

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G596	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/02/2012
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NAME OF PROVIDER OR SUPPLIER  REHABILITATION CENTER DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1426 S ALVORD LN EVANSVILLE, IN 47714
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 10/29, 10/30, 10/31 and 11/2/12</p> <p>Facility Number: 001110 Provider Number: 15G596 AIMS Number: 100240090</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 11/9/12 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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W0153	<p>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 1 of 3 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to ensure facility staff and/or outside providers immediately reported all allegations to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for client #2.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/29/12 at 1:34 PM. The facility's 8/31/12 reportable incident report indicated "[Name of day program] Nursing staff discovered while helping [client #2] during restroom procedures that there were drawings on his knees one a flower and on the other knee a smiley face. When nurses remarked on the drawings [client #2] informed them staff drew it on him the night before. [Client #2] stated he told staff he did not want to</p>	W0153	<p>On 9/5/12, administration received a follow-up reportable request from a reportable by the day program, Evansville ARC on 8/31/12. This report regarding client #2 was not communicated to RCDS at all. Generally, Evansville ARC calls the group home manager with this information and RCDS addresses the situation immediately. Administration immediately called the EARC supervisor. Administration was told that the supervisor was off and the person reporting tried to call the group home and no one answered. So they did not relay the information. I reminded her that we need to know immediately of all reportables. I also reminded her of the list of phone numbers she had been given to call if they could not reach the group home manager at the group home. Preventatively, via phone call on 9/5/12, the EARC supervisor and I developed a protocol which includes who to call first and additional names and phone numbers they are to call until a live person is reached. Also, she will train her staff on what to do in her absence, if this</p>	12/02/2012			

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	<p>be drawn on. [Name of day program] staff questioned [client #2] several times on this and he was adamant that he did not want the staff to draw on him. [Name of day program staff] have taken pictures of the drawings on his knees. During the coarse (sic) of the examination staff noticed the left foot had redness and swelling. Foot was warm to touch..."</p> <p>The 8/31/12 reportable incident report indicated staff #1 (group home staff) was notified of the incident on 8/31/12.</p> <p>The facility's 9/5/12 follow-up report indicated "[Name of day program] failed to notify the group home, or administration of this finding. An e-mail from BQIS (Bureau of Quality Improvement Services) requesting follow-up dated 9-4-2012, is how administration found out. At that time, administration suspended the alleged staff (staff #1), who is also, the group home manager, until investigation...."</p> <p>Interview with administrative staff #2 on 10/29/12 at 2:15 PM indicated the day program should have immediately informed her of the allegation. Administrative staff #2 stated the "[Name of day program] filed and sent to [staff #1] instead of us. [Staff #1] turned in Monday. I was off and seen Tuesday." Administrative staff #2 indicated she did</p>		<p>scenario arises again. Administration will monthly call the EARC supervisor to check on reportable and other issues.</p>				

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	not know of the allegation until BQIS sent an e-mail and asked for a follow-up to the allegation.  9-3-2(a)			

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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 1 of 3 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct a thorough investigation in regard to an allegation of abuse with client #2.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/29/12 at 1:34 PM. The facility's 8/31/12 reportable incident report indicated "[Name of day program] Nursing staff discovered while helping [client #2] during restroom procedures that there were drawings on his knees one a flower and on the other knee a smiley face. When nurses remarked on the drawings [client #2] informed them staff drew it on him the night before. [Client #2] stated he told staff he did not want to be drawn on. [Name of day program] staff questioned [client #2] several times on this and he was adamant that he did not want the staff to draw on him. [Name of day program staff] have taken pictures of the drawings on his knees. During the coarse (sic) of the examination staff noticed the left foot had redness and swelling. Foot was warm to touch.</p>	W0154	<p>RCDS consistently, thoroughly investigates all alleged violations as written in RCDS policy. In this case, RCDS received the information days later from BQIS, not the Evansville ARC where the incident was reported. Upon it being received, it was thoroughly investigated with the client and staff involved. The Group Home Coordinator observed all of the other clients to check for any issues, as they cannot speak. Unfortunately, this was not documented. The staff involved was interviewed. No other interviews were done after that interview, as it was substantiated. The situation was resolved immediately and the use of homemade tattoos does not occur in the group homes.</p> <p>Preventatively, all Group Home Managers and Assistant Managers were reminded of resident's rights and client/staff boundaries. Likewise, the investigations protocol was reviewed for appropriateness then in-serviced to all professional staff, specifically regarding documenting.</p>	12/02/2012			

