

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G807		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/07/2012	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330			
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W0000	<p>This visit was for a post-certification revisit survey to the investigation of complaints #IN00104104 and #IN00104527 completed on 3/23/12.</p> <p>Complaint #IN00104104-Not Corrected.</p> <p>Complaint #IN00104527-Not Corrected.</p> <p>Unrelated deficiencies-Not Corrected.</p> <p>Dates of Survey: 5/2, 5/3 and 5/7/12</p> <p>Facility Number: 0012632 Provider Number: 15G807 Aim Number: 201045480</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/14/12 by Ruth Shackelford, Medical Surveyor III.</p>			W0000			

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

TITLE

(X6) DATE

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

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W0102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on interview and record review for 1 of 2 sampled clients (A), the governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of a client in regard to a suicide attempt and to ensure the facility conducted a thorough investigation in regard to the incident.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 1 of 2 sampled clients (A). The governing body failed to implement its policy and procedures to prevent neglect of the client in regard to a suicide gesture and threats of suicide. The governing body failed to implement its policy and procedures to conduct a thorough investigation. Please see W122.</li> <li>The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of client A in regard to the client's self-injurious behaviors of making suicide gestures and/or threats. The governing body failed to ensure an allegation of abuse and/or</li> </ol>	W0102	<p><b>CORRECTION:</b> <i>The Governing Body must exercise general policy, budget and operating direction over the facility.</i> Specifically, the Governing Body has implemented a system for review and tracking of incidents to assist the team with conducting thorough investigation and development of preventative measures to eliminate the potential for neglect. The governing body has also provided increased staffing hours for the facility to promote additional support during behavior episodes.</p> <p><b>PREVENTION:</b> The Governing Body has established a separate Quality Assurance Department to assist with auditing facility systems and developing sound risk management practices, including but not limited to incident investigation and management and development of preventative behavior support strategies.. The Quality Assurance and Operations Teams will work closely to assure the facility receives an appropriate level of support from the Governing Body.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Support Associates, Behavior Support Coordinator, Quality Assurance Team,, Operations Team</p>	06/06/2012			

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	<p>neglect was investigated thoroughly in regard to a 4/27/12 incident with client A. Please see W149.</p> <p>This deficiency was cited on 3/23/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaints #IN00104104 and #IN00104527.</p> <p>9-3-1(a)</p>			

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review for 1 of 2 sampled clients (A), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of a client and to ensure the facility conducted thorough investigations.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client A in regard to the client's self-injurious behaviors of making suicide gestures and/or threats. Please see W149.</li> <li>The governing body failed to exercise general policy and operating direction over the facility facility to ensure an allegation of abuse and/or neglect was investigated thoroughly in regard to a 4/27/12 incident with client A. Please see W154.</li> </ol> <p>This deficiency was cited on 3/23/12. The facility failed to implement a</p>	W0104	<p><b>CORRECTION:</b> <i>The Governing Body must exercise general policy, budget and operating direction over the facility. Specifically, the governing body has directed the interdisciplinary team to modify Client A's Behavior Support Plan to include proactive sweeps of Client A's bedroom to remove potentially harmful objects at the beginning of each shift and Client A's Behavior Support Plan has been modified to include specific protocols for when men are expected in the home. Additionally, the Governing Body has implemented a system for review and tracking of incidents to assist the team with conducting thorough investigation and development of preventative measures to eliminate the potential for neglect. The Governing Body has also provided increased staffing hours for the facility to promote additional support during behavioral episodes.</i></p> <p><b>PREVENTION:</b> The Governing Body has established a separate Quality Assurance Department to assist with auditing facility systems and developing sound risk management practices, including but not limited to incident investigation and</p>	06/06/2012	

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	<p>systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaints #IN00104104 and #IN00104527.</p> <p>9-3-1(a)</p>		<p>management and development of preventative behavior support strategies.. The Quality Assurance and Operations Teams will work closely to assure the facility receives an appropriate level of support from the Governing Body.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Support Associates, Behavior Support Coordinator, Quality Assurance Team, Operations Team</p>	

