

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G251	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/23/2015
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NAME OF PROVIDER OR SUPPLIER  REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 511 COUNTRY CLUB LN ANDERSON, IN 46015
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W 0000  Bldg. 00	<p>This visit was a post certification revisit to a post certification revisit completed on 8/18/15 to a pre-determined full recertification and state licensure survey completed on 7/10/15.</p> <p>This visit was in conjunction with a post certification revisit to a post certification revisit to the investigation of complaint #IN00172930.</p> <p>Dates of Survey: October 19, 20 and 23, 2015.</p> <p>Facility number: 000771 Provider number: 15G251 AIM number: 100243430</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/5/15.</p>	W 0000		
W 0111  Bldg. 00	<p>483.410(c)(1) CLIENT RECORDS</p> <p>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's</p>			

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

TITLE

(X6) DATE

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

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	<p>rights.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client C) to maintain an accurate record keeping system to document medical and risk plan implementation information in the record.</p> <p>Findings include:</p> <p>Client C's digital October, 2015 Medication Administration Record (MAR) was reviewed on 10/19/15 at 6:14 PM. The MAR indicated there was missing documentation on 10/11/15 for skin checks daily at 8:00 PM. There was missing documentation for toileting on 10/11/15 at 2:00 PM and at 10:00 PM, and on 10/17/15 and on 10/18/15 at 10:00 PM. The MAR indicated missing documentation for accurate medication checks on 10/18/15 at 11:00 AM, 4:00 PM and 8:00 PM. The MAR indicated for Wound care-Balmex, "Complete wound care daily and PRN (as needed), especially after incontinence episodes. Wound care instructions: 1. Make sure the areas are THOROUGHLY cleaned. 2. Pat dry with clean cloth or allow to air dry. 3. Apply Balmex and coat the wounds in a thick layer. 4. Document in the skin/wound module."</p> <p>Client C's paper documentation of client</p>	W 0111	<p><b>W 111 Client Records</b></p> <p>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of client rights.</p> <p><b>1. What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Staff meeting scheduled on 11-20-15 to review documentation requirements, brother's keeper expectations and the expectations for the MAR.</li> <li>· Program Coordinator/QIDP/nurse oversight of the MAR on a daily basis.</li> <li>· The repositioning schedule has now been added to the MAR for ease of documentation and oversight.</li> </ul> <p><b>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the same deficient practice.</li> <li>· Program Coordinator/QIDP/nurse oversight of the MAR's on a daily basis when in the home to ensure it is completed and holes are addressed appropriately.</li> <li>· Staff meeting scheduled on 11-20-15 to review documentation requirements, brother's keeper expectations and the expectations for the MAR.</li> </ul>	11/22/2015			

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	<p>C's hourly repositioning schedule in the group home was reviewed on 10/19/15 at 6:25 PM. The paper documentation indicated missing documentation on 9/22/15 at 12:00 AM, on 9/29/15, 6:00-7:00 AM, 4:00 PM until 4:00 AM, on 10/4/15, 5:00 PM until 10:00 PM, on 10/10/15, 10:00 AM-11:00 PM, and on 10/11/15 and 4:00 PM-7:00 PM.</p> <p>Client C's record was reviewed on 10/20/15 at 9:40 AM. A Risk Plan updated 8/19/15 indicated client C was at risk for impaired skin integrity and broken skin (impaired integrity) "...results in open wounds, pressure sores, infection and pain. Prevention: The key to keeping the skin intact is keeping it dry and pressure free...Pressure can be relieved by repositioning the client or prompting to reposition and encouraging functional alignment when sitting upright. [Client C] has a wheelchair that leans back which she can do independently. While the chair is leaned back she can maneuver herself into a more comfortable position...[Client C] is continent, however uses adult incontinent products in case of accidents. Staff assist her with changing, as needed. [Client C] is able to tell staff when she needs to use the restroom. Staff will ensure they respond promptly to [client C] when she needs to use the restroom and will assist</p>		<ul style="list-style-type: none"> <li>· Random medication practicums to be completed with the staff by the nurse and the Program Coordinator on a monthly basis to ensure staff are following proper medication passing and documentation procedures.</li> <li>· Nurse to complete medication practicums with staff who continually make errors (documentation or actual med errors) to ensure competency prior to passing medication again.</li> <li>· Monthly supervisor visit check sheets to be completed by the QIDP. This check sheet includes oversight of the individuals MAR's.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· Program Coordinator/QIDP/nurse oversight of the MAR's on a daily basis when in the home to ensure it is completed and holes are addressed appropriately.</li> <li>· Staff meeting scheduled on 11-20-15 to review documentation requirements, brother's keeper expectations and the expectations for the MAR.</li> <li>· Random medication practicums to be completed with the staff by the nurse and the Program Coordinator on a monthly basis to ensure staff are following proper medication passing and documentation procedures.</li> <li>· Nurse to complete medication</li> </ul>				

