. 3-14-14, Client A's new physical therapy home program. 2-20-14, Review of client A's risk plans, goal to wear seizure helmet, review of guidelines for video monitor, new ISP goals, sending the seizure helmet with Client A to Lakeside and documenting on bowel chart. 1-15-14, review of client A's risk plan for falls from seizures and protocol for communicating with Client A's mother re: injuries and when to take Client A to the ER. 12-3-13, Review of client A's risk plan for seizures and doctor's order for high fiber, fluid intake chart. 10-7-13, review of how seizures affect Client A's cognition and behavior, wearing head buddy or hat with foam ring, what to do when he falls and has an injury and his behavior plan and how to deal with noncompliance. Program was put into place to have Client A come out of his bedroom more, November 2014. Responsible persons: Traci Hardesty, QIDP. Chair with arms is to be used when sitting in the dining room or kitchen, 12/5/14. A meeting has been requested to discuss Client A's continual and increased need for supervision. Responsible person: Sheila O'Dell, Group	

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			Home Director, Client A's family & BDDS. All management staff will be trained on effective corrective measures to help prevent future incidents from occurring. Responsible person: Sheila O'Dell, Group Home Director. To ensure future compliance, all internal and state IR's will be reviewed at least monthly to make sure sufficient/effective corrective actions are in place to prevent recurrence. Responsible person: Sherri DiMarco, RN, Traci Hardesty, QIDP & Sheila O'Dell, Group Home Director. Staff is trained by the nurse upon hire and annually there after on seizures, medication administration, first aid, etc. Staff are also trained on each clients high risk plans and the tracking forms. Responsible person: Sherri DiMarco, RN & Traci Hardesty, QIDP. Staff were trained on the following dates: 12-3-14, Client A is to wear helmet at all time…, program to document refusals, review of all protective measures that are in place, form revisions, revised high risk plans, reporting procedures, reportable incidents, contact/time frames, completing reports and investigation. 11-6-14, incident reporting and review of Client A's risk plans. 8-27-14, following protocols and who to call when an emergency arises and documentation for Client A. 3-14-14, Client A's new physical therapy home program.	

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			2-20-14, Review of client A's risk plans, goal to wear seizure helmet, review of guidelines for video monitor, new ISP goals, sending the seizure helmet with Client A to Lakeside and documenting on bowel chart. 1-15-14, review of client A's risk plan for falls from seizures and protocol for communicating with Client A's mother re: injuries and when to take Client A to the ER. 12-3-13, Review of client A's risk plan for seizures and doctor's order for high fiber, fluid intake chart. 10-7-13, review of how seizures affect Client A's cognition and behavior, wearing head buddy or hat with foam ring, what to do when he falls and has an injury and his behavior plan and how to deal with noncompliance. Responsible person: Traci Hardesty, QIDP. Seizure protocol dated 2/1/14 was updated on 10/1/14 to include protective head wear and updated again on 11/17/14 to include to be worn at all time unless sleeping. It was updated again on 11/19/14 to include calling her and Client A's guardian. Responsible person: Sherri DiMarco, RN. Constipation protocol dated 2/1/14 was updated on 10/1/14 to include medication change and 11/19/14 on when and who to call if after no BM after 3 days. Responsible person: Sherri DiMarco, RN. Fall protocol dated 2/1/14 was updated on 2/4/14 to	

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			include head wear, 10/1/14 & 11/17/14 to include when and who to contact, 11/17/14 to include body checks, and 11/19/14 o include filling out an incident report and to call Client A's mom for any falls. Responsible person: Sherri DiMarco, RN. The internal incident report was revised on 12/5/14 to include what and when to contact the nurse. High risk plan implementation was also added. Whenever, staff have to implement a high risk; they will need to fill out an incident report. Responsible person: Sheila O'Dell, Group Home Director & Traci Hardesty, QIDP. Management staff including RN were trained on the revision to the internal incident report. Responsible person: Sheila O'Dell, Group Home Director. Staff were trained on the revision to the internal incident report. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, record books have been reorganized to ensure ease of use, pertinent charting of medical conditions, etc. The nurse will be able to find the current tracking sheets, incident reports, etc every time that she goes out to visit the homes/clients. Responsible person: Traci Hardesty, QIDP.	
W000122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client			

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	protections requirements are met. Based on interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 of 3 sampled clients and 1 additional client (clients A and F). The facility failed to implement its written policies and procedures to prevent abuse/neglect of clients. The facility failed to immediately report injuries of unknown origin. The facility failed to put in place sufficient/effective corrective measures to prevent client A's falls with injury and injuries of unknown origin. The facility failed to provide written evidence that thorough investigations were conducted in regard to injuries of unknown origin and staff abuse. The facility failed to promptly notify client A's legally appointed decision makers, of his falls with injury and injuries of unknown origin. The facility failed to ensure the facility's nursing services addressed client A's health care needs. Findings include: 1. Please refer to W148: The facility failed for 1 of 3 sampled clients (client A), to promptly notify client A's legally appointed decision makers/health care representatives/family members of falls which resulted in injury and injuries of	W000122	All incidents of unknown origin or falls with injuries will be reported to the family within 24 hours. The family will be notified promptly, if it is a more serious injury/illness (ER visit). Responsible person: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. We will be requesting that all verbal communication is followed up in writing. Responsible person: Sheila O'Dell, Group Home Director. Documentation of contact with the family is noted on the BDDS state incident reports and now will be noted on internal incident report, a parent contact log &/or by e-mail. Responsible person: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. When to contact his family was then added to his high risk seizure protocol on 11/3/14. Responsible person: Traci Hardesty, QIDP & Sherri DiMarco, RN. All management staff will be retrained on promptly notifying client's parents/guardian of any significant incident(s) and that contact needs to be documented. Responsible person: Sheila O'Dell, Group Home Director. All staff will be retrained on promptly notifying client's parents/guardian of any significant incident(s) and that contacts needs to be documented. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, at least monthly when internal IRs	12/14/2014

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	unknown injury. 2. Please refer to W149: The facility neglected for 1 of 3 sampled clients and 1 additional client (clients A and F), to implement written policy and procedures to prevent abuse/neglect of a client who had a history of falls with injuries and a pattern of injuries of unknown origin. The facility neglected to put in place measures to prevent potential harm and/or recurrence in regard to client A's falls with injury and a pattern of injuries of unknown origin. The facility neglected to specifically address/develop a protocol/risk plan for client A's use of protective head wear and the use of of a hand held, portable monitoring system. The facility neglected to deploy sufficient staffing at the group home to supervise client A in regards to the client's falls with injury. The facility neglected to conduct thorough investigations in regard to abuse/neglect and injuries of unknown origin. 3. Please refer to W153: The facility failed for 1 of 3 sampled clients (client A), to report injuries of unknown origin immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.		are being reviewed by upper management; they will check to see if there has been documented contact with the family that is corresponding with the dates of the IRs. BDDS reportable incident reports would be reviewed and noted contacted with family within 24 hours of the incident. Responsible person: Sheila O'Dell, Group Home Director & Traci Hardesty, QIDP. All management staff will be re-trained on the abuse/neglect policy, Responsible person: Sheila O'Dell, Group Home Director. All staff will be re-trained on the abuse/neglect policy. Responsible person: Traci Hardesty, QIDP. A reliability will be completed with each staff to ensure competency. Responsible person: Airielle Rogers, Group Home Manager. To ensure future compliance, the Manager will review all internal incident reports daily when present for injury of unknown origin, falls and significant injuries &/or allegations. Responsible person: Airielle Rogers, Group Home Manager. To ensure future compliance, the QIDP will review in the home three times a month, all internal incident reports for injury of unknown, origin, falls and significant injuries &/or allegations the first month and then monthly there after. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, all incident reports	

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	4. Please refer to W154: The facility failed for 1 of 3 sampled clients and 1 additional client (clients A and F), to provide written evidence thorough investigations were conducted in regard to injuries of unknown origin and an allegation of staff abuse. 5. Please refer to W157: The facility failed for 1 of 3 sampled clients (client A), to ensure the facility took sufficient/effective corrective measures in regard to preventing client A's falls with injury and injuries of unknown origin. 6. Please refer to W331: The facility failed for 1 of 3 sampled clients (client A), to ensure the facility's nursing services specifically addressed/developed a protocol for client A's use of protective head wear. This federal tag relates to complaint #IN00158472. 9-3-2(a)		will be reviewed at least monthly during the program status review and at least monthly by our Nurse to ensure that the facility's abuse and neglect policy has been followed. Responsible person: Traci Hardesty, QIDP, Sheila O'Dell Group Home Director, and Sherri Dimarrco, RN. Staff is trained by the nurse upon hire and annually there after on seizures, medication administration, first aid, etc. Staff are also trained on each clients high risk plans and the tracking forms. Responsible person: Sherri DiMarco, RN & Traci Hardesty, QIDP. Staff were trained on the following dates: 12-3-14, Client A is to wear helmet at all time…, program to document refusals, review of all protective measures that are in place, form revisions, revised high risk plans, reporting procedures, reportable incidents, contact/time frames, completing reports and investigation. 11-6-14, incident reporting and review of Client A's risk plans. 8-27-14, following protocols and who to call when an emergency arises and documentation for Client A. 3-14-14, Client A's new physical therapy home program. 2-20-14, Review of client A's risk plans, goal to wear seizure helmet, review of guidelines for video monitor, new ISP goals, sending the seizure helmet with Dan to Lakeside and documenting on bowel chart.	

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			1-15-14, review of client A's risk plan for falls from seizures and protocol for communicating with Client A's mother re: injuries and when to take Client A to the ER. 12-3-13, Review of client A's risk plan for seizures and doctor's order for high fiber, fluid intake chart. 10-7-13, review of how seizures affect Client A's cognition and behavior, wearing head buddy or hat with foam ring, what to do when he falls and has an injury and his behavior plan and how to deal with noncompliance. Responsible person: Traci Hardesty, QIDP. Seizure protocol dated 2/1/14 was updated on 10/1/14 to include protective head wear and updated again on 11/17/14 to include to be worn at all time unless sleeping. It was updated again on 11/19/14 to include calling her and Client A's guardian. Responsible person: Sherri DiMarco, RN. Constipation protocol dated 2/1/14 was updated on 10/1/14 to include medication change and 11/19/14 on when and who to call if after no BM after 3 days. Responsible person: Sherri DiMarco, RN. Fall protocol dated 2/1/14 was updated on 2/4/14 to include head wear, 10/1/14 & 11/17/14 to include when and who to contact, 11/17/14 to include body checks, and 11/19/14 o include filling out an incident report and to call mom for any falls. Responsible person:	

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			Sherri DiMarco, RN. The internal incident report was revised on 12/5/14 to include what and when to contact the nurse. High risk plan implementation was also added. Whenever, staff have to implement a high risk; they will need to fill out an incident report. Responsible person: Sheila O'Dell, Group Home Director & Traci Hardesty, QIDP. Management staff including RN were trained on the revision to the internal incident report. Responsible person: Sheila O'Dell, Group Home Director. Staff were trained on the revision to the internal incident report. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, record books have been reorganized to ensure ease of use, pertinent charting of medical conditions, etc. The nurse will be able to find the current tracking sheets, incident reports, etc every time that she goes out to visit the homes/clients. Responsible person: Traci Hardesty, QIDP.	
W000148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.			
	Based on record review and interview for	W000148	All incidents of unknown origin or	12/14/2014