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 of 2 sampled clients (A). The facility failed to implement its policy and procedures to prevent neglect of the client in regard to suicide threats and/or attempts. The facility failed to implement its policy and procedures to conduct and/or document thorough investigations in regard to an allegation of neglect.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The facility failed to implement its policy and procedures to prevent neglect of client A in regard to the client's self-injurious behaviors/suicide threats/gestures. Please see W149.</li> <li>2. The facility failed to ensure allegations of abuse, neglect, injuries of unknown origin were investigated thoroughly in regard to an incident involving a knife with client A. Please see W154.</li> </ol> <p>This deficiency was cited on 3/23/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>	W0122	<p><b>CORRECTION:</b> <i>The facility must ensure that specific client protections requirements are met. Specifically, the interdisciplinary team has modified Client A's Behavior Support Plan to include proactive sweeps of Client A's bedroom to remove potentially harmful objects at the beginning of each shift and the plan has also been modified to include specific protocols for when men are expected in the home. Additionally, the team will complete an investigation into Client A's suicidal gestures which occurred on 4/27/12. The facility has also arranged for increased staffing hours to promote additional support during behavioral episodes and the team is using portable two-way radios to streamline communication when multiple behavior incidents occur simultaneously.</i></p> <p><b>PREVENTION:</b> <i>Client B and C's Behavior Support plans have been modified to include additional preventative measures. The team will continue to make modifications to all client's behavior supports based on ongoing assessment and in response to significant behavioral episodes. Members of the Quality Assurance and Operations Teams will periodically review behavior supports and compare</i></p>	06/06/2012

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	This federal tag relates to complaints #IN00104104 and #IN00104527.  9-3-2(a)		<i>them with incident reports and other documentation to assure that all current behavioral needs are addressed. In addition, the Quality Assurance Manager will review all incident documentation and follow-up with the QDDP regarding incidents that require investigation. The Quality Assurance Team will track facility investigations and the QDDP will submit copies of investigation reports and interdisciplinary team follow-up to the Quality Assurance Manager.</i> <b>RESPONSIBLE PARTIES:</b> QDDP, Support Associates, Behavior Support Coordinator, Quality Assurance Team, Operations Team		

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on interview and record review for 1 of 2 sampled clients (A), the facility neglected to implement its policy and procedures to prevent neglect of a client in regard to suicide threats and/or attempts.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 5/3/12 at 5:15 PM. The facility's reportable incident reports indicated the following:</p> <p>-4/27/12 "[Client A] (individual we support) was in the kitchen with her 1:1 (one on one) staff assisting with dinner prep. As staff was assisting [client A] to open the oven to remove the dinner item, [client A] reached over to the counter where another staff had been using a knife for dinner prep. [Client A] held the knife point edge against her stomach; staff next to her immediately removed the knife from [client A's] hand. [Client A] was moved from the kitchen into a quiet area of the house. She was checked for injury. A pea sized red area was noted from where she had pressed the knife...Staff</p>	W0149	<p><b>CORRECTION:</b> <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically, the interdisciplinary team has modified Client A's Behavior Support Plan to include proactive sweeps of Client A's bedroom to remove potentially harmful objects at the beginning of each shift. Additionally, Client A's Behavior Support Plan has been modified to include specific protocols for when men are expected in the home. The facility has also arranged for increased staffing hours to promote additional support during behavioral episodes and the team is using portable two-way radios to streamline communication when multiple behavior incidents occur simultaneously.</i></p> <p><b>PREVENTION:</b> <i>Client B and C's Behavior Support plans have been modified to include additional preventative measures. The team will continue to make modifications to all clients' behavior supports based on ongoing assessment and in response to significant behavioral episodes. Members of the Quality Assurance and Operations Teams will periodically review behavior supports and compare</i></p>	06/06/2012			

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	<p>remained within arms length of [client A] through the rest of the evening and night. All sharps were removed from [client A's] immediate environment. [Client A] returned from the hospital earlier in the week where she was admitted due to threats to harm herself and experiencing voices telling her to hurt herself. [Client A] has a BSP (Behavior Support Plan) which addresses self-injurious behavior as well as threats to harm self. Per the BSP, [client A] was placed on 1:1 staffing upon her return and this status is reviewed with [client A] every 24 hours and remains dependent upon staff observation of [client A's] actions and affect as well as [client A's] input on her feelings...."</p> <p>The facility's 4/27/12 Injury Follow-Up Flow Chart indicated "[Client A] was in kitchen with one-on-one staff and while staff was pulling food out of oven (sic) [client A] grabbed a sharp knife and pushed it into her stomach." The injury flow chart indicated client A received a "Pea size bruise that is red around the bruise..." which was located above client A's belly button.</p> <p>The facility's 4/27/12 Incident/Accident Report indicated "...Staff will ensure [client A's] safety when on 1-1 by keeping hands face at all times during 1:1 (sic). [Client A] should not be in the kitchen</p>		<p><i>them with incident reports and other documentation to assure that all current behavioral needs are addressed. <b>RESPONSIBLE PARTIES:</b> QDDP, Support Associates, Behavior Support Coordinator, Quality Assurance Team, Operations Team</i></p>				