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	<p>her in cleaning her thoroughly after using the restroom. Staff are trained to report anything unusual (including injuries to the skin) to the HM (House Manager)/PD (Program Director) along with how to document in [digital record keeping system]. Body mechanics is taught as part of orientation and good body alignment is included. [Client C] uses a wheelchair for mobility. Staff will prompt and provide assistance with re-positioning at least every 1 hours (sic) and document. [Client C] utilizes a standing lift for transfers. [Client C] has impaired skin integrity and is being treated for open areas. Staff are completing treatments as ordered by MD (Medical Doctor), monitoring skin checks and documenting in the skin wound module. Staff will report (with a phone call) any new skin issues, open areas and skin changes to the HM who will consult with MD/nurse...."</p> <p>Paper documentation of client C's hourly re-positioning completed in the group home brought in by the PD was reviewed on 10/20/15 at 11:52 AM and indicated no missing documentation as noted upon review of the documentation on 10/19/15 at 6:25 PM.</p> <p>The PD was interviewed on 10/20/15 at 11:52 AM. When asked who reviewed the documentation, she stated, "I do,</p>		<p>practicums with staff who continually make errors (documentation or actual med errors) to ensure competency prior to passing medication again.</p> <ul style="list-style-type: none"> <li>· Monthly supervisor visit check sheets to be completed by the QIDP. This check sheet includes oversight of the individuals MAR's.</li> </ul> <p><b>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· Medication practicums that are completed by the Program Coordinator will be forwarded to the QIDP and the nurse for review.</li> <li>· Monthly supervisory visit check sheets to be completed by the QIDP. These will be forwarded to the Area Director for review.</li> <li>· Oversight of the MAR will be completed by the Program Coordinator, QIDP, and nurse.</li> </ul> <p><b>5. What is the date by which the systemic changes will be completed?</b></p> <ul style="list-style-type: none"> <li>· November 22nd, 2015</li> </ul>		

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	<p>weekly," and indicated the nurse also reviewed the documentation weekly at the group home. The PD indicated staff were notified of missing documentation via digital messages and the PD or HM reviewed the need to document at staff training. She stated "It's being done." When asked about the discrepancy between the documentation reviewed on 10/19/15 and 10/20/15, she indicated staff were asked if they completed the repositioning when documentation was found missing and filled in the missing documentation if they were certain they had completed the repositioning. When asked if staff should complete documentation after days had passed, she stated, it's "not ideal." The PD stated, "Honestly, this is cumbersome-the MAR should be documented. It's hard to keep up with."</p> <p>The group home nurse was interviewed on 10/20/15 at 12:15 PM and when asked about documentation in client C's record, stated, "We should try to communicate daily." When asked about the missing documentation, she indicated the PD and PC (Program Coordinator/House Manager) communicate daily. The nurse stated, "If we find something missing, we can talk to staff on (on duty) if they remembered (they had completed hourly repositioning), it's OK to document. We</p>			

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W 0191 Bldg. 00	<p>want to follow up on why it's missing."</p> <p>9-3-1(a)</p> <p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs.</p> <p>Based upon observation, interview and record review for 1 of 4 sampled clients (client C), the facility failed ensure staff were trained to competency to implement and document client C's risk plan and interventions to prevent skin breakdown/pressure wounds.</p> <p>Findings include:</p> <p>During observations at the group home from 6:00 PM until 6:40 PM on 10/19/15, client C sat in a recliner in the group home living room with her feet elevated.</p> <p>Client C's digital October, 2015 Medication Administration Record (MAR) was reviewed on 10/19/15 at 6:14 PM. The MAR indicated there was missing documentation on 10/11/15 for</p>	W 0191	<p><b>W 191 Staff Training Program</b> For employees who work with clients, training must focus on skills and competencies directed towards clients' behavioral needs.</p> <p><b>1. What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Staff meeting scheduled on 11-20-15 to review documentation requirements, brother's keeper expectations and the expectations for the MAR.</li> <li>· Program Coordinator/QIDP/nurse oversight of the MAR on a daily basis.</li> <li>· The repositioning schedule has now been added to the MAR for ease of documentation and oversight.</li> <li>· Client C's risk plan for skin integrity will be reviewed and revised as necessary.</li> <li>· Staff will be retrained on Client C's risk plan for skin integrity on 11-20-15.</li> <li>· Programming will be</li> </ul>	11/22/2015	