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	<p>Easterseals (Rehabilitation Center) will investigate [client #2's] claims and act accordingly to their policy...."</p> <p>The facility's 9/5/12 follow-up report indicated "[Name of day program] failed to notify the group home, or administration of this finding. An e-mail from BQIS (Bureau of Quality Improvement Services) requesting follow-up dated 9-4-2012, is how administration found out. At that time, administration suspended the alleged staff (staff #1), who is also, the group home manager, until investigation. [Client #2] was immediately spoke (sic) to in regard to the incident. He spoke with administration and confirmed that his legs had been drawn on by [staff #1], the group home manager. He stated it is something they do sometimes and he enjoys it. However, after the [name of day program] nurse at [name of workshop] saw them, he was upset because she bothered about them being there. Generally, he says they wash off that same day when he gets his shower. He stated that he was embarrassed that they were still there and not washed off. He said that he likes the homemade tattoos, but after they did not wash off, he would prefer to not have them on him anymore. [Staff #1], the manager, as well as the Alvord staff, were immediately</p>			

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	<p>in-serviced that they cannot make homemade tattoos on clients anymore. [Staff #1] was released to return to work after the situation was resolved as no abuse or neglect was founded (sic)...In regard to [client #2's] foot appearing red and swollen, he has poor circulation in his lower extremities and his feet swell at times just from being down in his wheelchair. He came home on Friday, 8-31-2012, due to the swelling and the RCDS nurse observed his feet at the home. AT (sic) that time, the nurse stated to elevate them and the swelling should subside. [Client #2's] feet were elevated for about an hour or so, and his feet resumed their normal appearance. The staff working with [client #2] at [name of workshop] is newer and may not be familiar with [client #2's] history with his legs/feet swelling at times. Generally, he just props them on a footstool routinely while at work as well to ensure they do not swell..."</p> <p>The facility's typed 9/5/12 investigation indicated client #2, the group home coordinator and staff #1 were interviewed. The facility's typed investigation did not indicate any other staff and/or clients were interviewed in regard to the allegation and/or abuse.</p> <p>Interview with administrative staff #2 on</p>						

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	<p>10/29/12 at 2:15 PM indicated the facility suspended staff #1 and conducted an investigation in regard to the allegation. Administrative staff #2 indicated no other clients were interviewed as no other client was affected by the allegation. Administrative staff #2 indicated no other staff besides staff #1 and the group home coordinator were interviewed. Administrative staff #2 indicated clients #1, #3, #4, #5, #6, #7 and #8 had not received homemade tattoos.</p> <p>9-3-2(a)</p>						

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to implement clients' Individual Program Plan (IPP) objectives when formal and/or informal training opportunities existed.</p> <p>Findings include:</p> <p>1. During the 10/29/12 observation period between 4:20 PM and 6:30 PM, at the group home, client #4 stayed in his bedroom with the door closed except to eat dinner. Although staff periodically knocked on client #4's door and checked on the client, staff did not prompt and/or encourage the client to come out of his bedroom until 6:21 PM to get his fingernails painted. Facility staff did not offer the client activities and/or training to participate in. During the above mentioned observation period client #4 scooted himself on the floor to get around the group home. Staff did not prompt and/or encourage the client to ambulate/walk with the assistance of a</p>	W0249	<p>All group home staff were retrained specifically on IPP objectives that were not run formally or informally.</p> <ul style="list-style-type: none"> <li>·Client #4 to interact with peers, identify coins, clean his room, assist in meal preparations, tell time, and ambulate with a gait belt.</li> <li>·Client #2 to have his food cut into ½ inch pieces.</li> <li>·Client #1 to use hearing aids, place fork or spoon down between bites, and hand washing.</li> <li>·Client #3 to assist in meal preparation, say words loud enough to hear, and communicate yes or no.</li> </ul> <p>Likewise, staff were retrained on the importance of continual active treatment using every opportunity to train formally and informally.</p> <p>All professional staff were retrained on their role in ensuring active treatment occurs.</p> <p>Observations of the listed objectives and all active treatment will be conducted once per week for 1 month and then continually</p>	12/02/2012			