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	<p>area while sharps are in use."</p> <p>The facility's 4/27/12 reportable incident report and/or investigations from 4/23/12 to 5/2/12 indicated the facility neglected to conduct and/or document a thorough investigation in regard to the 4/27/12 incident involving how and why client A, who was suicidal, was able to have access to a sharp/knife.</p> <p>-4/24/12 "[Client A] (individual supported by ResCare) spoke to her mother on the phone and upon completing the call, [client A] threw the phone on the table. Staff asked her what was wrong and she said nothing and went to the wall and punched it four to five times with her right fist. Staff intervened and she asked to go for a walk. While walking [client A] told staff her mother said she didn't lover (sic) her and not to call back. [Client A] said she might as well kill herself. As a result of hitting the wall, [client A] had slight bruising and swelling on her right knuckles...The QMRP (Qualified Mental Retardation Professional) placed [client A] on one to one observation, contacted the Program Manager SGL (Supervised Group Living) and the Director of Behavior Services and began making arrangements for inpatient psychiatric treatment due to [client A's] history and likelihood that her suicidal</p>						

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	<p>behavior would escalate...." The 4/24/12 reportable incident report indicated client A was taken to a local emergency room for treatment and evaluation. The reportable incident report indicated client A was admitted to the hospital due to "... [client A's] mental status...for acute in-patient treatment...."</p> <p>The facility's 5/3/12 follow-up report indicated "[Client A] was observed and released on 4/25/12 with no new orders. Upon arrival home, [client A] stated she was still thinking of hurting herself and she told hospital staff and they still let her come home. Per BSP protocol addressing [client A's] threats to harm herself, a 1:1 was initiated...."</p> <p>Client A's record was reviewed on 5/3/12 at 2:10 PM. Client A's Progress Notes indicated the following:</p> <p>-4/27/12 "[Client A] asked to go check on dinner in the oven so we went in there. When I bent down to take dinner out of the oven (sic) she grabbed a a sharp knife and stabbed herself."</p> <p>-4/24/12 Client A demonstrated "Self-injurious (behavior), suicide threats." The 4/24/12 note indicated when client A returned from her walk "...she made a suicide threat. A</p>						

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	<p>transporter was called and [client A] was taken by ambulance to [name of hospital]."</p> <p>Client A's 4/3/12 Progress Note also indicated "...[Client A] talked about jumping off a bridge w/PC (with Program Coordinator). Not on a 1:1 but are supposed to keep an eye on her." Client A's 4/4/12 note indicated client A "Tried strangling herself." The note indicated "[Client A] had a psych appointment today and did not get back until after 7 (PM). She took her meds and went to her room. When checked on she was found with string around her neck. One-on-one started and room was swept."</p> <p>Client A's record indicated the following hospital visits and/or admissions since 4/12:</p> <p>-4/5/12 Health Care Services note indicated "Last night the patient tried to strangle herself using a string. The attending staff at the group home said that her face was red, but she was not blue or gray and did not have any apnea. Today she hit her head on a wall and reopened a previous head wound...." The note indicated "...The patient, upon interviewing and examination, did express that she intermittently hears voices...Her history is significant for</p>			

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	<p>previous admissions for similar presentations in the past,...."</p> <p>-4/8/12 Health Care Service Note indicated "...The patient had a recent admission on April 5, 2012, and was discharged the next day. The patient had subsequently returned the same day by the group home staff with similar presentation of wanting to bang her head on the wall, being increasingly difficult to redirect at the group home, and also the staff reported that the patient had used a string to coil around her neck a couple of days ago, but did not describe this as being a recent behavioral onset (sic)...."</p> <p>-4/12/12 History and Physical indicated "The patient reported that lately she was feeling more depressed. She reported that she was hearing voices telling her to hurt herself and others. She says she was also seeing things. The patient reports that she did bang her head on the wall a couple of times and also tried to strangle herself with a string 1 or 2 times in the last 1 to 2 weeks. The patient was admitted to the acute psychiatric inpatient unit...She is reporting hearing voices telling her to hurt herself...The patient has a long history of hallucinations and mood swings. The patient also has a history of depression over the years...The patient reports a history of suicide attempts in the past</p>			