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	8 of 8 incident reports reviewed, involving 1 of 3 sampled clients (client A), the facility failed to promptly notify client A's legally appointed decision makers/parents of falls which resulted in injury and injuries of unknown injury. Findings include: A review of the facility's records was conducted at the facility's administrative office on 11/5/14 at 2:35 P.M.. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated the following: -BDDS report dated 8/22/14...Date of Knowledge: 8/23/14...Submitted Date: 8/23/14 involving client A indicated: "[Client A] had a seizure and fell on his right arm. Staff checked him out right after the seizure. He did not have any redness, bruising, swelling and did not complain of pain. When he was showering the next morning, he said ouch when staff held his arm to assist him into the shower. [Client A]'s father came to pick him up for a home visit right after the shower and was informed about the seizure and fall. [Client A]'s arm was starting to swell and because [client A] has a high tolerance for pain, it was felt that this was a serious injury and he		falls with injuries will be reported to the family within 24 hours. The family will be notified promptly, if it is a more serious injury/illness (ER visit). Responsible person: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. We will be requesting that all verbal communication is followed up in writing. Responsible person: Sheila O'Dell, Group Home Director. Documentation of contact with the family is noted on the BDDS state incident reports and now will be noted on internal incident report, a parent contact log &/or by e-mail. Responsible person: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. When to contact family was added to his high risk seizure protocol on 11/3/14. Responsible person: Traci Hardesty, QIDP & Sherri DiMarco, RN. All management staff will be retrained on promptly notifying client's parents/guardian of any significant incident(s) and that contact needs to be documented. Responsible person: Sheila O'Dell, Group Home Director. All staff will be retrained on promptly notifying client's parents/guardian of any significant incident(s) and that contacts needs to be documented. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, at least monthly when internal IRs are being reviewed by upper management; they will check to	

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	needed to be taken to the ER (Emergency Room). Once there, his arm was x-rayed. His arm and wrist are broken and he was given a cast and pain meds. He is to follow up with an orthopedic doctor in 3 days." A review of the attached IR documented by staff dated 8/22/14 indicated: "[Client A] was in bedroom dancing (range of motion) right along the side of bed and had a cluster seizure lasting 5 minutes....And fell on long brown pillow. [Client A] fell on back. [Client A] has a quarter size abrasion on lower back (lumbar)." Review of the BDDS follow up report dated 8/29/14 indicated: "[Client A] was given a permanent cast by the orthopedic doctor on 8/25/14. He is to continue with pain medicine with (sic) needed and follow up in 2 weeks." Further review of the IR failed to indicate the facility immediately notified client A's legally appointed decision makers/parents of the fall with injury. -IR dated 9/5/14 involving client A indicated: "[Client A]'s hand was swollen. [Client A] stated got (sic) stung by a bee to staff (sic) at [Day Program]. [Client A]'s left hand swollen." Further review of the record failed to indicate the facility notified client A's legally appointed decision makers/parents of the injury of unknown origin.		see if there has been documented contact with the family that is corresponding with the dates of the IRs. BDDS reportable incident reports would be reviewed and noted contacted with family within 24 hours of the incident. Responsible person: Sheila O'Dell, Group Home Director & Traci Hardesty, QIDP.	

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	-IR dated 9/8/14 involving client A indicated: "While assisting [client A] with personal hygiene and grooming in the bathroom, staff saw a bruise on left lower leg. [Client A] fell on Aug. 22nd, 2014, Aug. 29th, 2014. [Client A] has a bruise on the left lower leg, just above calf muscle (quarter size, darkish colored)." Further review of the record failed to indicate the facility notified client A's legally appointed decision makers/parents of the injury of unknown origin. -IR dated 9/11/14 involving client A indicated: "While picking [client A] up from [Outside Day Program] a (sic) [Outside Day Program] rep. (representative) brought to my attention that [client A]'s left hand was swollen. I looked at [client A]'s left hand and it was swollen and red with two tiny bumps that were and (sic) inch apart. [Outside Day Program] rep. was unable to tell when it happened. Left hand swollen and red with two tiny bumps and (sic) inch apart from each other. Unknown injury investigation, will monitor daily and continue first aid as needed." Further review of the record failed to indicate the facility notified client A's legally appointed decision makers/parents of the injury of unknown origin.			

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	-IR dated 10/8/14 involving client A indicated: "[Client A] was in his bedroom, listening to music and doing range and motion. While staff was walking into the restroom to assist another consumer [client A] fell on his butt while having a seizure. He has 1/2 inch circle shape scratches on (3) of his knuckles on the right hand. Cleaned and Triple Antibiotic cream." Further review of the record failed to indicate the facility notified client A's legally appointed decision makers/parents of this fall with injury. -IR dated 10/10/14 involving client A indicated: "[Client A] was in room doing range and motion when he went into a 3 minute seizure that caused him to hit his back on his dresser and fall to the ground. Nickel sized bruise on lower back. Keep an eye on the bruise make sure it clear (sic) and not get worse (sic)." Further review of the record failed to indicate the facility notified client A's legally appointed decision makers/parents of the injury of unknown origin. -IR dated 10/15/14 involving client A indicated: "While assisting [client A] staff noticed a rectangular shaped bruise on [client A]'s left thigh. 2 inch x (by) 4 inch rectangle shaped black bruise on left			

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	thigh. We will keep an eye on the bruise to make sure it clears up and don't (sic) get worse." Further review of the record failed to indicate the facility notified client A's legally appointed decision makers/parents of the injury of unknown origin. -IR dated 10/17/14 involving client A indicated: "[Client A] got up from kitchen table had seizure and fell. Right side of forehead has a bruise and a (sic) inch scratch. Area or injury was cleaned with soap and water. Applied Bactine spray and Bacitracin Ointment. 15 minutes of ice pack was applied. Injury was bandaged. [Client A] will be monitored daily, first aid treatment will be given as needed." Further review of the record failed to indicate the facility notified client A's legally appointed decision makers/parents of this fall with injury. An interview with client A's mother was conducted on 11/6/14 at 12:40 P.M.. Client A's mother indicated client A is not able to self report injuries of unknown origin and indicated she requested the facility to notify her of all injuries of unknown origin and client A's falls. Client A's mother further indicated neither she nor client A's father were made aware of the documented falls with			

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	injury or injuries of unknown origin. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/12/14 at 1:30 P.M.. The QIDP indicated there was no written documentation available for review to indicate the facility notified client A's legally appointed decision makers/parents of the documented injuries of unknown origin and falls with injury. This federal tag relates to complaint #IN00158472. 9-3-2(a)			

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W000149	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 1 of 3 sampled clients and 1 additional client (clients A and F), the facility neglected to implement written policy and procedures to prevent abuse/neglect of a client who had a history of falls with injuries and a pattern of injuries of unknown origin. The facility failed to accurately report injuries of unknown origin and falls with injury. The facility neglected to put in place measures to prevent potential harm and/or recurrence in regard to client A's falls with injury and a pattern of injuries of unknown origin. The facility neglected to specifically address/develop a protocol/risk plan for client A's use of protective head wear and the use of a hand held, portable monitoring system. The facility neglected to deploy sufficient staffing at the group home to supervise client A in regards to the client's falls with injury. The facility neglected to conduct thorough investigations in regard to alleged abuse/neglect and injuries of unknown origin. Findings include:	W000149	All management staff will be re-trained on the abuse/neglect policy, Responsible person: Sheila O'Dell, Group Home Director. All staff will be re-trained on the abuse/neglect policy. Responsible person: Traci Hardesty, QIDP. A reliability will be completed with each staff to ensure competency. Responsible person: Airielle Rogers, Group Home Manager. To ensure future compliance, the Manager will review all internal incident reports daily when present for injury of unknown origin, falls and significant injuries &/or allegations. Responsible person: Airielle Rogers, Group Home Manager. To ensure future compliance, the QIDP will review in the home three times a month, all internal incident reports for injury of unknown, origin, falls and significant injuries &/or allegations the first month and then monthly there after. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, all incident reports will be reviewed at least monthly during the program status review and at least monthly by our Nurse to ensure that the facility's abuse and neglect policy has been	12/14/2014

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	1. A review of the facility's records was conducted at the facility's administrative office on 11/5/14 at 2:35 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated: -BDDS report dated 8/22/14...Date of Knowledge: 8/23/14...Submitted Date: 8/23/14 involving client A indicated: "[Client A] had a seizure and fell on his right arm. Staff checked him out right after the seizure. He did not have any redness, bruising, swelling and did not complain of pain. When he was showering the next morning, he said ouch when staff held his arm to assist him into the shower. [Client A]'s father came to pick him up for a home visit right after the shower and was informed about the seizure and fall. [Client A]'s arm was starting to swell and because [client A] has a high tolerance for pain, it was felt that this was a serious injury and he needed to be taken to the ER (Emergency Room). Once there, his arm was x-rayed. His arm and wrist are broken and he was given a cast and pain meds. He is to follow up with an orthopedic doctor in 3 days." A review of the attached IR documented by staff dated 8/22/14 indicated: "[Client A] was in bedroom		followed. Responsible person: Traci Hardesty, QIDP, Sheila O'Dell Group Home Director, and Sherri Dimarrco, RN.	

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	dancing (range of motion) right along the side of bed and had a cluster seizure lasting 5 minutes. And (sic) fell on long brown pillow. [Client A] fell on back. [Client A] has a quarter size abrasion on lower back (lumbar)." Review of the BDDS follow up report dated 8/29/14 indicated: "[Client A] was given a permanent cast by the orthopedic doctor on 8/25/14. He is to continue with pain medicine with (sic) needed and follow up in 2 weeks." Further review failed to indicate the facility conducted an investigation in regards to the difference in reporting of the same incident. Confidential interview #1 indicated when client A's father arrived at the group home to pick him up for a family visit, client A's father noticed client A's hand was swollen and asked staff what happened to his hand. Staff informed client A's father they did not know but informed him that client A had a seizure the previous night, and that could have been the cause of the swelling. Group home staff informed client A's father the facility was planning on transporting client A to the doctors later in the week. Client A's father insisted on transporting client A immediately and did not want to wait until later. Client A's father transported him to the hospital for evaluation.			

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	A review of client A's hospital record dated 8/23/14 was conducted at the hospital on 11/13/14 at 1:30 P.M.. Review of the hospital record indicated: "Notes by [Hospital Registered Nurse] on 8/23/14 at 1:07 P.M.....PT (patient) to ER (Emergency Room) C/O (complaints of) right arm pain. PT has HX (History) of seizure disorder and staff believes he may have injured his arm during seizure last night....Staff from group home reported typical seizure last night and fell out of bed. States now with some swelling and report of pain to RT (right) arm as well as some redness to left forearm. PT unable to provide reliable history due to mental disability and parents state high pain tolerance. States continues to appear to be in pain when touching arm or moving prompting ED (Emergency Department) evaluation....XR (X-ray) forearm left 2 views: Smooth bone density near the styloid process of the ulna (wrist)....XR forearm right 2 views: Oblique recent fracture through the distal ulna proximal to the styloid process (elbow)....Complete fracture through the olecranon (bony part of elbow) involving the articular surface. There appears to be partial union suggesting that this fracture is old....Encounter Diagnoses: 1. Right distal ulnar fracture, 2. Olecranon			

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	fracture, right." -BDDS report dated 5/5/14 involving client F indicated: "[Outside Day Program] staff overheard [client F]'s group home staff speaking to him in a loud voice, saying things like 'Keep your hands off me' and 'You need to hurry up' when he said that he needed to use the restroom." Further review of the record failed to indicate the facility interviewed the day program staff in regard to the incident. -IR dated 9/5/14 involving client A indicated: "[Client A]'s hand was swollen. [Client A] stated got (sic) stung by a bee to staff (sic) at [Day Program]. [Client A] left hand swollen." No written documentation was available for review to indicate an investigation was conducted in regard to this injury of unknown origin. -IR dated 9/8/14 involving client A indicated: "While assisting [client A] with personal hygiene and grooming in the bathroom, staff saw a bruise on left lower leg. [Client A] fell on Aug. 22nd, 2014, Aug. 29th, 2014. [Client A] has a bruise on the left lower leg, just above calf muscle (quarter size, darkish colored)." No written documentation was available for review to indicate an			