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	<p>gait belt.</p> <p>Client #4's record was reviewed on 10/30/12 at 1:45 PM. Client #4's 6/22/12 IPP indicated the client had objectives to interact with peers outside his bedroom, to identify coin, to clean his room, to assist in meal preparation and an objective to tell time which staff #1, #3 and #4 did not implement when formal and/or informal training opportunities existed.</p> <p>Client #4's 6/22/12 IPP and/or 11/1/12 physician's orders indicated client #4 was to ambulate with a gait belt daily.</p> <p>Interview with staff #1 and the Group Home Coordinator (GHC) on 10/31/12 at 9:45 AM indicated client #4 liked to stay in his bedroom. The GHC indicated it had improved since the client was admitted to the group home in 5/12. The GHC indicated client #4 would come out of his bedroom if you tell the client you will paint his nails. The GHC indicated client #4 wanted to be a rock star. The GHC and staff #1 indicated the client was to ambulate with his gait belt daily as ordered.</p> <p>2. During the 10/30/12 observation period between 5:25 AM and 8:33 AM, at the group home, client #2 had scrambled</p>		<p>on a random basis, to ensure appropriateness.</p> <p>Also preventatively, administration will observe at group homes to ensure active treatment is occurring.</p>				

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	<p>eggs and toast for his breakfast. The client ate a regular diet texture in that the client's food was not cut up/modified.</p> <p>The facility's reportable incident reports were reviewed on 10/29/12 at 1:34 PM. The facility's 10/30/11 reportable incident report indicated client #2 choked while eating a roll with his dinner in his bedroom. The reportable incident report indicated the client was sent out to a local hospital as the client indicated it felt like something was still in his throat after a small piece of the roll was coughed up. The reportable incident report indicated the client was admitted to the hospital to have a procedure done to remove the lodged food.</p> <p>Client #2's record was reviewed on 10/30/12 at 12:22 PM. Client #2's 11/29/11 Diet (dining) Plan indicated "...Cut all foods into 1/2 inch bite size pieces prior to serving to him...."</p> <p>Interview with staff #1 and the GHC on 10/31/12 at 8:45 AM indicated client #2's bread should be cut into bite size pieces per the client's program plan.</p> <p>3. During the 10/29/12 observation period between 4:20 PM and 6:30 PM and the 10/30/12 observation period between 5:25 AM and 8:33 AM, at the</p>			

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	<p>group home, client #1 did not wear hearing aids. During the 10/29/12 observation period, client #1 did not wash his hands prior to eating dinner. Also, during the 10/29/12 observation period, client #1 ate at a fast pace and/or took large bites of food while eating. Staff #1 sat next to client #1. Client #1 ate 5 bites of spaghetti at a fast pace before staff #1 prompted the client to slow down and take a drink. Staff did not encourage the client to place his fork down between bites of food.</p> <p>Client #1's record was reviewed on 10/30/12 at 11:38 AM. Client #1's 7/12/12 IPP indicated the client had objectives to increase toleration of his trial hearing aid on a daily basis, to place fork or teaspoon down on table after each bite of food and an objective to follow proper hand washing techniques after toileting which staff did not implement when opportunities for training existed.</p> <p>Interview with staff #1 and the GHC on 10/31/12 at 8:45 AM indicated clients should be encouraged to wash their hands prior to meals. The GHC stated "We need to work on this." Staff #1 indicated client #1 did not like to wear his trial hearing aids and he would not keep them in.</p>			

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	<p>4. During the 10/29/12 observation period between 4:20 PM and 6:30 PM and during the 10/30/12 observation period between 5:25 AM and 8:33 AM, at the group home, client #3 did not speak and/or use any communication devices during the observation periods. Specifically during the 10/30/12 observation period at 7:16 AM, client #3 came into the dining room for his breakfast. Staff #12 fixed client #3 scrambled eggs without involving the client and placed toast in a toaster without involving the client. The staff then fixed the client's plate and carried it to the dining room where client #3 was located. Client #3 was able to serve himself fruit (honey dew melon) without staff assistance.</p> <p>Client #3's record was reviewed on 10/30/12 at 11:38 AM. Client #3's IPP indicated the client had an objective to assist in meal preparation and an objective to say words loud enough to be heard. Staff did not implement the above mentioned objectives when formal and/or informal opportunities for training existed.</p> <p>Interview with staff #1 and the GHC on 10/31/12 at 9:45 AM indicated clients should be encouraged to participate in meal preparation to the extent they are</p>						