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	<p>skin checks daily at 8:00 PM. There was missing documentation for toileting on 10/11/15 at 2:00 PM and at 10:00 PM, and on 10/17/15 and 10/18/15 at 10:00 PM. The MAR indicated missing documentation for accurate medication checks on 10/18/15 at 11:00 AM, 4:00 PM and 8:00 PM. The MAR indicated for Wound care-Balmex, "Complete wound care daily and PRN (as needed), especially after incontinence episodes. Wound care instructions: 1. Make sure the areas are THOROUGHLY cleaned. 2. Pat dry with clean cloth or allow to air dry. 3. Apply Balmex and coat the wounds in a thick layer. 4. Document in the skin/wound module."</p> <p>Client C's paper documentation of client C's hourly repositioning schedule in the group home was reviewed on 10/19/15 at 6:25 PM. The paper documentation indicated missing documentation on 9/22/15 at 12:00 AM, on 9/29/15, 6:00-7:00 AM, 4:00 PM until 4:00 AM, on 10/4/15, 5:00 PM until 10:00 PM, on 10/10/15, 10:00 AM-11:00 PM, and on 10/11/15 and 4:00 PM-7:00 PM.</p> <p>During observations at the group home from 6:30 AM until 7:30 AM on 10/20/15, client C sat in a wheelchair in the dining room and was taken to the medication room by staff in her</p>		<p>implemented for Client C to address her refusals to follow recommendations to help prevent skin issues.</p> <ul style="list-style-type: none"> <li>· A new nurse is currently going through training. The importance of documenting her assessments accurately and ongoing will be addressed.</li> <li>· The expectation of completing nursing assessments and monitoring of skin/wound issues will be reviewed with the new nurse.</li> <li>· Staff will be retrained on how to complete the skin/wound documentation and when to notify the Program Coordinator/QIDP/nurse for skin/wound issues on 11-20-15.</li> </ul> <p><b>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the same deficient practice.</li> <li>· Program Coordinator/QIDP/nurse oversight of the MAR's on a daily basis when in the home to ensure it is completed and holes are addressed appropriately.</li> <li>· Staff meeting scheduled on 11-20-15 to review documentation requirements, brother's keeper expectations and the expectations for the MAR.</li> <li>· Random medication practicums to be completed with the</li> </ul>				

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	<p>wheelchair.</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 10/20/15 at 9:25 AM. A BDDS report dated 9/21/15 at 10:00 PM indicated "while completing a skin check, staff discovered a 1 cm (centimeter) x (by) 1 cm open sore on [client C's] apron fold (abdomen)." Corrective action indicated "Staff applied prn (as needed) Balmex to the wound. Nurse observed the wound on 9/22/15." The report indicated client C had "an appointment with her PCP (primary care physician) on Friday, 9/25/15 to determine whether a wound care clinic referral is necessary as she is currently discharged from there...wound is very small. Will monitor for healing. She is on a turning schedule every hour and will continue these as well as skin checks daily. The cause of the wound is due to immobility, diabetes diagnosis and obesity."</p> <p>Client C's record was reviewed on 10/20/15 at 9:40 AM. A Risk Plan updated 8/19/15 indicated client C was at risk for impaired skin integrity and broken skin (impaired integrity) "...results in open wounds, pressure sores, infection and pain. Prevention: The key to keeping the skin intact is keeping it dry</p>		<p>staff by the nurse and the Program Coordinator on a monthly basis to ensure staff are following proper medication passing and documentation procedures.</p> <ul style="list-style-type: none"> <li>· Nurse to complete medication practicums with staff who continually make errors (documentation or actual med errors) to ensure competency prior to passing medication again.</li> <li>· Monthly supervisor visit check sheets to be completed by the QIDP. This check sheet includes oversight of the individuals MAR's.</li> <li>· The QIDP will monitor and review the resident's needs. As the needs arise, formal programming will be implemented.</li> <li>· The nurse will complete weekly assessments of Client C to ensure there are no skin/wound issues or other concerns that arise until the IDT determines that they are no longer necessary.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· Program Coordinator/QIDP/nurse oversight of the MAR's on a daily basis when in the home to ensure it is completed and holes are addressed appropriately.</li> <li>· Staff meeting scheduled on 11-20-15 to review documentation requirements, brother's keeper expectations and the expectations for</li> </ul>				