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	<p>when she has tried to hang herself or drown herself or stab herself...."</p> <p>-4/24/12 Health care Services note indicated "...She punched a wall several times...She is also threatening to kill herself. We found out later that she was going to run in front of a car...."</p> <p>A 4/4/12 psychiatric evaluation indicated "...Staff reports a long history of both suicidal attempts and gestures. Most recently, she even attempted to choke herself while in her room with the door open while receiving 15-minute checks by wrapping yarn around her neck. In the past, other significant self-injurious behaviors included refusing to eat or drink, attempting to suffocating (sic) herself, attempting to hang herself, and consuming potentially dangerous substances as well...."</p> <p>Client A's 4/17/12 BSP indicated client A demonstrated the targeted behaviors of "Suicide Threats: threats to harm or kill herself, or indicates having a plan in which to carry out her threats of harm. Suicide Attempt: using sharps or other items to cause bodily harm (i.e. rubbing off skin, cutting open her skin, picking at healing wounds, using items to strangle herself), this also includes if she is attempting to ingest chemicals." Client</p>			

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	<p>A's 4/17/12 BSP indicated if client A demonstrated precursor behaviors (verbal threats of hurting and/or killing herself, reporting hallucinations, dropping her head and/or talking to staff about her history), the staff were to</p> <p>"-...Immediately ensure that there is nothing in the immediate environment that she can use to harm herself and others</p> <p>-Notify the Program Coordinator (PC) and Behavior Clinician (BC). The Program Coordinator and Behavior Clinician will notify the team that the safety protocol will be implemented...."</p> <p>Client A's BSP indicated "...Safety Protocol will be in effect for at a minimum of 24 hours and the IDT (interdisciplinary team) will discuss the continued need in 24 hour intervals until the team feels she no longer poses a threat to herself or others:</p> <p>-[Client A] will have enhanced supervision (as defined as [client A] in the same room as staff, in the staff's line of sight and staff will be close enough to intervene if she attempts to harm self or others), until additional staff are available at the site...." Client A's 4/17/12 BSP indicated "...Sharps not to be left out."</p> <p>The facility neglected to implement client A's safety protocol of enhanced supervision after client A made a suicide threat on 4/3/12 and then was found in her</p>			

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	<p>room on 4/4/12 with a string coiled around her neck. The facility neglected to ensure client A's BSP had a proactive/preventative strategy to conduct room sweeps to prevent any suicide attempts versus sweeping the room after the client made an attempt. The facility neglected to implement/follow client A's 4/17/12 BSP to ensure client A was not around sharps as the client was on enhanced supervision due to a hospital visit due to self-harm and suicidal threats.</p> <p>Interview with staff #2 on 5/2/12 at 2:22 PM stated "She has been very depressed lately. She will not do anything." Staff #2 stated client A "tried to stab herself in the stomach with a sharp knife." Staff #2 indicated client A had a one on one staff person with her at the time of the incident.</p> <p>Interview with administrative staff #1 and the PC on 5/3/12 at 6:00 PM indicated client A had 4 emergency room visits and hospitalizations in the past month. The PC stated client A "appeared to be more depressed." The PC and administrative staff #1 indicated client A was in the kitchen with staff checking on the dinner meal when the client grabbed the knife and "stabbed her stomach." The PC and administrative staff #1 indicated a staff person had used the knife to cut up</p>			