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	capable. Staff #1 and the GHC indicated facility staff should encourage client #3 say words to communicate and/or answer yes or no questions.  9-3-4(a)			

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W0312	<p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 1 of 2 clients on behavioral medications (#1), the facility failed to develop an active treatment program for the use of a psychotropic medication used for pre-sedation for dental appointments.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 10/30/12 at 11:38 AM. Client #1's 1/12 to 3/12 Nurse Quarterly Assessment indicated client #1 required the use of a pre-medication for dental procedures. The nurse quarterly assessment indicated on 3/7/12 client #1 received Ativan 2 milligrams, Atarax 100 milligrams and Risperdal 2 milligrams to sedate the client for his dental appointment.</p> <p>Client #1's 5/28/10 Behavior Medication Implementation and Reduction Plan indicated client #1's guardian and the facility's Human Rights Committee approved the use of the Atarax, Risperdal and Ativan to be used for sedation for dental appointments.</p>	W0312	<p>An IDT will be held to review client #1's use of a pre-medication, to develop a desensitization plan and medication reduction plan.</p> <p>The new programming will be in-serviced to all staff at the group home.</p> <p>The Behavioral Coordinator will be retrained on her role to ensure all behavior and medication plans are kept up to date and appropriate.</p> <p>Additionally, the V.P. of Residential Services will review and sign all behavior medication and programs.</p>	12/02/2012			

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	<p>Client #1's 7/12/12 Individual Program Plan (IPP) and/or the client's 11/30/11 Behavior Strategy did not indicate the client had an active treatment (desensitization) program to address the behaviors for which the client received the pre-medications to attend dental appointments.</p> <p>Interview with staff #1 and the Group Home Coordinator (GHC) on 10/31/12 at 8:45 AM indicated client #1 required the use of pre-medication for sedation when going to the dentist. Staff #1 indicated client #1 was not cooperative at the last dental appointment with the use of the pre-sedation medications. Staff #1 indicated the dentist would not look at using general anesthesia to perform routine dental procedures. Staff #1 and the GHC indicated client #1 should have an active treatment/desensitization program in place.</p> <p>9-3-5(a)</p>				

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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review for 3 of 4 sampled clients (#1, #2 and #3), the facility's nursing services failed to meet the nursing/healthcare needs of the clients. The facility's nursing services failed to develop specific risk plans for the clients' medical needs, and/or failed to obtain clarification in regard to monitoring a client's blood pressure.</p> <p>Findings include:</p> <p>1. Client #2's record was reviewed on 10/30/12 at 12:22 PM. Client #2's 11/1/12 physician's orders indicated client #2's diagnoses included, but were not limited to, Neurogenic Bladder and Bowel and Chronic Urinary Tract Infection (UTI). Client #2's 11/1/12 physician's orders indicated an "In-out Straight Cath (catheterization) 5 X (times)/day - Staff to do when @ (at) home (Using Sterile Technique)." The 11/1/12 physician's orders indicated client #2 also received Cozaar 100 milligrams daily for Hypertension and the client's vital signs were to be done monthly.</p> <p>Client #2's 2/23/09 Catheterization Protocol indicated "In and Out Catheterization -Bladder drained</p>	W0331	<p>The medical team will update client #2's Catheterization Protocol to include description of the appropriate technique, specific signs and symptoms and specifically when to call the nurse.</p> <p>Client #2's Hypertension Protocol will be reviewed by the medical team regarding what signs and symptoms staff are to monitor for and when to call the nurse.</p> <p>Client #3's Hypertension Protocol will be updated by the medical tem to include checking his blood pressure monthly by the nurse and documented. Likewise, it will be indicated when staff are to call the nurse.</p> <p>Client #1's Hypertension Protocol will be updated by the medical team. The amount of times and by whom blood pressure will be checked will be added to the protocol; signs and symptoms, as well as when to contact the nurse will be added.</p> <p>Preventatively, Administration and the Nurse Coordinator developed a High Risk Protocol format for Hypertension and Catheterization. All future High Risk Protocol formats will be approved by administration.</p>	12/02/2012			