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	and pressure free...Pressure can be relieved by repositioning the client or prompting to reposition and encouraging functional alignment when sitting upright. [Client C] has a wheelchair that leans back which she can do independently. While the chair is leaned back she can maneuver herself into a more comfortable position...[Client C] is continent, however uses adult incontinent products in case of accidents. Staff assist her with changing, as needed. [Client C] is able to tell staff when she needs to use the restroom. Staff will ensure they respond promptly to [client C] when she needs to use the restroom and will assist her in cleaning her thoroughly after using the restroom. Staff are trained to report anything unusual (including injuries to the skin) to the HM (House Manager)/PD (Program Director) along with how to document in [digital record keeping system]. Body mechanics is taught as part of orientation and good body alignment is included. [Client C] uses a wheelchair for mobility. Staff will prompt and provide assistance with re-positioning at least every 1 hours (sic) and document. [Client C] utilizes a standing lift for transfers. [Client C] has impaired skin integrity and is being treated for open areas. Staff are completing treatments as ordered by MD (Medical Doctor), monitoring skin checks and documenting in the skin		the MAR. · Random medication practicums to be completed with the staff by the nurse and the Program Coordinator on a monthly basis to ensure staff are following proper medication passing and documentation procedures. · Nurse to complete medication practicums with staff who continually make errors (documentation or actual med errors) to ensure competency prior to passing medication again. · Monthly supervisor visit check sheets to be completed by the QIDP. This check sheet includes oversight of the individuals MAR's. · The QIDP will monitor and review the resident's needs. As the needs arise, formal programming will be implemented. · The nurse will complete weekly assessments of Client C to ensure there are no skin/wound issues or other concerns that arise until the IDT determines that they are no longer necessary.  <b>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</b> · Medication practicums that are completed by the Program Coordinator will be forwarded to the QIDP and the nurse for review. · Monthly supervisory visit check sheets to be completed by the QIDP. These will be forwarded to the Area Director for review. · Oversight of the MAR will be completed by the Program				

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	<p>wound module. Staff will report (with a phone call) any new skin issues, open areas and skin changes to the HM who will consult with MD/nurse...."</p> <p>Skin/Wound Assessments in client C's record dated 9/21/15 at 8:25 PM indicated a "skin tear, redness, hard or hot 1.5 cm, reported to on call area is red located under the abdominal fold." Assessments dated 9/30/15 indicated "perineal irritation" and "gaulding (chafing) to inner gluteal (sic) folds" noted by the group home nurse at 4:29 PM and at 9:49 PM note written by direct support staff #7 indicated "between buttocks appears to be red client reported itching, reported to nurse."</p> <p>T-Log entries in client C's record entered by the nurse indicated on 9/22/15 client C "has a 1 cm split on left side of abd (abdominal) fold, area is very superficial in nature, area pink, no s/sx (signs and symptoms) of infection, no c/o (complaints of) pain, back and sides of legs checked, no open areas noted. Will have res (resident) seen at wound clinic for evaluation." Client C was seen again by the nurse on 9/23/15 and on 9/24/15 with no changes indicated in the note in regards to the status of the 1 cm split found under client C's abdominal fold.</p>		<p>Coordinator, QIDP, and nurse.</p> <ul style="list-style-type: none"> <li>· The nurse will be in the home at least weekly basis or more frequently to monitor for concerns and assess residents as needed.</li> <li>· New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, programming, and medication review.</li> <li>· The nurse will complete weekly assessments of Client C to ensure there are no skin/wound issues or other concerns that arise until the IDT determines that they are no longer necessary.</li> </ul> <p><b>5. What is the date by which the systemic changes will be completed?</b> November 22nd, 2015</p>				