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	investigation was conducted in regard to this injury of unknown origin. -IR dated 9/11/14 involving client A indicated: "While picking [client A] up from [Outside Day Program] a (sic) [Outside Day Program] rep. (representative) brought to my attention that [client A]'s left hand was swollen. I looked at [client A]'s left hand and it was swollen and red with two tiny bumps that were and (sic) inch apart. [Outside Day Program] rep. was unable to tell when it happened. Left hand swollen and red with two tiny bumps and (sic) inch apart from each other. Unknown injury investigation, will monitor daily and continue first aid as needed." No written documentation was available for review to indicate an investigation was conducted in regard to this injury of unknown origin. -IR dated 10/8/14 involving client A indicated: "[Client A] was in his bedroom, listening to music and doing range and motion. While staff was walking into the restroom to assist another consumer [client A] fell on his butt while having a seizure. He has 1/2 inch circle shape scratches on (3) of his knuckles on the right hand. Cleaned and Triple Antibiotic cream." Further review of the record failed to indicate the facility			

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	conducted an investigation in regard to this unwitnessed fall with injury. -IR dated 10/15/14 involving client A indicated: "While assisting [client A] staff noticed a rectangular shaped bruise on [client A]'s left thigh. 2 inch x (by) 4 inch rectangle shaped black bruise on left thigh. We will keep an eye on the bruise to make sure it clears up and don't get worse." Further review of the record failed to indicate the facility conducted an investigation in regard to the injury of unknown origin. An interview with the Group Home Director (GHD) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/12/14 at 1:30 P.M.. The QIDP indicated all allegations of abuse and neglect and injuries of unknown origin should be investigated. When asked if the above incidents were investigated, the QIDP indicated if the incidents were investigated the investigations would have been submitted. No investigations were submitted for review in regards to the mentioned incidents. 2. A review of the facility's records was conducted at the facility's administrative office on 11/5/14 at 2:35 P.M.. Review of the facility's Bureau of Developmental			

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	Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated: -IR dated 9/5/14 involving client A indicated: "[Client A]'s hand was swollen. [Client A] stated got (sic) stung by a bee to staff (sic) at [Day Program]. [Client A's] left hand swollen." Further review of the record failed to indicate the facility immediately notified the administrator of the injury of unknown origin. An interview with the outside day program staff was conducted on 11/12/14 at 3:00 P.M.. The outside day program staff indicated client A was not stung by a bee while at the outside day program and further indicated client A was transported by the group home staff to the day program with his hand swollen. The day program staff indicated when the day program staff inquired about his swollen hand, the group home staff indicated client A was stung by a bee while on an outing with the group home. -IR dated 9/8/14 involving client A indicated: "While assisting [client A] with personal hygiene and grooming in the bathroom, staff saw a bruise on left lower leg. [Client A] fell on Aug. 22nd, 2014, Aug. 29th, 2014. [Client A] has a			

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	bruise on the left lower leg, just above calf muscle (quarter size, darkish colored)." Further review of the record failed to indicate the facility immediately notified the administrator of the injury of unknown origin. -IR dated 9/11/14 involving client A indicated: "While picking [client A] up from [Outside Day Program] a (sic) [Outside Day Program] rep. (representative) brought to my attention that [client A]'s left hand was swollen. I looked at [client A]'s left hand and it was swollen and red with two tiny bumps that were and (sic) inch apart. [Outside Day Program] rep. was unable to tell when it happened. Left hand swollen and red with two tiny bumps and (sic) inch apart from each other. Unknown injury investigation, will monitor daily and continue first aid as needed." Further review of the record failed to indicate the facility immediately notified the administrator of the injury of unknown origin. -IR dated 10/15/14 involving client A indicated: "While assisting [client A] staff noticed a rectangular shaped bruise on [client A]'s left thigh. 2 inch x (by) 4 inch rectangle shaped black bruise on left thigh. We will keep an eye on the bruise to make sure it clears up and don't get			

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	worse." Further review of the record failed to indicate the administrator was immediately notified of this injury of unknown origin. An interview with the Group Home Director (GHD) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/12/14 at 1:30 P.M.. The QIDP indicated there was no written documentation to indicate the administrator was immediately notified of the injuries of unknown origin. The QIDP further indicated the administrator should have been immediately notified of the the mentioned injuries of unknown origin. 3. A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR) and investigation records was conducted on 11/5/14 at 2:35 P.M.. Review of the records indicated: -BDDS reports dated 8/29/14 involving client A indicated: "[Client A] was getting out of bed, had a seizure and fell on the floor. He hit his head on the floor and it was bleeding. Staff applied first aid treatment, called his guardians and took him to the Emergency Room for evaluation. [Client A] had a CAT scan (xray) but no concussion was noted. ER			

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	personnel cleaned and dressed the wound then discharged him." A review of client A's "Emergency Department" notes dated 8/29/14 was conducted at the hospital on 11/13/14 at 1:30 P.M.. and indicated: "Final Diagnoses: Head injury, unspecified, Contusion of face, scalp and neck except eye(s)...ED (Emergency Department) Notes: Pt (patient) to ed for eval (evaluation) of head lac (laceration) s/p fall. Pt has history of seizures care giver states he may have had one today during the fall unwitnessed. Per care giver pt lives at group home. Mother was notified and is requesting the wound be glue (sic) not staples....9:04 A.M., [client A] is a 30 y.o. (year old) male who presents to the ED for a head injury which occurred during seizure activity. Pt's caregiver states she is uncertain of the type of seizure but believes the patient struck his head. Caregiver reports a history of grand mal seizures." -Outside Day Program BDDS report dated 9/18/14 involving client A indicated: "[Client A] was in transition to the next activity. Staff noticed [client A] on the floor having a seizure. Staff swiped his VNS (Vagus Nerve Stimulator) and noticed droplets of blood			

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	under his head. The nurse was called. Nurse noticed a wound approximately 1/2 - 3/4 inch that was bleeding. Wound was cleaned and an ice pack and pressure was applied. Bleeding subsided but did not completely stop. [Facility] was contacted. The nurse recommended that [client A] be checked out by a physician. [Client A] remained awake, alert and talkative throughout the event. [Facility] staff came and picked [client A] up. Staff was taking [client A] to be checked by a physician." A review of client A's "Emergency Department" notes dated 8/29/14 was conducted at the hospital on 11/13/14 at 1:30 P.M.. and indicated: "Encounter Diagnoses: Scalp abrasion...Mother reports that he has absent, tonic/clonic, atonic, myoclonic seizures....Patient's caregiver is in the room and states patient had his typical seizure and fell backwards and scrapped (sic) his head on the doorknob. Caregiver and Mother are in the room and state that he appears his normal self. Patient has an extensive seizure history and his neurologist is at [Hospital name]. They state that he has been on 40 different seizure meds over the course of his disease process and has seizures on a daily basis...."			

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	An evening observation was conducted at the group home on 11/5/14 from 4:10 P.M. until 5:15 P.M.. During the entire observation, client A walked around his room and did not wear protective head gear or a seizure helmet. Client A did not and was not prompted to wear a seizure helmet or protective head gear. An interview with Direct Support Professional (DSP) #3 was conducted on 11/5/14 at 4:30 P.M.. DSP #3 indicated client A was non compliant in wearing a seizure helmet. DSP #3 indicated client A wore a brimmed hat with a black sponge around the top that his mother made for him. DSP A indicated client A did not wear a protective head garment to protect him from head injury while mobile. A review of client A's record was conducted on 11/7/14 at 10:50 A.M.. Review of client A's record failed to indicate an assessment had been completed to address the use of protective head wear to prevent injury due to seizures. An outside day program observation was conducted on 11/12/14 from 1:30 P.M. until 2:55 P.M.. During the entire observation period client A wore a			

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	seizure helmet while he interacted with staff, playing horse shoes. At 3:00 P.M., client A was observed entering the elevator leaving with his staff going to the group home. Client A was wearing a brimmed hat with a black circular sponge at the top. An interview with the outside day program line specialist was conducted on 11/12/14 at 2:30 P.M.. The line specialist indicated client A wears a brimmed hat to the day program and then changes into a seizure helmet to protect his head from injury. The line specialist indicated client A is compliant with wearing the seizure helmet. The line specialist indicated when group home staff arrive to transport client A he then puts back on the brimmed hat with the circular sponge at the top. The line specialist further indicated the seizure helmet is kept at the day program to prevent him from having falls with injury when he has seizures while at the day program. An interview with the Group Home Director (GHD) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/12/14 at 1:30 P.M.. The QIDP indicated client A had not been assessed for the use of protective head gear to protect him from			

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	injury when he has seizures. The QIDP indicated client A has a history of falls with head injury due to seizure activity. No documentation was available for review to indicate the facility took sufficient/effective corrective action to prevent recurrence. An interview with the Group Home Director and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/12/14 at 1:30 P.M.. The GHD indicated the facility has moved client A's room furniture around and padded the furniture to prevent him from getting injured during seizure activity. 4. An evening observation was conducted at the group home on 11/5/14 from 4:10 P.M. until 5:15 P.M.. During the entire observation period client A was in his room unattended. At 4:20 P.M., client A got up from lying on his bedroom floor and walked over to his bedroom window with no protective head gear on and no supervision, and stood gazing out of the window. Direct Support Professional (DSP) #1 was in the kitchen with client C helping him with his snack and preparing dinner. DSP #2 carried a hand held monitor with him into			

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	the bathroom as he assisted client B in the bathroom with the door shut. DSP #3 was in the living room interacting with client D. Client E walked around the group home with no activity and client F stayed in his bedroom in the lower level of the group home. A review of the group home staff schedules dated 9/5/14 to 11/13/14 was reviewed on 11/7/14 at 6:00 P.M.. Review of the staffing schedules indicated 2 scheduled staff for the morning awake shift (6:00 A.M. to 2:00 P.M.), 3 scheduled staff for the evening awake shift (1:00 P.M. to 9:00 P.M.) and 1 scheduled staff for the overnight asleep shift (9:00 P.M. to 10:00 A.M.) The staff schedules dated 9/5/14 to 11/13/14 indicated the facility neglected to ensure sufficient staff were scheduled at the group home to provide 24 hour supervision for clients A and F. A review of client A's record was conducted on 11/7/14 at 10:50 A.M.. The Individual Support Plan (ISP) dated 2/12/14 indicated: "24 hour supervision is provided to assist in any emergency situation." Further review of the record indicated client A required supervision at all times due to his seizure activity and repeated falls with injury.			