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	<p>potatoes when client C started having behaviors and the staff had to leave the kitchen to assist staff with the client. The PC and administrative staff #1 indicated client A and her one on one staff were in the kitchen when the knife was left out on the counter. The PC stated client A had a "small area on stomach" where client A stabbed herself with the knife.</p> <p>Administrative staff #1 and the PC indicated the knife should not have been left out on the counter as client A was on one to one staffing due to recent suicide threats/attempts. Administrative staff #1 indicated she conducted an investigation in regard to the incident and documented what happened in the 4/27/12 reportable incident report. Administrative staff #1 indicated the staff conducted room sweeps/searches after client A made threats/attempts. The PC indicated client A did not go on one to one staffing after the client made a suicide threat on 4/3/12 about jumping off a bridge.</p> <p>Administrative staff #1 indicated the bridge the client was referring to was not a high bridge with deep water. The PC indicated on 4/4/12, client A went to get a psychiatric evaluation and was upset due to having to wait to see several doctors and a nurse practitioner. Administrative staff #1 and the PC indicated the consulting psychiatrist was in the process of starting client A on Clozaril.</p>			

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	<p>The facility's policy and procedures were reviewed on 5/3/12 at 1:45 PM. The facility's 12/7/10 policy and procedures entitled Abuse, Neglect, Exploitation, Mistreatment indicated "Emotional/physical neglect" was defined as "...failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being...and to provide a safe environment...."</p> <p>The facility's policy and procedures indicated the facility would conduct a thorough investigation in regard to allegations of neglect and/or abuse.</p> <p>This deficiency was cited on 3/23/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00104104 and #IN00104527.</p> <p>9-3-2(a)</p>				

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 1 of 2 allegations of neglect and/or abuse reviewed, the facility failed to conduct a thorough investigation and/or document an investigation in regard to a suicide attempt.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 5/3/12 at 5:15 PM. The facility's 4/27/12 reportable incident report indicated "[Client A] (individual we support) was in the kitchen with her 1:1 (one on one) staff assisting with dinner prep. As staff was assisting [client A] to open the oven to remove the dinner item, [client A] reached over to the counter where another staff had been using a knife for dinner prep. [Client A] held the knife point edge against her stomach; staff next to her immediately removed the knife from [client A's] hand. [Client A] was moved from the kitchen into a quiet area of the house. She was checked for injury. A pea sized red area was noted from where she had pressed the knife...Staff remained within arms length of [client A] through</p>	W0154	<p><b>CORRECTION:</b> <i>The facility must have evidence that all alleged violations are thoroughly investigated. Specifically, an investigation will be completed for Client A's suicidal gestures which occurred on 4/27/12.</i></p> <p><b>PREVENTION:</b> <i>The Quality Assurance Manager will review all incident documentation and follow-up with the QDDP regarding incidents that require investigation. The Quality Assurance Team will track facility investigations and the QDDP will submit copies of investigation reports and interdisciplinary team follow-up to the Quality Assurance Manager.</i></p> <p><b>RESPONSIBLE PARTIES:</b> <i>QDDP, Support Associates, Quality Assurance Team, Operations Team</i></p>	06/06/2012			

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	<p>the rest of the evening and night. All sharps were removed from [client A's] immediate environment. [Client A] returned from the hospital earlier in the week where she was admitted due to threats to harm herself and experiencing voices telling her to hurt herself...."</p> <p>The facility's 4/27/12 Injury Follow-Up Flow Chart indicated "[Client A] was in kitchen with one-on-one staff and while staff was pulling food out of oven (sic) [client A] grabbed a sharp knife and pushed it into her stomach." The injury flow chart indicated client A received a "Pea size bruise that is red around the bruise..." which was located above client A's belly button.</p> <p>The facility's 4/27/12 reportable incident report did not indicate the facility conducted and/or documented an investigation in regard to the 4/27/12 incident regarding neglect.</p> <p>Interview with staff #2 on 5/2/12 at 2:22 PM stated "She has been very depressed lately. She will not do anything." Staff #2 stated client A "tried to stab herself in the stomach with a sharp knife." Staff #2 indicated client A had a one on one staff person with her at the time of the incident.</p>			

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	<p>Interview with administrative staff #1 and the PC on 5/3/12 at 6:00 PM stated client A was in the kitchen with staff checking on the dinner meal when the client grabbed the knife and "stabbed her stomach." The PC and administrative staff #1 indicated a staff person had used the knife to cut up potatoes when client C started having behaviors and the staff had to leave the kitchen to assist staff with the client. The PC and administrative staff #1 indicated client A and her one on one staff were in the kitchen when the knife was left out on the counter. The PC stated client A had a "small area on stomach" where client A stabbed herself with the knife. Administrative staff #1 and the PC indicated the knife should not have been left out on the counter as client A was on one to one staffing due to recent suicide threats/attempts. Administrative staff #1 indicated she conducted an investigation in regard to the incident and documented what happened on the 4/27/12 reportable incident report.</p> <p>This deficiency was cited on 3/23/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>			