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	<p>A visit to client C's PCP dated 9/25/15 failed to indicate documentation client C's skin in the gluteal or abdominal fold area had been evaluated. The discussion note indicated "cont (continue) Tx (treatments)/Rx (medications)."</p> <p>A visit to a wound care clinic dated 10/6/15 in the record indicated client C was seen for ABD (abdomen) with instructions to "Apply powder to fold area daily and PRN (as needed) no ointment to fold areas. Okay to use/continue Balmex for rectal erythema (redness) as needed." There was no evidence in client C's record of a revision to her Risk Plan or MAR to address the recommendations made by the wound clinic to address her abdominal fold wound.</p> <p>Paper documentation of client C's hourly re-positioning completed in the group home brought in by the PD was reviewed on 10/20/15 at 11:52 AM and indicated no missing documentation as noted upon review of the documentation on 10/19/15 at 6:25 PM.</p> <p>The PD was interviewed on 10/20/15 at 11:52 AM. When asked who reviewed the documentation, she stated, "I do, weekly," and indicated the nurse also reviewed the documentation weekly at</p>			

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NAME OF PROVIDER OR SUPPLIER  REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 511 COUNTRY CLUB LN ANDERSON, IN 46015
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	<p>the group home. The PD indicated staff were notified of missing documentation via digital messages and the PD or HM reviewed the need to document at staff training. She stated "It's being done." When asked about the discrepancy between the documentation reviewed on 10/19/15 and 10/20/15, she indicated staff were asked if they completed the repositioning when documentation was found missing and filled in the missing documentation if they were certain they had completed the repositioning. When asked if staff should complete documentation after days had passed, she stated, it's "not ideal." The PD stated, "Honestly, this is cumbersome-the MAR should be documented. It's hard to keep up with."</p> <p>The group home nurse was interviewed on 10/20/15 at 12:15 PM and when asked about documentation in client C's record, stated, "We should try to communicate daily." When asked about the missing documentation, she indicated the PD and PC (Program Coordinator/House Manager) communicate daily. The nurse stated, "If we find something missing, we can talk to staff on (on duty) if they remembered (they had completed hourly repositioning), it's OK to document. We want to follow up on why it's missing." When asked about nursing assessments</p>			

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	<p>for client C after the reddened area on her gluteal area had been found on 9/30/15 and the wound found on 9/21/15 in client C's abdominal fold, she indicated the nurse should be completing weekly assessments of client C's skin or more often if staff noted concerns.</p> <p>This deficiency was cited on July 10 and August 18, 2015. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-3(a)</p>			
W 0331 Bldg. 00	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based upon observation, interview and record review for 1 of 4 sampled clients (client C), the facility's nursing services</p>	W 0331	<p><b>W 331 Nursing Services</b></p> <p>The facility must provide clients with nursing services in accordance with</p>	11/22/2015

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	<p>failed to ensure staff were trained to competency to document client C's risk plan and interventions to prevent skin breakdown/pressure wounds. The facility's nursing services failed to update client C's risk plan to address an abdominal wound, failed to complete timely nursing assessments to detect and address skin wounds, and failed to ensure client C's weight was obtained to address dietary recommendations to lose weight.</p> <p>Findings include:</p> <p>During observations at the group home from 6:00 PM until 6:40 PM on 10/19/15, client C sat in a recliner in the group home living room with her feet elevated.</p> <p>Client C's digital October, 2015 Medication Administration Record (MAR) was reviewed on 10/19/15 at 6:14 PM. The MAR indicated there was missing documentation on 10/11/15 for skin checks daily at 8:00 PM. There was missing documentation for toileting on 10/11/15 at 2:00 PM and at 10:00 PM, and on 10/17/15 and 10/18/15 at 10:00 PM. The MAR indicated missing documentation for accurate medication checks on 10/18/15 at 11:00 AM, 4:00 PM and 8:00 PM. The MAR indicated for Wound care-Balmex, "Complete</p>		<p>their needs.</p> <p><b>1. What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Staff meeting scheduled on 11-20-15 to review documentation requirements, brother's keeper expectations and the expectations for the MAR.</li> <li>· Program Coordinator/QIDP/nurse oversight of the MAR on a daily basis.</li> <li>· The repositioning schedule has now been added to the MAR for ease of documentation and oversight.</li> <li>· Client C's risk plan for skin integrity will be reviewed and revised as necessary.</li> <li>· Staff will be retrained on Client C's risk plan for skin integrity on 11-20-15.</li> <li>· Programming will be implemented for Client C to address her refusals to follow recommendations to help prevent skin issues.</li> <li>· A new nurse is currently going through training. The importance of documenting her assessments accurately and ongoing will be addressed.</li> <li>· The expectation of completing nursing assessments and monitoring of skin/wound issues will be reviewed with the new nurse.</li> <li>· Staff will be retrained on how to complete the skin/wound documentation and when to notify the Program Coordinator/QIDP/nurse for skin/wound issues on 11-20-15.</li> </ul>				