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	A review of client F's record was conducted on 11/7/14 at 11:30 A.M.. The ISP dated 12/11/13 indicated: "24 hour supervision is provided to assist in any emergency situation." An interview with the Group Home Director (GHD) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/12/14 at 1:30 P.M.. The QIDP indicated there are always 2 staff scheduled during the morning awake shift, 3 sometimes 4 scheduled staff during the evening awake shift and 1 scheduled staff during the overnight asleep shift. The QIDP indicated it was hard staffing more staff at the group home due to lack of available staff. The GHD indicated if the facility scheduled any more staff, it would put the facility out of budget. The GHD indicated client A required supervision at all times due to his seizure activity and falls with injury. A review of the facility's records was conducted at the facility's administrative office on 11/6/14 at 7:00 P.M.. Review of the facility's "28. POLICY ON REPORTING AND INVESTIGATING INCIDENTS AND ALLEGATIONS OF ABUSE AND NEGLECT", no date			

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	noted, indicated, in part, the following: "... Consumers must not be subjected to abuse by anyone, including, but not limited to, facility staff, other consumers...Until the incident is reported and investigated, one may not be able to determine whether it is abuse (willful), neglect, or mistreatment but the incident must be treated as an allegation of abuse, neglect or mistreatment and follow the regulations for reporting, responding, investigating and correcting... The term 'willful' does not have to do with 'competence' but with 'intent' to cause harm. Someone with a mental illness or mental retardation can willfully inflict harm to someone who has been bothering them, even though they may not be considered 'competent'... It is mandatory in all situations involving abuse, neglect, exploitation, mistreatment of an individual or the violation of an individual's rights that there is notification made to legal representative, guardian/parent, if applicable, Case Manager, if applicable, BDDS (Bureau of Developmental Disabilities Services), APS/CPS (Adult Protection Services/Child Protection Services) and other person the (sic) designated by the consumer...Physical-includes willful infliction of injury, unnecessary physical or chemical restraints or isolation, and punishment with resulting physical harm			

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	or pain....b. Neglect-includes failure to provide appropriate care, food, medical care or supervision." This federal tag relates to complaint #IN00158472. 9-3-2(a)			

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W000153	483.420(d)(2) STAFF TREATMENT OF CLIENTS 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. Based on record review and interview, the facility failed for 1 of 3 sampled clients (client A), to report injuries of unknown origin immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law. Findings include: A review of the facility's records was conducted at the facility's administrative office on 11/5/14 at 2:35 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated: -IR dated 9/5/14 involving client A indicated: "[Client A]'s hand was swollen. [Client A] stated got (sic) stung by a bee to staff (sic) at [Day Program]. [Client A] left hand swollen." Further review of the record failed to indicate the facility immediately notified the administrator of the injury of unknown origin.	W000153	All management staff will be re-trained on the abuse/neglect policy, which includes immediate reporting to administrator. Responsible person: Sheila O'Dell, Group Home Director. All staff will be re-trained on the abuse/neglect policy, which includes immediate reporting to administrator within 24 hours. Responsible person: Traci Hardesty, QIDP. A reliability will be completed with each staff to ensure competency. Responsible person: Airielle Rogers, Group Home Manager. To ensure future compliance, the Manager will review all internal incident reports daily when present for injury of unknown origin, falls and significant injuries &/or allegations. Responsible person: Airielle Rogers, Group Home Manager. To ensure future compliance, the QIDP will review in the home three times a month, all internal incident reports for injury of unknown, origin, falls and significant injuries &/or allegations the first month and then monthly there after. Responsible person: Traci Hardesty, QIDP. To ensure future	12/14/2014

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	An interview with the outside day program staff was conducted on 11/12/14 at 3:00 P.M.. The outside day program staff indicated client A was not stung by a bee while at the outside day program and further indicated client A was transported by the group home staff to the day program with his hand swollen. The day program staff indicated when the day program staff inquired about his swollen hand, the group home staff indicated client A was stung by a bee while on an outing with the group home. When asked if client A was capable of self reporting injuries, the day program staff indicated he was not. -IR dated 9/8/14 involving client A indicated: "While assisting [client A] with personal hygiene and grooming in the bathroom, staff saw a bruise on left lower leg. [Client A] fell on Aug. 22nd, 2014, Aug. 29th, 2014. [Client A] has a bruise on the left lower leg, just above calf muscle (quarter size, darkish colored)." Further review of the record failed to indicate the facility immediately notified the administrator of the injury of unknown origin. -IR dated 9/11/14 involving client A indicated: "While picking [client A] up from [Outside Day Program] a (sic)		compliance, all incident reports will be reviewed at least monthly during the program status review and at least monthly by our Nurse to ensure that the facility's abuse and neglect policy has been followed. Responsible person: Traci Hardesty, QIDP, Sheila O'Dell Group Home Director, and Sherri Dimarrco, RN.	

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NAME OF PROVIDER OR SUPPLIER IN-PACT INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9321 SULLIVAN LN CROWN POINT, IN 46307	

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	[Outside Day Program] rep. (representative) brought to my attention that [client A]'s left hand was swollen. I looked at [client A]'s left hand and it was swollen and red with two tiny bumps that were and (sic) inch apart. [Outside Day Program] rep. was unable to tell when it happened. Left hand swollen and red with two tiny bumps and (sic) inch apart from each other. Unknown injury investigation, will monitor daily and continue first aid as needed." Further review of the record failed to indicate the facility immediately notified the administrator of the injury of unknown origin.. -IR dated 10/15/14 involving client A indicated: "While assisting [client A] staff noticed a rectangular shaped bruise on [client A]'s left thigh. 2 inch x (by) 4 inch rectangle shaped black bruise on left thigh. We will keep an eye on the bruise to make sure it clears up and don't get worse." Further review of the record failed to indicate the administrator was immediately notified of this injury of unknown origin. An interview with the Group Home Director (GHD) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/12/14 at 1:30 P.M.. The QIDP indicated there			

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	was no written documentation to indicate the administrator was immediately notified of the injuries of unknown origin. The QIDP further indicated the administrator should have been immediately notified of the the mentioned injuries of unknown origin. This federal tag relates to complaint #IN00158472. 9-3-2(a)			
W000154	483.420(d)(3)			

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	STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 6 of 6 incidents, involving 1 of 3 sampled clients and 1 additional client (clients A and F), the facility failed to provide written evidence thorough investigations were conducted in regard to injuries of unknown origin and an allegation of staff abuse. Findings include: A review of the facility's records was conducted at the facility's administrative office on 11/5/14 at 2:35 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated: -BDDS report dated 5/5/14 involving client F indicated: "[Outside Day Program] staff overheard [client F]'s group home staff speaking to him in a loud voice, saying things like 'Keep your hands off me' and 'You need to hurry up' when he said that he needed to use the restroom." Further review of the record failed to indicate the facility interviewed the day program staff in regard to the incident. The record failed to indicate the facility conducted a thorough	W000154	All management staff will be re-trained on the abuse/neglect policy, which includes thorough investigation. Responsible person: Sheila O'Dell, Group Home Director. All staff will be re-trained on the abuse/neglect policy, which includes thorough investigation. Responsible person: Traci Hardesty, QIDP. A reliability will be completed with each staff to ensure competency. Responsible person: Airielle Rogers, Group Home Manager. To ensure future compliance, the Manager will review all internal incident reports daily when present for injury of unknown origin, falls and significant injuries &/or allegations. Responsible person: Airielle Rogers, Group Home Manager. To ensure future compliance, the QIDP will review in the home three times a month, all internal incident reports for injury of unknown, origin, falls and significant injuries &/or allegations the first month and then monthly there after. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, all incident reports will be reviewed at least monthly during the program status review and at least monthly by our Nurse to ensure that the facility's abuse and neglect policy has been followed. Responsible person:	12/14/2014

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	investigation in regard to this incident. -BDDS report dated 8/22/14...Date of Knowledge: 8/23/14...Submitted Date: 8/23/14 involving client A indicated: "[Client A] had a seizure and fell on his right arm. Staff checked him out right after the seizure. He did not have any redness, bruising, swelling and did not complain of pain. When he was showering the next morning, he said ouch when staff held his arm to assist him into the shower. [Client A]'s father came to pick him up for a home visit right after the shower and was informed about the seizure and fall. [Client A]'s arm was starting to swell and because [client A] has a high tolerance for pain, it was felt that this was a serious injury and he needed to be taken to the ER (Emergency Room). Once there, his arm was x-rayed. His arm and wrist are broken and he was given a cast and pain meds. He is to follow up with an orthopedic doctor in 3 days." A review of the attached IR documented by staff dated 8/22/14 indicated: "[Client A] was in bedroom dancing (range of motion) right along the side of bed and had a cluster seizure lasting 5 minutes....And fell on long brown pillow. [Client A] fell on back. [Client A] has a quarter size abrasion on lower back (lumbar)." Review of the BDDS follow up report dated 8/29/14		Traci Hardesty, QIDP, Sheila O'Dell Group Home Director, and Sherri Dimarrco, RN.	

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	indicated: "[Client A] was given a permanent cast by the orthopedic doctor on 8/25/14. He is to continue with pain medicine with (sic) needed and follow up in 2 weeks." A review of client A's hospital record dated 8/23/14 was conducted at the hospital on 11/13/14 at 1:30 P.M.. Review of the hospital record indicated: "Notes by [Hospital Registered Nurse] on 8/23/14 at 1:07 P.M.....PT (patient) to ER (Emergency Room) C/O (complaints of) right arm pain. PT has HX (History) of seizure disorder and staff believes he may have injured his arm during seizure last night....Staff from group home reported typical seizure last night and fell out of bed. States now with some swelling and report of pain to RT (right) arm as well as some redness to left forearm. PT unable to provide reliable history due to mental disability and parents state high pain tolerance. States continues to appear to be in pain when touching arm or moving prompting ED (Emergency Department) evaluation....XR (X-ray) forearm left 2 views: Smooth bone density near the styloid process of the ulna (wrist)....XR forearm right 2 views: Oblique recent fracture through the distal ulna proximal to the styloid process (elbow)....Complete fracture through the olecranon (bony part			

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	of elbow) involving the articular surface. There appear to be partial union suggesting that this fracture is old....Encounter Diagnoses: 1. Right distal ulnar fracture, 2. Olecranon fracture, right." Further review of the records failed to indicate the facility conducted an investigation in regard to the difference in the IR indicating client A fell on his back on a pillow and the BDDS report indicating he fell on his arm. -IR dated 9/5/14 involving client A indicated: "[Client A]'s hand was swollen. [Client A] stated got (sic) stung by a bee to staff (sic) at [Day Program]. [Client A]'s left hand swollen." No written documentation was available for review to indicate an investigation was conducted in regard to this injury of unknown origin. An interview with the outside day program staff was conducted on 11/12/14 at 3:00 P.M.. The outside day program staff indicated client A was not stung by a bee while at the outside day program and further indicated client A was transported by the group home staff to the day program with his hand swollen. The day program staff indicated when the day program staff inquired about his swollen			

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	hand, the group home staff indicated client A was stung by a bee while on an outing with the group home. When asked if client A was capable of self reporting injuries, the day program staff indicated he was not. -IR dated 9/8/14 involving client A indicated: "While assisting [client A] with personal hygiene and grooming in the bathroom, staff saw a bruise on left lower leg. [Client A] fell on Aug. 22nd, 2014, Aug. 29th, 2014. [Client A] has a bruise on the left lower leg, just above calf muscle (quarter size, darkish colored)." No written documentation was available for review to indicate an investigation was conducted in regard to this injury of unknown origin. -IR dated 9/11/14 involving client A indicated: "While picking [client A] up from [Outside Day Program] a (sic) [Outside Day Program] rep. (representative) brought to my attention that [client A]'s left hand was swollen. I looked at [client A]'s left hand and it was swollen and red with two tiny bumps that were and (sic) inch apart. [Outside Day Program] rep. was unable to tell when it happened. Left hand swollen and red with two tiny bumps and (sic) inch apart from each other. Unknown injury investigation, will monitor daily and			

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	continue first aid as needed." No written documentation was available for review to indicate an investigation was conducted in regard to this injury of unknown origin. -IR dated 10/8/14 involving client A indicated: "[Client A] was in his bedroom, listening to music and doing range and motion. While staff was walking into the restroom to assist another consumer [client A] fell on his butt while having a seizure. He has 1/2 inch circle shape scratches on (3) of his knuckles on the right hand. Cleaned and Triple Antibiotic cream." Further review of the record failed to indicate the facility conducted an investigation in regard to this unwitnessed fall with injury. An interview with the Group Home Director (GHD) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/12/14 at 1:30 P.M.. The QIDP indicated all allegations of abuse and neglect and injuries of unknown origin should be investigated. When asked if the above incidents were investigated, the QIDP indicated if the incidents were investigated the investigations would have been submitted. No investigations were submitted for review in regards to			