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W0263	<p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on interview and record review for 2 of 2 sampled clients (A and B) and for 1 additional client (C) with restrictive programs, the facility failed to obtain written informed consent for the restrictive programs/interventions.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 5/3/12 at 2:10 PM. Client A's 2/14/12 physician's script indicated "Resident may be fitted for helmet. She is to wear helmet due to increase frequency of head banging."</p> <p>Client A's 3/3/12 Behavior Support Plan (BSP) indicated client A had a "Soft Helmet Protocol" which indicated client A was to wear her helmet "During all waking hours; at Workshop and while in all community settings. Except while cooking, eating, showering and sleeping; however, this is contingent on mood and displayed behaviors. During periods when the helmet is not being worn, it must be located in an area that is easily accessible to staff in the event of precursor and target behaviors."</p>	W0263	<p><b>CORRECTION:</b> <i>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Specifically, the team has obtained written informed consent for the use of helmets for Client A and Client B and Client C.</i></p> <p><b>PREVENTION:</b> <i>Professional staff will be retrained regarding the fact that, in addition to Human Rights Committee Approval, the team needs to assure that clients who act as their own legal guardians give prior written informed consent for all restrictive programs. Members of the Quality Assurance Team and Operations Team will periodically review support and consent documents on an ongoing basis to assure the team has obtained written informed consent for all restrictive programs for all clients.</i></p> <p><b>RESPONSIBLE PARTIES:</b> <i>QDDP, Support Associates, Quality Assurance Team, Operations Team, Human Rights Committee</i></p>	06/06/2012	

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	<p>Client A's 2/1/12 ISP (Individual Support Plan) indicated client A was her own guardian. Client A's 2/1/12 ISP and/or 3/3/12 BSP indicated the facility failed to obtain written informed consent in regard to the the use of the soft helmet.</p> <p>2. Client B's record was reviewed on 5/3/12 at 4:55 PM. Client B's 4/18/12 BSP indicated client B was to wear a soft helmet, for self-injurious behavior, "During all waking hours; at Workshop and while in all community settings. -Except while cooking, eating showering and sleeping; however, this is contingent on mood and displayed behaviors. During periods when the helmet is not being worn, it must be located in an area that is easily accessible to staff in the event pr precursor and target behaviors."</p> <p>Client B's 11/29/11 ISP indicated client B was her own guardian. Client B's 11/29/11 ISP and/or 4/18/12 BSP indicated the facility failed to obtain written informed consent in regard to the use of the soft helmet.</p> <p>3. Client C's record was reviewed on 5/3/12 at 3:30 PM. An 11/17/11 typed letter by a doctor at a mental health center indicated "Due to [client C's] self-injurious behaviors, it is my</p>						

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	<p>recommendation that she wear a protective helmet as a medically necessary effort to protect [client C] against injury associated with these self-injurious behaviors...."</p> <p>Client C's 2/13/12 physician order/script indicated "Resident may be fitted for helmet. She is to wear helmet due to increase in banging head on wall and furniture."</p> <p>Client C's 3/3/12 Behavior Support Plan (BSP) indicated client C had a soft helmet protocol which indicated client C's helmet was to be worn: "During all waking hours; at Workshop and while in all community settings. Except while cooking, eating or showering and sleeping; however, this is contingent on mood and displayed behaviors. During periods when the helmet is not being worn, it must be located in an area that is easily accessible to staff in the event of precursor and target behaviors." Client C's 3/3/12 BSP indicated client C was her own guardian. Client C's 3/3/12 BSP and/or record did not indicate the facility obtained written informed consent for the use of the helmet.</p> <p>Interview with the PC on 5/3/12 at 6:00 PM indicated clients A, B and C demonstrated SIB and wore helmets to</p>			

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	<p>protect the clients from injury. The PC indicated she had not obtained written informed consent from the clients for the use of the clients' restrictive programs which included the use of the helmets. The PC indicated she had not received the forms she needed for the consents.</p> <p>This deficiency was cited on 3/23/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaints #IN00104104 and #IN00104527.</p> <p>9-3-4(a)</p>			