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	<p>wound care daily and PRN (as needed), especially after incontinence episodes. Wound care instructions: 1. Make sure the areas are THOROUGHLY cleaned. 2. Pat dry with clean cloth or allow to air dry. 3. Apply Balmex and coat the wounds in a thick layer. 4. Document in the skin/wound module."</p> <p>Client C's paper documentation of client C's hourly repositioning schedule in the group home was reviewed on 10/19/15 at 6:25 PM. The paper documentation indicated missing documentation on 9/22/15 at 12:00 AM, on 9/29/15, 6:00-7:00 AM, 4:00 PM until 4:00 AM, on 10/4/15, 5:00 PM until 10:00 PM, on 10/10/15, 10:00 AM-11:00 PM, and on 10/11/15 and 4:00 PM-7:00 PM.</p> <p>During observations at the group home from 6:30 AM until 7:30 AM on 10/20/15, client C sat in a wheelchair in the dining room and was taken to the medication room by staff in her wheelchair.</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 10/20/15 at 9:25 AM. A BDDS report dated 9/21/15 at 10:00 PM indicated "while completing a skin check, staff discovered a 1 cm (centimeter) x (by) 1 cm open sore on</p>		<ul style="list-style-type: none"> <li>· A wheelchair scale is available to accurately weigh Client C.</li> <li>· Monthly weights are to be obtained and documented for Client C.</li> <li>· Staff will be retrained on how to document the weights for the clients on 11-20-15.</li> <li>· Client C's dietary orders will be reviewed with her PCP.</li> <li>· Client C's dining plan will be updated to reflect her current dietary order.</li> <li>· Staff will be trained on Client C's dining plan and dietary orders.</li> <li>· The nurse will be trained on how to follow up with dietary recommendations from the dietician to ensure they are implemented and/or addressed by the IDT.</li> </ul> <p><b>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the same deficient practice.</li> <li>· Program Coordinator/QIDP/nurse oversight of the MAR's on a daily basis when in the home to ensure it is completed and holes are addressed appropriately.</li> <li>· Staff meeting scheduled on 11-20-15 to review documentation requirements, brother's keeper expectations and the expectations for the MAR.</li> </ul>				

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	<p>[client C's] apron fold (abdominal area)." Corrective action indicated "Staff applied prn (as needed) Balmex to the wound. Nurse observed the wound on 9/22/15." The report indicated client C had "an appointment with her PCP (primary care physician) on Friday, 9/25/15 to determine whether a wound care clinic referral is necessary as she is currently discharged from there...wound is very small. Will monitor for healing. She is on a turning schedule every hour and will continue these as well as skin checks daily. The cause of the wound is due to immobility, diabetes diagnosis and obesity."</p> <p>Client C's record was reviewed on 10/20/15 at 9:40 AM. A Risk Plan updated 8/19/15 indicated client C was at risk for impaired skin integrity and broken skin (impaired integrity) "...results in open wounds, pressure sores, infection and pain. Prevention: The key to keeping the skin intact is keeping it dry and pressure free...Pressure can be relieved by repositioning the client or prompting to reposition and encouraging functional alignment when sitting upright. [Client C] has a wheelchair that leans back which she can do independently. While the chair is leaned back she can maneuver herself into a more comfortable position...[Client C] is</p>		<ul style="list-style-type: none"> <li>· Random medication practicums to be completed with the staff by the nurse and the Program Coordinator on a monthly basis to ensure staff are following proper medication passing and documentation procedures.</li> <li>· Nurse to complete medication practicums with staff who continually make errors (documentation or actual med errors) to ensure competency prior to passing medication again.</li> <li>· Monthly supervisor visit check sheets to be completed by the QIDP. This check sheet includes oversight of the individuals MAR's.</li> <li>· The QIDP will monitor and review the resident's needs. As the needs arise, formal programming will be implemented.</li> <li>· The nurse will complete weekly assessments of Client C to ensure there are no skin/wound issues or other concerns that arise until the IDT determines that they are no longer necessary.</li> <li>· Staff will be retrained on how to complete the skin/wound documentation and when to notify the Program Coordinator/QIDP/nurse for skin/wound issues on 11-20-15.</li> <li>· Staff will be retrained on how to document the weights for the clients on 11-20-15.</li> <li>· The dining plans for all clients will be reviewed with the staff at their meeting on 11-20-15.</li> <li>· A wheelchair scale and regular scales are available to weigh the clients.</li> </ul>				