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	the mentioned incidents. This federal tag relates to complaint #IN00158472. 9-3-2(a)			
W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 3 sampled clients (client A), the facility failed to take sufficient/effective corrective measures in regard to addressing a pattern of injuries of unknown origin and falls with injury. Findings include: A review of the facility's records was conducted at the facility's administrative	W000157	Appropriate/sufficient corrective measures are put into place to help prevent future incidents from occurring. We continue to put effective measures in place, but due to the increase of seizures and increase of the severity of these seizures, it has been an ongoing process. It should be noted that many falls and injuries to Client A have been prevented, but not eliminated completely due to the nature of his disability. Client A's mother finally agreed	12/14/2014

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	office on 11/5/14 at 2:35 P.M.. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated the following: -BDDS report dated 8/22/14...Date of Knowledge: 8/23/14...Submitted Date: 8/23/14 involving client A indicated: "[Client A] had a seizure and fell on his right arm. Staff checked him out right after the seizure. He did not have any redness, bruising, swelling and did not complain of pain. When he was showering the next morning, he said ouch when staff held his arm to assist him into the shower. [Client A]'s father came to pick him up for a home visit right after the shower and was informed about the seizure and fall. [Client A]'s arm was starting to swell and because [client A] has a high tolerance for pain, it was felt that this was a serious injury and he needed to be taken to the ER (Emergency Room). Once there, his arm was x-rayed. His arm and wrist are broken and he was given a cast and pain meds. He is to follow up with an orthopedic doctor in 3 days." A review of the attached IR documented by staff dated 8/22/14 indicated: "[Client A] was in bedroom dancing (range of motion) right along the side of bed and had a cluster seizure lasting 5 minutes....And fell on long		to let Client A get a head buddy (protective headwear) and was purchased in September 2013. We also purchased a skull cap with his favorite theme on it to wear over the head buddy to help encourage him to wear the head buddy for more protection. Client A's mother made a foam bumper for him to wear on top of a hat of his choice. A script was then requested from the doctor to get a seizure helmet and it was ordered and picked up February 2014. A new helmet that fit better was picked up on April 2014. A program was put into place February 2014 to help encourage and lengthen the time Client A wears the seizure helmet. It was revised December 2014 to track refusals, as we are now requiring him to wear only the helmet, per his doctor's orders. Responsible person: Traci Hardesty, QIDP. Protocol was written for taking Client A to ER (due to falls/possible injuries) and when and who to contact per Client A's mother's request on January 2014. Seizure management risk plan was updated February 2014 and again November 2014. Responsible persons: Sherri DiMarco, RN. Video monitoring system was purchased late December 2013 and the protocol for its use implemented 1-2-14. It is used every day when client A is home. Responsible person: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. A fall	

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	brown pillow. [Client A] fell on back. [Client A] has a quarter size abrasion on lower back (lumbar)" Review of the BDDS follow up report dated 8/29/14 indicated: "[Client A] was given a permanent cast by the orthopedic doctor on 8/25/14. He is to continue with pain medicine with (sic) needed and follow up in 2 weeks." A review of client A's hospital record dated 8/23/14 was conducted at the hospital on 11/13/14 at 1:30 P.M.. Review of the hospital record indicated: "Notes by [Hospital Registered Nurse] on 8/23/14 at 1:07 P.M.....PT (patient) to ER (Emergency Room) C/O (complaints of) right arm pain. PT has HX (History) of seizure disorder and staff believes he may have injured his arm during seizure last night....Staff from group home reported typical seizure last night and fell out of bed. States now with some swelling and report of pain to RT (right) arm as well as some redness to left forearm. PT unable to provide reliable history due to mental disability and parents state high pain tolerance. States continues to appear to be in pain when touching arm or moving prompting ED (Emergency Department) evaluation....XR (X-ray) forearm left 2 views: Smooth bone density near the styloid process of the ulna (wrist)....XR		risk plan was implemented for client A on Oct. 2013, since he had an increase of falls. This protocol was updated on February 2014 to include protective headwear and a video monitoring system. It was updated again on 11-3-14 to include body checks after each fall and again on 11-17-14 to include the use of the helmet only. Responsible persons: Sherri DiMarco, RN & Traci Hardesty, QIDP. Old bed was covered with padding, was placed directly on the floor and surrounded by body pillows. Current dresser corners covered with foam. Padding placed on both fireplaces. New, bigger bed purchased in October 2014, which is still surrounded by body pillows on the floor. The old bed was removed due to the wood frame/foot board (wood was covered in foam padding), which he had fallen on with his arm. Responsible persons: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. During times of increased seizure activity and whenever staffing hours allowed, Client A does receives 1:1 staffing. Responsible persons: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. Several anticonvulsant medication changes (new med Fycompa 4/2/14) and VNS adjustments (10/22/14) have been made. Responsible persons: Sherri DiMarco, RN & Airielle	

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	forearm right 2 views: Oblique recent fracture through the distal ulna proximal to the styloid process (elbow)....Complete fracture through the olecranon (bony part of elbow) involving the articular surface. There appears to be partial union suggesting that this fracture is old....Encounter Diagnoses: 1. Right distal ulnar fracture, 2. Olecranon fracture, right." -IR dated 9/8/14 involving client A indicated: "While assisting [client A] with personal hygiene and grooming in the bathroom, staff saw a bruise on left lower leg. [Client A] fell on Aug. 22nd, 2014, Aug. 29th, 2014. [Client A] has a bruise on the left lower leg, just above calf muscle (quarter size, darkish colored)." -IR dated 9/11/14 involving client A indicated: "While picking [client A] up from [Outside Day Program] a (sic) [Outside Day Program] rep. (representative) brought to my attention that [client A]'s left hand was swollen. I looked at [client A]'s left hand and it was swollen and red with two tiny bumps that were and (sic) inch apart. [Outside Day Program] rep. was unable to tell when it happened. Left hand swollen and red with two tiny bumps and (sic) inch apart from each other. Unknown injury		Rogers, Group Home Manager. Staff training: 12-3-14, Client A is to wear helmet at all time…, program to document refusals, review of all protective measures that are in place, form revisions, revised high risk plans, reporting procedures, reportable incidents, contact/time frames, completing reports and investigation. 11-6-14, incident reporting and review of Client A's risk plans. 8-27-14, following protocols and who to call when an emergency arises and documentation for Client A. 3-14-14, Client A's new physical therapy home program. 2-20-14, Review of client A's risk plans, goal to wear seizure helmet, review of guidelines for video monitor, new ISP goals, sending the seizure helmet with Dan to Lakeside and documenting on bowel chart. 1-15-14, review of client A's risk plan for falls from seizures and protocol for communicating with Client A's mother re: injuries and when to take Client A to the ER. 12-3-13, Review of client A's risk plan for seizures and doctor's order for high fiber, fluid intake chart. 10-7-13, review of how seizures affect Client A's cognition and behavior, wearing head buddy or hat with foam ring, what to do when he falls and has an injury and his behavior plan and how to deal with noncompliance. Program was put into place to have Client A come out of his bedroom more,	

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	investigation, will monitor daily and continue first aid as needed." -IR dated 10/8/14 involving client A indicated: "[Client A] was in his bedroom, listening to music and doing range and motion. While staff was walking into the restroom to assist another consumer [client A] fell on his butt while having a seizure. He has 1/2 inch circle shape scratches on (3) of his knuckles on the right hand. Cleaned and Triple Antibiotic cream." -IR dated 10/10/14 involving client A indicated: "[Client A] was in room doing range and motion when he went into a 3 minute seizure that caused him to hit his back on his dresser and fall to the ground. Nickel sized bruise on lower back. Keep an eye on the bruise make sure it clear (sic) and not get worse (sic)." -IR dated 10/15/14 involving client A indicated: "While assisting [client A] staff noticed a rectangular shaped bruise on [client A]'s left thigh. 2 inch x (by) 4 inch rectangle shaped black bruise on left thigh. We will keep an eye on the bruise to make sure it clears up and don't get worse." -IR dated 10/17/14 involving client A indicated: "[Client A] got up from		November 2014. Responsible persons: Traci Hardesty, QIDP. Chair with arms is to be used when sitting in the dining room or kitchen, 12/5/14. A meeting has been requested to discuss Client A's continual and increased need for supervision. Responsible person: Sheila O'Dell, Group Home Director, Client A's family & BDDS. All management staff will be trained on effective corrective measures to help prevent future incidents from occurring. Responsible person: Sheila O'Dell, Group Home Director. To ensure future compliance, all internal and state IR's will be reviewed at least monthly to make sure sufficient/effective corrective actions are in place to prevent recurrence. Responsible person: Sherri DiMarco, RN, Traci Hardesty, QIDP & Sheila O'Dell, Group Home Director.	

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	kitchen table had seizure and fell. Right side of forehead has a bruise and a (sic) inch scratch. Area or injury was cleaned with soap and water. Applied Bactine spray and Bacitracin Ointment. 15 minutes of ice pack was applied. Injury was bandaged. [Client A] will be monitored daily, first aid treatment will be given as needed." A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR) and investigation records was conducted on 11/5/14 at 2:35 P.M.. Review of the records indicated: -BDDS reports dated 8/29/14 involving client A indicated: "[Client A] was getting out of bed, had a seizure and fell on the floor. He hit his head on the floor and it was bleeding. Staff applied first aid treatment, called his guardians and took him to the Emergency Room for evaluation. [Client A] had a CAT scan (xray) but no concussion was noted. ER personnel cleaned and dressed the wound then discharged him." A review of client A's "Emergency Department" notes dated 8/29/14 was conducted at the hospital on 11/13/14 at 1:30 P.M.. and indicated:			

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	"Final Diagnoses: Head injury, unspecified, Contusion of face, scalp and neck except eye(s)...ED (Emergency Department) Notes: Pt (patient) to ed for eval (evaluation) of head lac (laceration) s/p fall. Pt has history of seizures care giver states he may have had one today during the fall unwitnessed. Per care giver pt lives at group home. Mother was notified and is requesting the wound be glue (sic) not staples....9:04 A.M., [client A] is a 30 y.o. (year old) male who presents to the ED for a head injury which occurred during seizure activity. Pt's caregiver states she is uncertain of the type of seizure but believes the patient struck his head. Caregiver reports a history of grand mal seizures." -Outside Day Program BDDS report dated 9/18/14 involving client A indicated: "[Client A] was in transition to the next activity. Staff noticed [client A] on the floor having a seizure. Staff swiped his VNS (Vagus Nerve Stimulator)and noticed droplets of blood under his head. The nurse was called. Nurse noticed a wound approximately 1/2 - 3/4 inch that was bleeding. Wound was cleaned and an ice pack and pressure was applied. Bleeding subsided but did not completely stop. [Facility] was contacted. The nurse recommended that [client A] be checked out by a physician.			