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	<p>intermittently at designated times Perform procedure using appropriate technique Prevention of infection/Monitor for infection</p> <p>Individualized Plan: -Cathed 5 x/day via sterile technique -Nurses @ [name of workshop] perform cathing during the day -Temp (temperature) is monitored 2x/day -UA (urinalysis) C &amp; S (Culture and Sensitivity) (checked) Quarterly -Receives Cranberry juice BID (two times a day) -Takes meds routinely to (decrease) bladder spasms to allow emptying."</p> <p>Client #2's 2/23/09 protocol/risk plan did not specifically indicate/describe the appropriate technique, specifically indicate what signs and symptoms staff were to look for/monitor and/or indicate when the nurse should be called.</p> <p>Client #2's 7/30/07 Hypertension Protocol "-High blood pressure refers to blood traveling through the arteries at a pressure too high for good health. Tx (treatment): -Weight Control -Exercise -Diet-avoid excessive salt intake -Medication -Monitoring</p>				

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	<p>Individualized Plan: 8/23/12 -Enc (encourage) physical exercise Receives antihypertensive Rx (medication) BP (blood pressure) monitored monthly."</p> <p>Client #2's 7/30/07 protocol/risk plan did not specifically indicate when staff should call the nurse in regard to the client's blood pressure and/or what they were to monitor for.</p> <p>Interview with staff #1 on 10/31/12 at 9:45 AM indicated facility staff did not monitor client #2's blood pressure. Staff #1 indicated the facility nurse took/monitored the client's blood pressure. Staff #1 indicated client #2's blood pressure protocol and/or catheterization protocol did not indicate when the staff should call the nurse. Staff #1 indicated facility staff did client #2's catheterization. Staff #1 indicated client #2's catheterization protocol did not indicate what specific signs of infection staff should monitor for. Staff #1 indicated facility staff monitored how client #2's urine in regard to how it looked, the input and out put.</p> <p>Interview with RN #2 on 10/31/12 at 11:25 AM indicated she was the nurse for</p>			

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	<p>the group home and she started on 10/1/12. RN #2 indicated the nursing staff monitored clients' blood pressures. RN #2 indicated client #2 Hypertension Protocol would need to be updated. RN #2 indicated the protocol did not indicate when the nurse should be called and/or what signs symptoms staff should be monitoring to know when to call the nurse. RN #2 indicated client #2's protocol for the catheterization should also be updated to include what staff were to specifically do, include the signs of infection staff should look for and when to call the nurse.</p> <p>2. Client #3's record was reviewed on 10/30/12 at 11:38 AM. Client #3's 11/1/12 physician's orders indicated client #2 received Norvasc 5 milligrams daily, Toprol XL 50 milligrams daily and Hyzaar 100-25 daily for Hypertension. Client #3's 11/1/12 physician's order indicated the client's blood pressure was to be checked monthly.</p> <p>Client #3's Quarterly Nursing Summaries from 1/12 to 9/12 indicated the following (not all inclusive):</p> <p>-2/16/12 Cozaar 100 milligrams daily ordered for client #3's blood pressure which was 158/90 on 2/15/12.</p>						

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	<p>-8/9/12 B/P 160/98 left arm and 150/100 in the right arm. The 7/12 to 9/12 quarterly assessment indicated client #3's doctor discontinued the Cozaar and started the client on Hyzaar 100/25 daily and ordered weekly blood pressure checks.</p> <p>-8/10/12 B/P 140/80</p> <p>-8/14/12 B/P 160/80</p> <p>-8/15/12 Toprol XL was added to the client's routine medications to address the client's Hypertension.</p> <p>-8/24/12 B/P 130/80</p> <p>-9/12/12 B/P 120/70</p> <p>Client #3's April 2012 Hypertension Protocol indicated "-High blood pressure refers to blood traveling through the arteries at a pressure too high for good health. Tx (treatment):</p> <ul style="list-style-type: none"> <li>-Weight Control</li> <li>-Exercise</li> <li>-Diet-avoid excessive salt intake</li> <li>-Medication</li> <li>-Monitoring</li> </ul> <p>Individualized Plan:</p> <ul style="list-style-type: none"> <li>-Maintain weight</li> <li>-Encourage as much upper body exercise</li> </ul>						