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	continent, however uses adult incontinent products in case of accidents. Staff assist her with changing, as needed. [Client C] is able to tell staff when she needs to use the restroom. Staff will ensure they respond promptly to [client C] when she needs to use the restroom and will assist her in cleaning her thoroughly after using the restroom. Staff are trained to report anything unusual (including injuries to the skin) to the HM (House Manager)/PD (Program Director) along with how to document in [digital record keeping system]. Body mechanics is taught as part of orientation and good body alignment is included. [Client C] uses a wheelchair for mobility. Staff will prompt and provide assistance with re-positioning at least every 1 hours (sic) and document. [Client C] utilizes a standing lift for transfers. [Client C] has impaired skin integrity and is being treated for open areas. Staff are completing treatments as ordered by MD (Medical Doctor), monitoring skin checks and documenting in the skin wound module. Staff will report (with a phone call) any new skin issues, open areas and skin changes to the HM who will consult with MD/nurse...."  Skin/Wound Assessments in client C's record dated 9/21/15 at 8:25 PM indicated a "skin tear, redness, hard or hot 1.5 cm, reported to on call area is red		<ul style="list-style-type: none"> <li>· The nurse will be trained on how to follow up with dietary recommendations from the dietician to ensure they are implemented and/or addressed by the IDT.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· Program Coordinator/QIDP/nurse oversight of the MAR's on a daily basis when in the home to ensure it is completed and holes are addressed appropriately.</li> <li>· Staff meeting scheduled on 11-20-15 to review documentation requirements, brother's keeper expectations and the expectations for the MAR.</li> <li>· Random medication practicums to be completed with the staff by the nurse and the Program Coordinator on a monthly basis to ensure staff are following proper medication passing and documentation procedures.</li> <li>· Nurse to complete medication practicums with staff who continually make errors (documentation or actual med errors) to ensure competency prior to passing medication again.</li> <li>· Monthly supervisor visit check sheets to be completed by the QIDP. This check sheet includes oversight of the individuals MAR's.</li> <li>· The QIDP will monitor and review the resident's needs. As the needs arise, formal programming will</li> </ul>		

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	<p>located under the abdominal fold." Assessments dated 9/30/15 indicated "perineal irritation" and "gaulding (chafing) to inner gluteal (sic) folds" noted by the group home nurse at 4:29 PM and at 9:49 PM a note written by direct support staff #7 indicated "between buttocks appears to be red client reported itching, reported to nurse."</p> <p>T-Log entries in client C's record entered by the nurse indicated on 9/22/15 client C "has a 1 cm split on left side of abd (abdominal) fold, area is very superficial in nature, area pink, no s/sx (signs and symptoms) of infection, no c/o (complaints of) pain, back and sides of legs checked, no open areas noted. Will have res (resident) seen at wound clinic for evaluation." Client C was seen again by the nurse on 9/23/15 and on 9/24/15 with no changes indicated in the note in regards to the status of the 1 cm split found under client C's abdominal fold. There was no evidence of an assessment by client C's nurse after 9/30/15 of her skin integrity.</p> <p>A visit to client C's PCP dated 9/25/15 failed to indicate documentation client C's skin in the gluteal or abdominal fold area had been evaluated. The discussion note indicated "cont (continue) Tx (treatments)/Rx (medications)." The visit</p>		<p>be implemented.</p> <ul style="list-style-type: none"> <li>· The nurse will complete weekly assessments of Client C to ensure there are no skin/wound issues or other concerns that arise until the IDT determines that they are no longer necessary.</li> <li>· Staff will be retrained on how to complete the skin/wound documentation and when to notify the Program Coordinator/QIDP/nurse for skin/wound issues on 11-20-15.</li> <li>· Staff will be retrained on how to document the weights for the clients on 11-20-15.</li> <li>· The dining plans for all clients will be reviewed with the staff at their meeting on 11-20-15.</li> <li>· A wheelchair scale and regular scales are available to weigh the clients.</li> <li>· The nurse will be trained on how to follow up with dietary recommendations from the dietician to ensure they are implemented and/or addressed by the IDT.</li> </ul> <p><b>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· Medication practicums that are completed by the Program Coordinator will be forwarded to the QIDP and the nurse for review.</li> <li>· Monthly supervisory visit check sheets to be completed by the QIDP. These will be forwarded to the Area Director for review.</li> <li>· Oversight of the MAR will be completed by the Program</li> </ul>	