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	[Client A] remained awake, alert and talkative throughout the event. [Facility] staff came and picked [client A] up. Staff was taking [client A] to be checked by a physician." A review of client A's "Emergency Department" notes dated 8/29/14 was conducted at the hospital on 11/13/14 at 1:30 P.M.. and indicated: "Encounter Diagnoses: Scalp abrasion...Mother reports that he has absent, tonic/clonic, atonic, myoclonic seizures....Patient's caregiver is in the room and states patient had his typical seizure and fell backwards and scrapped his head on the doorknob. Caregiver and Mother are in the room and state that he appears his normal self. Patient has an extensive seizure history and his neurologist is at [Hospital name]. They state that he has been on 40 different seizure meds over the course of his disease process and has seizures on a daily basis...." No documentation was available for review to indicate the facility took sufficient/effective corrective action to prevent recurrence. An interview with the Group Home Director and the Qualified Intellectual			

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	Disabilities Professional (QIDP) was conducted on 11/12/14 at 1:30 P.M.. The GHD indicated the facility has moved client A's room furniture around and padded the furniture to prevent him from getting injured during seizure activity. This federal tag relates to complaint #IN00158472. 9-3-2(a)			
W000186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation, record review and	W000186	We increase our time with Client	12/14/2014

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	interview, the facility failed for 1 of 3 sampled clients (client A), to deploy direct care staff in a manner to effectively supervise client A in regard to the pattern of injuries/falls. Findings include: An evening observation was conducted at the group home on 11/5/14 from 4:10 P.M. until 5:15 P.M.. During the entire observation period client A was in his room unattended. At 4:20 P.M., client A got up from lying on his bedroom floor and walked over to his bedroom window with no protective head gear on and no supervision, and stood gazing out of the window for 15 minutes. Direct Support Professional (DSP) #1 was in the kitchen with client C helping him with his snack and preparing dinner. DSP #2 had a portable monitor clipped to his waist as he entered into the bathroom and assisted client B in the bathroom with the door shut. DSP #3 was in the upstairs living room interacting with client D. Client E walked around the group home with no activity and client F stayed in his bedroom in the lower downstairs level of the group home with no activity or staff interaction. A review of the group home staff schedules dated 9/5/14 to 11/13/14 was		A when he is having a seizure &/or a rough day of seizures and for doctor appointment &/or ER visits as we would with all clients or ones that may be having behaviors. Other activities may need to be delayed &/or another staff, manager &/or the QIDP may need to be called into work to fulfill this, if needed. Responsible person: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. Client A has a program in place to increase his time to wear the helmet dated 2/14 and was revised to track refusals to wear the helmet 11/15/14. Responsible person: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. A portable video monitoring system was purchased in 12/13 and a protocol for its use was implemented on 1/2/14. The monitor is to allow Client A time in his room if he chooses to be there. Staff always carry the monitor, so they would be immediately notified if there were to be a problem. Responsible person: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager. Due to Client A's seizure disorder, a risk fall assessment was completed and a high risk fall protocol was implemented on 10/13, updated on 2/14 and updated again on 11/14. Responsible person: Sherri DiMarrco, RN & Traci	

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	reviewed on 11/7/14 at 6:00 P.M.. Review of the staffing schedules indicated 2 scheduled staff for the morning awake shift (6:00 A.M. to 2:00 P.M.), 3 scheduled staff for the evening awake shift (1:00 P.M. to 9:00 P.M.) and 1 scheduled staff for the overnight asleep shift (9:00 P.M. to 10:00 A.M.) The staff schedules dated 9/5/14 to 11/13/14 indicated the facility neglected to deploy staff to provide supervision for client A. A review of client A's record was conducted on 11/7/14 at 10:50 A.M.. The Individual Support Plan (ISP) dated 2/12/14 indicated: "24 hour supervision is provided to assist in any emergency situation." Review of client A's "Risk Management Plan-Potential for falls due to Seizure Disorder" dated 2/4/14 indicated: "[Client A] has a seizure disorder. He can have seizures at any time and without warning. This makes him at risk of falls and injury. He has had falls from a seizure in the past; resulting in injury requiring stitches." An interview with the Group Home Director (GHD) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/12/14 at		Hardesty, QIDP. Client A's bedroom furniture had been padded and a new bigger bed was purchased without a wood frame to help prevent injury while in bedroom. Responsible person: Traci Hardesty, QIDP & Sheila O'Dell, Group Home Director. A meeting has been requested to discuss Client A's continual and increased need for supervision. Responsible person: Sheila O'Dell, Group Home Director, Client A's family & BDDS. To ensure future compliance, there will be increased staffing to 4 per evening shift until we can meet with the family. Responsible person: Traci Hardesty, QIDP, Airielle Roger, Group Home Manager & Sheila O'Dell, Group Home Director.	

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	1:30 P.M.. The QIDP indicated there are always 2 staff scheduled during the morning awake shift, 3 sometimes 4 scheduled staff during the evening awake shift and 1 scheduled staff during the overnight asleep shift. The QIDP indicated it was hard staffing more staff at the group home due to lack of available staff. The GHD indicated if the facility scheduled any more staff, it would put the facility out of budget. The GHD indicated client A requires supervision at all times due to his seizure activity and falls with injury. This federal tag relates to complaint #IN00158472. 9-3-3(a)			
W000189	483.430(e)(1) STAFF TRAINING PROGRAM			

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	The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on record review and interview for 1 of 3 sampled clients (client A), the facility failed to ensure all staff who worked with the client A were sufficiently trained to assure competence in following client A's constipation protocol. Findings include: A review of client A's record was conducted on 11/7/14 at 10:50 A.M.. A review of client A's "High Risk Management Plan-Constipation" dated 2/1/14 indicated: "[Client A] has been diagnosed with constipation. 1. Monitor bowel movement pattern on a daily, ongoing basis. 2. Document bowel movements as they occur. Note the shape, size, consistency, and color. Pay close attention to any changes in the bowel movement. 3. Encourage fluid intake, especially water. 4. Maintain a healthy diet, high in fiber, vegetables and fruit as outlined by the Dietician. 5. [Client A] has recently been started on Glycolax (Poly Glycol). His dose is	W000189	The fluid intake form has been revised to include documentation of his home visits. Responsible person: Traci Hardesty, QIDP. Client A's family and day service will be requested to fill out the fluid intake. Responsible person: Sheila O'Dell, Group Home Director & Traci Hardesty, QIDP. The bowel tracking form has been revised to include documentation of his home visits. Responsible person: Traci Hardesty, QIDP. Client A's family and day service will be requested to fill out the bowel tracking form. Responsible person: Sheila O'Dell, Group Home Director & Traci Hardesty, QIDP. Client A's high risk constipation plan was last updated on 10/1/14 to include the changes that the doctor had made. Responsible person: Sherri DiMarrco, RN. Staff were trained on 12/3/13, 2/20/14 and 11/6/14 for his constipation high risk plan, fluid intake and documentation. Staff were retrained again and reviewed the revisions made on the tracking forms. Responsible person: Traci Hardesty, QIDP. The internal incident report was revised on 12/5/14 to include what and when to contact the nurse. High risk plan implementation was also	12/14/2014

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	being adjusted starting at 1 tsp (teaspoon) daily. 6. Encourage physical activity that is appropriate for [client A]. 7. If [client A] goes longer than 3 days without a bowel movement, staff is to administer Bisacodyl 1 tablet 2 times a day until he has a bowel movement. 8. Notify the physician of any change in bowel pattern and observe for any symptoms of constipation such as: firm abdomen, cramping, irritability, decreased appetite, vomiting, and change in normal bowel pattern." Further review of the risk plan failed to indicate when the facility's nursing services were to be contacted. A review of client A's record was conducted on 11/7/14 at 10:50 A.M.. A review of client A's MARs for the month of 10/1/14 to 10/31/14 indicated client A's Bisacodyl medication was discontinued and Miralax 16 gm (grams) 1 scoop daily was started. A review of client A's fluid intake documentation dated 2/1/14 to 10/31/14 indicated: "Staff needs to keep track of [client A]'s liquid intake every day due to a medication that could cause liver dysfunction. Document what he drank and approximately how much he had to		added. Whenever, staff have to implement a high risk; they will need to fill out an incident report. Responsible person: Sheila O'Dell, Group Home Director & Traci Hardesty, QIDP. Management staff were trained on the revision to the internal incident report. Responsible person: Sheila O'Dell, Group Home Director. Staff were trained on the revision to the internal incident report. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, a reliability/test will be created for Client A's high risk plans to show competency. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, this reliability/test will be given and each staff will need to get a score of 100%. Responsible person: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager.	

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	drink. He should be encourage and get at least 8-8oz. (ounces) glasses of fluids daily (water, gatorade, white grape juice...) are acceptable. He can have pop or milk (not a favorite). Please avoid drinks that are caffeinated." Review of the record indicated no fluid intake documented on 2/4/14, 2/18/14, 3/2/14, 3/15/14, 5/26/14, 6/21/14, 6/24/14, 7/5/14, 7/27/14, 8/1/14, 8/11/14, 8/17/14, 9/26/14, 9/27/14, 9/5/14, 9/11/14, 10/5/14, 10/11/14, 10/12/14, 10/16/14, 10/18/14 and 10/19/14. Further review indicated client A did not have 8-8oz glasses of fluid on 2/1, 2/5, 2/11, 2/19, 2/20, 2/21, 2/23, 2/24, 2/25, 2/26, 2/28, 3/3, 3/4, 3/5, 3/7, 3/9, 3/11, 3/13, 3/14, 3/17, 3/18, 3/19, 3/25, 3/26, 3/27, 3/31, 8/5, 8/6, 8/7, 8/12, 8/14, 8/21, 8/26, 8/28, 8/29, 8/31, 9/3, 9/13, 9/16, 9/20, 10/1, 10/2, 10/9, 10/21, 10/24 and 10/27. A review of client A's bowel tracking sheets indicated: No documented bowel movement on 2/1, 2/3, 2/4, 2/7, 2/11, 2/16, 2/17, 2/20, 2/12, 2/22, 2/25, 2/26, 2/28, 3/1, 3/2, 3/5, 3/8, 3/9, 3/13, 3/15, 3/17, 3/20, 3/29, 3/30, 4/1, 4/2, 4/3, 4/6, 4/8, 4/9, 4/11, 4/13, 4/15, 4/16, 4/17, 4/19, 4/20, 4/21, 4/23, 4/24, 4/25, 4/26, 5/1, 5/2, 5/3, 5/4, 5/6, 5/7, 5/9, 5/10, 5/20, 5/21, 5/22, 5/23, 5/24, 5/25, small bowel movement on 5/26, 5/27, 5/16 no bowel on 6/1, 6/2, 6/3, 6/4, 6/8, 6/9, 6/10,			

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	6/11, 6/13, 6/14, 6/15, 6/16, 6/17, 6/18, 6/19, 6/20, 6/21, 6/22, 6/23, 6/24, 6/26, 6/27, 6/28, 6/29, 7/1, 7/2, 7/3, 7/4, 7/5, 7/9, 7/10, 7/11, 7/12, 7/13 7/25, 7/26, 7/27, 7/28, 8/3, 8/4, 8/5, 8/6, 8/25, 8/26, 8/27, 8/28, 9/15, 9/16, 9/17, 10/17, 10/18, 10/19, 10/20, 10/21, There was no documentation to indicate the physician was contacted as directed in his "Constipation Protocol" dated 2/1/14. Review of the documentation failed to indicate staff note the shape, size, consistency, and color of client A's bowels as noted in his protocol. An interview with the Group Home Director (GHD) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/12/14 at 1:30 P.M.. The QIDP indicated client A's constipation protocol had not been updated with the medication change. The QIDP indicated all staff who work at the group home have been trained on the clients' risk plans and how to document properly upon hire, annually and when changes are made to the plans. The QIDP indicated all staff are to document client A's fluid intake as written in his plan and document his bowel movement. The QIDP indicated there was no written documentation to indicate the facility notified the physician of client A's lack of			

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	bowel movements. This federal tag relates to complaint #IN00158472. 9-3-3(a)			
W000218	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, record review and interview, the facility failed for 1 of 3 sampled clients (client A), to assess client A's need for the use a seizure helmet/protective head gear to prevent head injury. Findings include: A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR) and investigation records was conducted on	W000218	A head buddy (protective headwear) and was purchased in September 2013. We also purchased a skull cap with his favorite theme on it to wear over the head buddy to help encourage him to wear the head buddy for more protection. Client A's mother made a foam bumper for him to wear on top of a hat of his choice. A script was then requested from the doctor to get a seizure helmet and it was ordered and picked up February 2014. A new helmet that fit better was picked up on April 2014. The script was found for the	12/14/2014