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	<p>as possible</p> <p>-10/10-to ambulate with walker 1 time daily</p> <p>-Takes antihypertensive 4/12 additional antihypertensive med added</p> <p>-B/P to be checked monthly."</p> <p>Client #3's record, nurse notes and/or physician's orders did not indicate the facility's nurse monitored the client's blood pressure weekly past 9/12/12, and/or contacted the client's doctor to clarify how often the client's blood pressure was to be monitored.</p> <p>Interview with staff #1 on 10/31/12 at 9:45 AM indicated facility staff did not monitor client #3's blood pressure as the nurse monitored the client's blood pressure. Staff #1 indicated client #3's protocol did not indicate when facility staff were to contact the nurse in regard to the client's blood pressure and/or indicate what signs/symptoms staff should watch for to contact the nurse.</p> <p>Interview with RN #2 on 10/31/12 at 11:25 AM indicated she had been the nurse at the group home since 10/1/12. When shown client #3's nurse quarterly summaries, RN #1 indicated it appeared client #3's doctor changed the client's blood pressure to be checked weekly. RN #1 indicated nursing staff monitored</p>			

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	<p>clients' blood pressures. RN #2 indicated she was not aware she was to monitor client #3's blood pressure weekly. RN #2 indicated she did not know if the client's doctor changed the monitoring back to monthly or wanted the client's blood pressure checked weekly.</p> <p>3. Client #1's record was reviewed on 10/30/12 at 10:18 AM. Client #1's 11/1/12 physician's orders indicated client #1 received Catapres 0.1 milligrams two times a day for high blood pressure. The physician's order indicated the client's blood pressure was to be monitored quarterly.</p> <p>Client #1's 4/24/12 Hypertension Protocol indicated "-High blood pressure refers to blood traveling through the arteries at a pressure too high for good health. Tx (treatment):</p> <ul style="list-style-type: none"> <li>-Weight Control</li> <li>-Exercise</li> <li>-Diet-avoid excessive salt intake</li> <li>-Medication</li> <li>-Monitoring</li> </ul> <p>Individualized Plan:</p> <ul style="list-style-type: none"> <li>"-NCS (no concentrated sweets) Diet/no seconds/no bread</li> <li>-Up &amp; about independently</li> <li>-Receives antihypertensive</li> <li>-Blood pressure monitored monthly."</li> </ul>			

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	<p>Client #1's record and/or 2012 nurse notes did not indicate the facility's nurse clarified how often client #1's blood pressure was to be monitored and/or updated the client's protocol/risk plan.</p> <p>Interview with staff #1 on 10/31/12 at 9:45 AM indicated facility staff did not monitor client #1's blood pressure as the nurse monitored the client's blood pressure. Staff #1 indicated client #1's protocol did not indicate when facility staff were to contact the nurse in regard to the client's blood pressure, and/or indicate what signs/symptoms staff should watch for to contact the nurse.</p> <p>Interview with RN #2 on 10/31/12 at 11:25 AM indicated she had been the nurse at the group home since 10/1/12. RN #1 indicated nursing staff monitored clients' blood pressures. RN #2 indicated clients' blood pressures were monitored quarterly unless the clients' doctors indicated otherwise. RN#2 indicated client #1's protocol should be updated.</p> <p>9-3-6(a)</p>				

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W0342	<p>483.460(c)(5)(iii) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.</p> <p>Based on interview and record review for 1 of 4 sampled clients (#2), the facility's nursing services failed to specifically train staff in regard to performing the catheterization of a client, and/or to ensure all staff were competent in performing the medical/health procedure.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 10/30/12 at 12:22 PM. Client #2's 11/1/12 physician's orders indicated client #2's diagnoses included, but were not limited to, Neurogenic Bladder and Bowel and Chronic Urinary Tract Infection (UTI). Client #2's 11/1/12 physician's orders indicated an "In-out Straight Cath (catheterization) 5 X (times)/day - Staff to do when @ (at) home (Using Sterile Technique)."</p> <p>Client #2's 2/23/09 Catheterization Protocol indicated "In and Out Catheterization -Bladder drained</p>	W0342	<p>The Group Home Coordinator, Group Home Manager, Group Home Assistant Manager, and all direct care staff will be trained on client #1's Catheterization Protocol by a licensed nurse.</p> <p>Preventatively, the Nursing Coordinator and V.P. of Residential Services developed a training protocol to ensure all staff are trained by a licensed nurse for all basic skills required to meet the health needs of clients daily catheterizations.</p>	12/02/2012