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	<p>note indicated client C had refused to be weighed at the visit.</p> <p>A visit to a wound care clinic dated 10/6/15 in the record indicated client C was seen for ABD (abdomen) with instructions to "Apply powder to fold area daily and PRN (as needed) no ointment to fold areas. Okay to use/continue Balmex for rectal erythema (redness) as needed." There was no evidence in client C's record of a revision to her Risk Plan or MAR to address the recommendations made by the wound clinic to address client C's abdominal wound.</p> <p>Paper documentation of client C's hourly re-positioning completed in the group home brought in by the PD was reviewed on 10/20/15 at 11:52 AM and indicated no missing documentation as noted upon review of the documentation on 10/19/15 at 6:25 PM.</p> <p>A nutritional assessment dated 4/21/15 indicated "no current weight, but wt (weight) range noted at 250-270 # (pounds)." Diagnoses included, but were not limited to diabetes, and indicated client C's ideal weight range was 99-121 pounds, and indicated nutrition concerns which included, but were not limited to obesity, an open wound and diabetes.</p>		<p>Coordinator, QIDP, and nurse.</p> <ul style="list-style-type: none"> <li>· The nurse will be in the home at least weekly basis or more frequently to monitor for concerns and assess residents as needed.</li> <li>· New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, programming, and medication review.</li> <li>· The nurse will complete weekly assessments of Client C to ensure there are no skin/wound issues or other concerns that arise until the IDT determines that they are no longer necessary.</li> </ul> <p><b>5. What is the date by which the systemic changes will be completed?</b> November 22nd, 2015</p>				

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	<p>Recommendations included, but were not limited to an 1800 calorie diet, 1 oz (ounce) of extra protein at dinner to aid in wound healing, obtain a current weight and to reduce client C's weight by 10-15 pounds through 3/16.</p> <p>The PD was interviewed on 10/20/15 at 11:52 AM. When asked who reviewed the documentation, she stated, "I do, weekly," and indicated the nurse also reviewed the documentation weekly at the group home. The PD indicated staff were notified of missing documentation via digital messages and the PD or HM reviewed the need to document at staff training. She stated "It's being done." When asked about the discrepancy between the documentation reviewed on 10/19/15 and 10/20/15, she indicated staff were asked if they completed the repositioning when documentation was found missing and filled in the missing documentation if they were certain they had completed the repositioning. When asked if staff should complete documentation after days had passed, she stated, it's "not ideal." The PD stated, "Honestly, this is cumbersome-the MAR should be documented. It's hard to keep up with."</p> <p>The group home nurse was interviewed on 10/20/15 at 12:15 PM and when asked</p>				

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	<p>about documentation in client C's record, stated, "We should try to communicate daily." When asked about the missing documentation, she indicated the PD and PC (Program Coordinator/House Manager) communicate daily. The nurse stated, "If we find something missing, we can talk to staff on (on duty) if they remembered (they had completed hourly repositioning), it's OK to document. We want to follow up on why it's missing." When asked about nursing assessments for client C after the reddened area on her gluteal area had been found on 9/30/15 and the wound found on 9/21/15 in client C's abdominal fold, she indicated the nurse should be completing weekly assessments of client C's skin or more often if staff noted concerns. When asked about documentation of client C's weight, she indicated client C should be weighed weekly. When asked about the location in the record, she reviewed client C's digital record and indicated client C had weighed 236 pounds on 8/12/15. She indicated she was unable to find other evidence of a weight obtained for client C as she had refused to be weighed at her visit with the PCP on 9/25/15.</p> <p>This deficiency was cited on July 10 and August 18, 2015. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p>			

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