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	11/5/14 at 2:35 P.M.. Review of the records indicated: -BDDS reports dated 8/29/14 involving client A indicated: "[Client A] was getting out of bed, had a seizure and fell on the floor. He hit his head on the floor and it was bleeding. Staff applied first aid treatment, called his guardians and took him to the Emergency Room for evaluation. [Client A] had a CAT scan (xray) but no concussion was noted. ER personnel cleaned and dressed the wound then discharged him." A review of client A's "Emergency Department" notes dated 8/29/14 was conducted at the hospital on 11/13/14 at 1:30 P.M.. and indicated: "Final Diagnoses: Head injury, unspecified, Contusion of face, scalp and neck except eye(s)...ED (Emergency Department) Notes: Pt (patient) to ed for eval (evaluation) of head lac (laceration) s/p fall. Pt has history of seizures care giver states he may have had one today during the fall unwitnessed. Per care giver pt lives at group home. Mother was notified and is requesting the wound be glue (sic) not staples....9:04 A.M., [client A] is a 30 y.o. (year old) male who presents to the ED for a head injury which occurred during seizure activity.		headgear. Contact was made with that doctor for clarification on the type of headgear that Client A should be allowed to wear. He is to only wear the seizure helmet. Documentation of this is noted in the chronological narratives in Client's medical book. Responsible person: Traci Hardesty, QIDP. A program was put into place February 2014 to help encourage and lengthen the time Client A wears the seizure helmet. It now has been revised 11/15/14 to track refusals, as we are now requiring him to wear only the helmet, per his doctor's orders. Responsible person: Traci Hardesty, QIDP. Seizure protocol dated 2/1/14 was updated on 10/1/14 to include protective head wear and updated again on 11/17/14 to include to be worn at all time unless sleeping. Responsible person: Sherri DiMarco, RN. To ensure future compliance, a reliability/test will be created for Client A's high risk plans to show competency. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, this reliability/test will be given and each staff will need to get a score of 100%. Responsible person: Traci Hardesty, QIDP & Airielle Rogers, Group Home Manager.	

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	Pt's caregiver states she is uncertain of the type of seizure but believes the patient struck his head. Caregiver reports a history of grand mal seizures." -Outside Day Program BDDS report dated 9/18/14 involving client A indicated: "[Client A] was in transition to the next activity. Staff noticed [client A] on the floor having a seizure. Staff swiped his VNS (Vagus Nerve Stimulator)and noticed droplets of blood under his head. The nurse was called. Nurse noticed a wound approximately 1/2 - 3/4 inch that was bleeding. Wound was cleaned and an ice pack and pressure was applied. Bleeding subsided but did not completely stop. [Facility] was contacted. The nurse recommended that [client A] be checked out by a physician. [Client A] remained awake, alert and talkative throughout the event. [Facility] staff came and picked [client A] up. Staff was taking [client A] to be checked by a physician." A review of client A's "Emergency Department" notes dated 8/29/14 was conducted at the hospital on 11/13/14 at 1:30 P.M.. and indicated: "Encounter Diagnoses: Scalp abrasion...Mother reports that he has absent, tonic/clonic, atonic, myoclonic			

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	seizures....Patient's caregiver is in the room and states patient had his typical seizure and fell backwards and scrapped his head on the doorknob. Caregiver and Mother are in the room and state that he appears his normal self. Patient has an extensive seizure history and his neurologist is at [Hospital name]. They state that he has been on 40 different seizure meds over the course of his disease process and has seizures on a daily basis...." An evening observation was conducted at the group home on 11/5/14 from 4:10 P.M. until 5:15 P.M.. During the entire observation, client A walked around his room and did not wear protective head gear or a seizure helmet. Client A did not and was not prompted to wear a seizure helmet or protective head gear. An interview with Direct Support Professional (DSP) #3 was conducted on 11/5/14 at 4:30 P.M.. DSP #3 indicated client A was non compliant in wearing a seizure helmet. DSP #3 indicated client A wore a brimmed hat with a black sponge around the top that his mother made for him. DSP A indicated client A did not wear a protective head garment to protect him from head injury while mobile.			

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	A review of client A's record was conducted on 11/7/14 at 10:50 A.M.. Review of client A's record failed to indicate an assessment had been completed to address the use of protective head wear to prevent injury due to seizures. An outside day program observation was conducted on 11/12/14 from 1:30 P.M. until 2:55 P.M.. During the entire observation period client A wore a seizure helmet while he interacted with staff, playing horse shoes. At 3:00 P.M., client A was observed entering the elevator leaving with his staff going to the group home. Client A was wearing a brimmed hat with a black circular sponge at the top. An interview with the outside day program line specialist was conducted on 11/12/14 at 2:30 P.M.. The line specialist indicated client A wears a brimmed hat to the day program and then changes into a seizure helmet to protect his head from injury. The line specialist indicated client A is compliant with wearing the seizure helmet. The line specialist indicated when group home staff arrive to transport client A he then puts back on the brimmed hat with the circular sponge at the top. The line specialist further indicated the seizure			

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	helmet is kept at the day program to prevent him from having falls with injury when he has seizures while at the day program. An interview with the Group Home Director (GHD) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/12/14 at 1:30 P.M.. The QIDP indicated client A had not been assessed for the use of protective head gear to protect him from injury when he has seizures. The QIDP indicated client A has a history of falls with head injury due to seizure activity. The QIDP indicated client A had seizure helmets but will not wear a seizure helmet. The QIDP further indicated client A's mother was against him wearing a seizure helmet. This federal tag relates to complaint #IN00158472. 9-3-4(a)			
W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 3 sampled clients (client A), the facility's nursing staff	W000331	Staff is trained by the nurse upon hire and annually there after on seizures, medication administration, first aid, etc. Staff	12/14/2014

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	failed to ensure facility staff were adequately trained and showed competency in regard to documenting/tracking client A's bowel movements, fluid intake and implementing client A's constipation protocol. The facility's nursing staff failed to monitor client A's constipation to prevent blockage on a more frequent basis. The facility's nursing staff failed to update health risk protocols and to specifically address what type of protective head gear client A should wear to prevent injury during seizures. Findings include: 1. A review of client A's record was conducted on 11/7/14 at 10:50 A.M.. Review of client A's "Risk Management Plan-Potential for Falls due to Seizure Disorder" dated 2/4/14 indicated: "[Client A] has seizure disorder. He can have seizures at any time and without warning. This makes him at risk of falls and injury. He has had falls from a seizure in the past, resulting in injury requiring stitches. 1. [Client A] is independent and ambulates independently in his home and the community. 2. [Client A] needs to take all his seizure		are also trained on each clients high risk plans and the tracking forms. Responsible person: Sherri DiMarco, RN & Traci Hardesty, QIDP. Staff were trained on the following dates: 12-3-14, Client A is to wear helmet at all time…, program to document refusals, review of all protective measures that are in place, form revisions, revised high risk plans, reporting procedures, reportable incidents, contact/time frames, completing reports and investigation. 11-6-14, incident reporting and review of Client A's risk plans. 8-27-14, following protocols and who to call when an emergency arises and documentation for Client A. 3-14-14, Client A's new physical therapy home program. 2-20-14, Review of client A's risk plans, goal to wear seizure helmet, review of guidelines for video monitor, new ISP goals, sending the seizure helmet with Client A to Lakeside and documenting on bowel chart. 1-15-14, review of client A's risk plan for falls from seizures and protocol for communicating with Client A's mother re: injuries and when to take Client A to the ER. 12-3-13, Review of client A's risk plan for seizures and doctor's order for high fiber, fluid intake chart. 10-7-13, review of how seizures affect Client A's cognition and behavior, wearing head buddy or hat with foam ring, what to do when he falls and has	

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	medication as ordered on time. 3. [Client A] has a special protective head garment that he is to wear anytime he is up and ambulating. It may be removed when showering and sleeping. 4. If [client A] is having a day when he is not feeling well, keep a close eye on him and encourage rest. 5. Keep [client A]'s environment safe and free from hazzard's (sic) that will prevent any injuries. [Client A] has a bed that is very low to the floor to avoid falls. 6. [Client A] is never to take a bath, only a shower. Staff is to stand right outside the shower in the event that [client A] needs assistance or begins to have a seizure. 7. A monitoring system is going to be installed in [client A]'s bedroom with a camera and sound system. It will be portable and held and used by staff to be able to better monitor [client A]'s safety. 8. [Client A] has recently begun wearing protective hear (sic) wear to help protect his head if he does fall or hit his head during a seizure. A plan is in place to help [client A] adjust to wearing the head wear.		an injury and his behavior plan and how to deal with noncompliance. Responsible person: Traci Hardesty, QIDP. Seizure protocol dated 2/1/14 was updated on 10/1/14 to include protective head wear and updated again on 11/17/14 to include to be worn at all time unless sleeping. It was updated again on 11/19/14 to include calling her and Client A's guardian. Responsible person: Sherri DiMarco, RN. Constipation protocol dated 2/1/14 was updated on 10/1/14 to include medication change and 11/19/14 on when and who to call if after no BM after 3 days. Responsible person: Sherri DiMarco, RN. Fall protocol dated 2/1/14 was updated on 2/4/14 to include head wear, 10/1/14 & 11/17/14 to include when and who to contact, 11/17/14 to include body checks, and 11/19/14 o include filling out an incident report and to call client A's mom for any falls. Responsible person: Sherri DiMarco, RN. The internal incident report was revised on 12/5/14 to include what and when to contact the nurse. High risk plan implementation was also added. Whenever, staff have to implement a high risk; they will need to fill out an incident report. Responsible person: Sheila O'Dell, Group Home Director & Traci Hardesty, QIDP. Management staff including RN	

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	9. In the event of any fall related injury, staff is to seek medical care as needed, complete an incident report and notify the supervisor immediately." Further review of the protocol failed to specifically indicate what head gear client A should wear to prevent injury during seizures. A review of client A's "High Risk Management Plan-Constipation" dated 2/1/14 indicated: "[Client A] has been diagnosed with constipation. 1. Monitor bowel movement pattern on a daily, ongoing basis. 2. Document bowel movements as they occur. Note the shape, size, consistency, and color. Pay close attention to any changes in the bowel movement. 3. Encourage fluid intake, especially water. 4. Maintain a healthy diet, high in fiber, vegetables and fruit as outlined by the Dietician. 5. [Client A] has recently been started on Glycolax (Poly Glycol). His dose is being adjusted starting at 1 tsp (teaspoon) daily. 6. Encourage physical activity that is appropriate for [client A]. 7. If [client A] goes longer than 3 days without a bowel movement, staff is to administer Bisacodyl 1 tablet 2 times a		were trained on the revision to the internal incident report. Responsible person: Sheila O'Dell, Group Home Director. Staff were trained on the revision to the internal incident report. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, record books have been reorganized to ensure ease of use, pertinent charting of medical conditions, etc. The nurse will be able to find the current tracking sheets, incident reports, etc every time that she goes out to visit the homes/clients. Responsible person: Traci Hardesty, QIDP.	