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	<p>intermittently at designated times Perform procedure using appropriate technique Prevention of infection/Monitor for infection</p> <p>Individualized Plan: -Cathed 5 x/day via sterile technique -Nurses @ [name of workshop] perform cathing during the day...."</p> <p>The facility's undated Specializes Tasks sheet was reviewed on 10/31/12 at 11:54 AM. The undated sheet indicated "Annually, the nurses will observe management perform specialized task(s) necessary at their residences to ascertain their competency level. Subsequently, on an annual basis, the managers will observe their staff perform the same task(s). Competency Forms are to be completed...." The undated memo/sheet indicated the Alvord Group Home specialized testing for Straight Catheterization, VNS (Vagal Nerve Stimulator) and CPAP (sleep apnea machine) would be completed in September.</p> <p>The facility's training records were reviewed on 10/31/12 at 12:55 PM and at 3:00 PM. Staff #1's 9/14/12 Statement of Competency indicated staff #1 was trained in regard to Straight</p>						

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	<p>Catheterization and competency was performed on 9/14/12 by RN #3. The facility's Staff Performance Records indicated staff #3, #9, #10, #11 and #12 were trained by staff #1 (unlicensed staff) in regard to Straight Catheterization from 11/11 to 9/12. The facility did not provide any documentation of training for staff #2, #4, #5, #6, #7 and #8 in regard to catheterization training and/or demonstrated competency.</p> <p>Interview with staff #1 on 10/31/12 at 9:45 AM indicated she (staff #1) was trained by the facility's nurse to do straight catheterization on client #2. Staff #1 indicated she then trained the facility staff to perform the procedure technique. Staff #1 indicated new staff would watch the procedure be performed 3 times and then they would be observed 3 times before the she would sign the staff were competent to do the procedure. Staff #1 indicated she was not a licensed nurse or medical staff. Staff #1 indicated the facility's nurse did not train staff in regard to the medical procedure. Staff #1 also indicated staff #1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11 had been trained in regard to the procedure.</p> <p>Interview with RN #2 on 10/31/12 at 11:25 AM indicated she had been the nurse for the group home since 10/1/12.</p>						

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	<p>RN #2 indicated she had not trained staff in regard to straight catheterization. RN #2 indicated she thought nursing staff was doing training/competency checks once a year.</p> <p>Interview with RN #1, RN #3 and LPN #1 on 10/31/12 at 12:40 PM indicated staff #1 was the only staff trained by nursing staff to perform straight catheterization on client #2. RN #1 indicated staff #1 trained the other staff in the group home. When asked if staff #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11 had been checked off/monitored for competency, RN #1, #3 and LPN #1 did not know. RN #1 indicated staff #1 would also monitor/check the staff off in regard to competency. RN #1 indicated staff #1 checked the staff for competency annually. RN #1 indicated the facility's nursing staff did not monitor/check unlicensed facility staff, who performed a medical procedure, for competency.</p> <p>9-3-6(a)</p>						

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W0455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation, interview and record review for 3 of 4 sampled clients (#1, #3 and #4) and for 1 additional client (#7), the facility failed to ensure clients washed their hands prior to eating at meals to avoid transmission of germs/disease.</p> <p>Findings include:</p> <p>During the 10/29/12 observation period between 4:20 PM and 6:30 PM, at the group home at 4:45 PM, staff went into client #4's bedroom and told the client it was time for dinner. Client #4 scooted himself on the floor with his right hand and dragging his feet behind him to the dining room area. Client #4 then lifted himself into the dining room chair. Staff #1, #3 and/or #4 did not encourage client #4 to wash his hands after he used his right hand to scoot from the back of the house to the dining room area. Staff also told client #3 it was time to eat. Client #3 rolled himself in his wheelchair to the front of the house. Staff #1, #3 and #4 did not encourage client #3 to wash his hands prior to serving himself and eating his dinner meals. Client #1 who, was standing in the dining room tearing a page</p>	W0455	<p>All staff were retrained on the importance of sanitation and hand washing. They were also retrained on client #1's objective to wash his hands after toileting.</p> <p>Observations will be completed on client #1's objective to wash his hands as well as that all residents wash their hands prior to meals and otherwise as needed.</p>	12/02/2012			

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	<p>out of a book, was not prompted and/or encouraged to wash his hands prior to eating dinner. Staff also did not prompt and/or encourage client #7 to wash his hands.</p> <p>Client #1's record was reviewed on 10/30/12 at 10:18 AM. Client #1's 7/12/12 Individual Program Plan (IPP) indicated the client had an objective to wash his hands after toileting.</p> <p>Interview with staff #1 and the Group Home Coordinator (GHC) on 10/31/12 at 9:45 AM indicated clients should be encouraged to wash their hands prior to eating to avoid transmission of germs. The GHC stated "We need to work on this."</p> <p>9-3-7(a)</p>			

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W0488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and for 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure clients were involved in all aspects of the meal preparation to the extent of their capabilities.</p> <p>Findings include:</p> <p>During the 10/29/12 observation period between 4:20 PM and 6:30 PM at the group home, clients #6 and #7 were periodically in the kitchen to assist with the dinner meal. Client #6 pushed a button to puree food items and client #6 placed bread on a cookie sheet. Facility staff #4 placed silverware on the table as client #1 stood in the dining room tearing a page out of a book, client #5 was sitting on the couch in the living room looking around and client #3 was in his bedroom. The Group Home Coordinator (GHC) carried the salad, dressing, and spaghetti sauce to the table without involving clients #1, #2, #3, #4, #5, #6, #7 and/or #8 to the extent of their capabilities. Staff #1 poured client #3's milk and Kool-aid/juice in the client's cup without hand over hand assistance/training. Staff #1 cut up client</p>	W0488	<p>All professional and Alvord group home staff were retrained on ensuring all clients are involved in meal preparation according to their ability. Particularly, client #1's goal to put his fork down between bites and client #3's and #4's goals to assist in meal preparation.</p> <p>Observations of cited meal preparation goals and general client involvement in meal preparation will occur once per week for four weeks to ensure it is occurring appropriately.</p> <p>Preventatively, the Group Home Coordinator will observe meal preparation and client involvement at least three times for one month on an ongoing basis.</p>	12/02/2012			

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	<p>#1's spaghetti and meatballs without involving the client. The GHC cut up client #2's meatballs on his plate and served client #3's spaghetti sauce with meatballs without involving the client. Although staff #1 sat next to client #1, client #1 ate 5 bites of spaghetti at a fast pace before staff #1 prompted the client to slow down and take a drink. Staff did not encourage the client to place his fork down between bites of food.</p> <p>During the 10/30/12 observation period between 5:25 AM and 8:33 AM, at the group home, client #1 was sitting at the kitchen counter eating scrambled eggs and toast/english muffins. At 5:46 AM, staff #1 asked client #2 if he wanted a glass of milk and then client #2 if he wanted chocolate in his milk. Client #2 stated "Yes." Staff #1 poured milk into a cup and poured some chocolate into the client's milk without involving the client. Client #2 was able to feed himself and capable of serving himself. At 6:05 AM, staff #12 assisted client #6 to come into the kitchen area/counter to eat his breakfast. Staff #12 retrieved eggs from a serving dish (which were already cooked) and placed the eggs in a high sided plate for the client. Staff poured coffee in a cup and cream for client #6. Staff asked if the client wanted Splenda and placed the sweetener into the cup. At 7:16 AM,</p>			

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	<p>client #3 came into the dining room for his breakfast. Staff #12 fixed client #3 scrambled eggs without involving the client and placed toast in a toaster without involving the client. The staff then fixed the client's plate and carried it to the dining room where client #3 was located. Client #3 was able to serve himself fruit (honey dew melon) without staff assistance. At 7:35 AM, client #1 came into the dining room to eat his breakfast. Staff #12 prepared scrambled eggs for the client with cheese and made client #1 a bowl of grits without involving the client. Once staff #12 carried the client's plate of food to him, client #1 asked staff to put cheese in his grits. Staff did not encourage the client to go and get the cheese and place the cheese in his grits. Client #4 also came to the table and staff #12 fixed client #4's plate (eggs) and english muffin and carried it to the table. Staff also fixed client #8's breakfast (eggs and toast) without involving the client.</p> <p>Client #1's record was reviewed on 10/30/12 at 10:18 AM. Client #1's 7/12/12 Individual Program Plan (IPP) indicated client #1 had an objective to put his fork down between bites.</p> <p>Client #3's record was reviewed on 10/30/12 at 11:38 AM. Client #3's IPP indicated the client had an objective to</p>			

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	<p>assist in meal preparation.</p> <p>Client #4's record was reviewed on 10/30/12 at 1:45 PM. Client #4's 6/22/12 IPP indicated the client had an objective to assist in meal preparation.</p> <p>Interview with staff #1 and the Group Home Coordinator (GHC) on 10/31/12 at 9:45 AM indicated clients #1, #2, #3, #4, #5, #6, #7 and #8 should be involved in meal preparation to the extent of their capabilities.</p> <p>9-3-8(a)</p>			