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	day until he has a bowel movement. 8. Notify the physician of any change in bowel pattern and observe for any symptoms of constipation such as: firm abdomen, cramping, irritability, decreased appetite, vomiting, and change in normal bowel pattern." Further review of the risk plan failed to indicate when the facility's nursing services were to be contacted. A review of client A's record was conducted on 11/7/14 at 10:50 A.M.. A review of client A's MARs for the month of 10/1/14 to 10/31/14 indicated client A's Bisacodyl medication was discontinued and Miralax 16 gm (grams) 1 scoop daily was started. A review of client A's fluid intake documentation dated 2/1/14 to 10/31/14 indicated: "Staff needs to keep track of [client A]'s liquid intake every day due to a medication that could cause liver dysfunction. Document what he drank and approximately how much he had to drink. He should be encourage and get at least 8-8oz. (ounces) glasses of fluids daily (water, gatorade, white grape juice...) are acceptable. He can have pop or milk (not a favorite). Please avoid drinks that are caffeinated." Review of the record indicated no fluid intake			

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	documented on 2/4/14, 2/18/14, 3/2/14, 3/15/14, 5/26/14, 6/21/14, 6/24/14, 7/5/14, 7/27/14, 8/1/14, 8/11/14, 8/17/14, 9/26/14, 9/27/14, 9/5/14, 9/11/14, 10/5/14, 10/11/14, 10/12/14, 10/16/14, 10/18/14 and 10/19/14. Further review indicated client A did not have 8-8oz glasses of fluid on 2/1, 2/5, 2/11, 2/19, 2/20, 2/21, 2/23, 2/24, 2/25, 2/26, 2/28, 3/3, 3/4, 3/5, 3/7, 3/9, 3/11, 3/13, 3/14, 3/17, 3/18, 3/19, 3/25, 3/26, 3/27, 3/31, 8/5, 8/6, 8/7, 8/12, 8/14, 8/21, 8/26, 8/28, 8/29, 8/31, 9/3, 9/13, 9/16, 9/20, 10/1, 10/2, 10/9, 10/21, 10/24 and 10/27. A review of client A's bowel tracking sheets indicated: No documented bowel movement on 2/1, 2/3, 2/4, 2/7, 2/11, 2/16, 2/17, 2/20, 2/12, 2/22, 2/25, 2/26, 2/28, 3/1, 3/2, 3/5, 3/8, 3/9, 3/13, 3/15, 3/17, 3/20, 3/29, 3/30, 4/1, 4/2, 4/3, 4/6, 4/8, 4/9, 4/11, 4/13, 4/15, 4/16, 4/17, 4/19, 4/20, 4/21, 4/23, 4/24, 4/25, 4/26, 5/1, 5/2, 5/3, 5/4, 5/6, 5/7, 5/9, 5/10, 5/20, 5/21, 5/22, 5/23, 5/24, 5/25, small bowel movement on 5/26, 5/27, 5/16 no bowel on 6/1, 6/2, 6/3, 6/4, 6/8, 6/9, 6/10, 6/11, 6/13, 6/14, 6/15, 6/16, 6/17, 6/18, 6/19, 6/20, 6/21, 6/22, 6/23, 6/24, 6/26, 6/27, 6/28, 6/29, 7/1, 7/2, 7/3, 7/4, 7/5, 7/9, 7/10, 7/11, 7/12, 7/13 7/25, 7/26, 7/27, 7/28, 8/3, 8/4, 8/5, 8/6, 8/25, 8/26, 8/27, 8/28, 9/15, 9/16, 9/17, 10/17, 10/18, 10/19, 10/20, 10/21, There was no			

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	documentation to indicate the physician was contacted as directed in his "Constipation Protocol" dated 2/1/14. Review of the documentation failed to indicate staff note the shape, size, consistency, and color of client A's bowels as noted in his protocol. An interview with the Group Home Director (GHD) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/12/14 at 1:30 P.M.. The QIDP indicated client A's constipation protocol had not been updated with the medication change. The QIDP indicated all staff are to document client A's fluid intake as written in his plan and document his bowel movement. The QIDP indicated there was no written documentation to indicate the facility notified the physician of client A's lack of bowel movements. The QIDP indicated there was no documentation available for review to indicate the facility's nursing services updated client A's constipation protocol, monitored client A's fluid intake and bowel movements. 2. A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR) and investigation records was conducted on 11/5/14 at 2:35 P.M.. Review of the records indicated:			

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	-BDDS reports dated 8/29/14 involving client A indicated: "[Client A] was getting out of bed, had a seizure and fell on the floor. He hit his head on the floor and it was bleeding. Staff applied first aid treatment, called his guardians and took him to the Emergency Room for evaluation. [Client A] had a CAT scan (xray) but no concussion was noted. ER personnel cleaned and dressed the wound then discharged him." A review of client A's "Emergency Department" notes dated 8/29/14 was conducted at the hospital on 11/13/14 at 1:30 P.M.. and indicated: "Final Diagnoses: Head injury, unspecified, Contusion of face, scalp and neck except eye(s)...ED (Emergency Department) Notes: Pt (patient) to ed for eval (evaluation) of head lac (laceration) s/p fall. Pt has history of seizures care giver states he may have had one today during the fall unwitnessed. Per care giver pt lives at group home. Mother was notified and is requesting the wound be glue (sic) not staples....9:04 A.M., [client A] is a 30 y.o. (year old) male who presents to the ED for a head injury which occurred during seizure activity. Pt's caregiver states she is uncertain of the type of seizure but believes the			

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	patient struck his head. Caregiver reports a history of grand mal seizures." -Outside Day Program BDDS report dated 9/18/14 involving client A indicated: "[Client A] was in transition to the next activity. Staff noticed [client A] on the floor having a seizure. Staff swiped his VNS (Vagus Nerve Stimulator) and noticed droplets of blood under his head. The nurse was called. Nurse noticed a wound approximately 1/2 - 3/4 inch that was bleeding. Wound was cleaned and an ice pack and pressure was applied. Bleeding subsided but did not completely stop. [Facility] was contacted. The nurse recommended that [client A] be checked out by a physician. [Client A] remained awake, alert and talkative throughout the event. [Facility] staff came and picked [client A] up. Staff was taking [client A] to be checked by a physician." A review of client A's "Emergency Department" notes dated 8/29/14 was conducted at the hospital on 11/13/14 at 1:30 P.M.. and indicated: "Encounter Diagnoses: Scalp abrasion...Mother reports that he has absent, tonic/clonic, atonic, myoclonic seizures....Patient's caregiver is in the room and states patient had his typical			

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NAME OF PROVIDER OR SUPPLIER IN-PACT INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9321 SULLIVAN LN CROWN POINT, IN 46307	

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	seizure and fell backwards and scrapped his head on the doorknob. Caregiver and Mother are in the room and state that he appears his normal self. Patient has an extensive seizure history and his neurologist is at [Hospital name]. They state that he has been on 40 different seizure meds over the course of his disease process and has seizures on a daily basis...." An evening observation was conducted at the group home on 11/5/14 from 4:10 P.M. until 5:15 P.M.. During the entire observation, client A walked around his room and did not wear protective head gear or a seizure helmet. Client A did not and was not prompted to wear a seizure helmet or protective head gear. An interview with Direct Support Professional (DSP) #3 was conducted on 11/5/14 at 4:30 P.M.. DSP #3 indicated client A was non compliant in wearing a seizure helmet. DSP #3 indicated client A wore a brimmed hat with a black sponge around the top that his mother made for him. DSP A indicated client A did not wear a protective head garment to protect him from head injury while mobile. A review of client A's record was conducted on 11/7/14 at 10:50 A.M..			

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	Review of client A's record failed to indicate an assessment had been completed to address the use of protective head wear to prevent injury due to seizures. An outside day program observation was conducted on 11/12/14 from 1:30 P.M. until 2:55 P.M.. During the entire observation period client A wore a seizure helmet while he interacted with staff, playing horse shoes. At 3:00 P.M., client A was observed entering the elevator leaving with his staff going to the group home. Client A was wearing a brimmed hat with a black circular sponge at the top. An interview with the outside day program line specialist was conducted on 11/12/14 at 2:30 P.M.. The line specialist indicated client A wears a brimmed hat to the day program and then changes into a seizure helmet to protect his head from injury. The line specialist indicated client A is compliant with wearing the seizure helmet. The line specialist indicated when group home staff arrive to transport client A he then puts back on the brimmed hat with the circular sponge at the top. The line specialist further indicated the seizure helmet is kept at the day program to prevent him from having falls with injury			

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	when he has seizures while at the day program. An interview with the Group Home Director (GHD) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/12/14 at 1:30 P.M.. The QIDP indicated client A had not been assessed for the use of protective head gear to protect him from injury when he has seizures. The QIDP indicated client A has a history of falls with head injury due to seizure activity. This federal tag relates to complaint #IN00158472. 9-3-6(a)			
W009999	State Findings: 460 IAC 9-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities	W009999	All management staff will be re-trained on the abuse/neglect policy, which includes immediate reporting to BDDS within 24 hours . Responsible person: Sheila O'Dell, Group	12/14/2014

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	rule was not met: The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division. This state rule is not met as evidenced by: Based on record review and interview, the facility failed for 1 of 3 sampled clients (client A), to report falls with injury to the Bureau of Developmental Disabilities Services (BDDS). Findings include: A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident Reports (IR) and/or investigations was conducted on 11/5/14 at 2:35 P.M.. The facility's reports indicated the following: -IR dated 10/8/14 involving client A indicated: "[Client A] was in his bedroom, listening to music and doing range and motion. While staff was walking into the restroom to assist another consumer [client A] fell on his butt while having a seizure. He has 1/2 inch circle shape scratches on (3) of his knuckles on the right hand. Cleaned and		Home Director. All staff will be re-trained on the abuse/neglect policy, which includes immediate reporting to administrator within 24 hours. Responsible person: Traci Hardesty, QIDP. A reliability will be completed with each staff to ensure competency. Responsible person: Airielle Rogers, Group Home Manager. To ensure future compliance, the Manager will review all internal incident reports daily when present for injury of unknown origin, falls and significant injuries &/or allegations. Responsible person: Airielle Rogers, Group Home Manager. To ensure future compliance, the QIDP will review in the home three times a month, all internal incident reports for injury of unknown, origin, falls and significant injuries &/or allegations the first month and then monthly there after. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, all incident reports will be reviewed at least monthly during the program status review and at least monthly by our Nurse to ensure that the facility's abuse and neglect policy has been followed. Responsible person: Traci Hardesty, QIDP, Sheila O'Dell Group Home Director, and Sherri Dimarrco, RN.	

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	Triple Antibiotic cream." Further review of the record failed to indicate the facility reported this fall with injury to BDDS. -IR dated 10/10/14 involving client A indicated: "[Client A] was in room doing range and motion when he went into a 3 minute seizure that caused him to hit his back on his dresser and fall to the ground. Nickel sized bruise on lower back. Keep an eye on the bruise make sure it clear (sic) and not get worse (sic)." Further review of the record failed to indicate the facility reported this fall with injury to BDDS. -IR dated 10/17/14 involving client A indicated: "[Client A] got up from kitchen table had seizure and fell. Right side of forehead has a bruise and a (sic) inch scratch. Area or injury was cleaned with soap and water. Applied Bactine spray and Bacitracin Ointment. 15 minutes of ice pack was applied. Injury was bandaged. [Client A] will be monitored daily, first aid treatment will be given as needed." Further review of the record failed to indicate the facility reported this fall with injury to BDDS. A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 11/10/14 at			

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	5:50 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS....Incidents to be reported to BDDS...Any injury to an individual when the cause in unknown and the injury could be indicative of abuse, neglect or exploitation....14. A significant injury to an individual that includes but is not limited to: a. a fracture...15. A fall resulting in injury, regardless of the severity of the injury." An interview with the Group Home Director (GHD) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 11/12/14 at 1:30 P.M.. The QIDP indicated the incidents should have been reported immediately to the administrator and within 24 hours to BDDS. The QIDP further indicated the incidents were not reported/reported timely to BDDS. 9-3-1(b)			

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