

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/19/2015
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3705 E 116TH ST CARMEL, IN 46032
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W 0000 Bldg. 00	<p>This visit was for a full annual recertification and state licensure survey. This visit resulted in an IMMEDIATE JEOPARDY.</p> <p>Dates of Survey: September 21, 22, 23, 24, 25, 28, 29, 30, and October 19, 2015.</p> <p>Facility number: 001174 Provider number: 15G625 AIM number: 100235590</p> <p>The following federal deficiencies also reflect state findings under 460 IAC 9. Quality Review of this report completed by #15068 on 10/29/15.</p>	W 0000		
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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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W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Governing Body and Management by failing to exercise operating direction over the facility and by not meeting the requirements for the Condition of Participation: Client Protections, the Condition of Participation: Facility Staffing, the Condition of Participation: Health Care Services, and the Condition of Participation: Dietetic Services. This failure potentially affected 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) who lived in the facility.</p> <p>Findings include:</p> <p>1. The Governing Body failed to meet the Condition of Participation: Client Protections. The governing body neglected to implement its policy and procedures to prevent neglect and</p>	W 0102	<ol style="list-style-type: none"> 1. Please refer to W122 2. Please refer to W158 3. Please refer to W318 4. Please refer to W459 5. Please refer to W104 	11/18/2015

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	<p>mistreatment for 2 of 4 sampled clients (clients #1 and #2). The governing body neglected to have a system in place to identify injuries of unknown origin, document them, report the unknown injuries to the administrator and to BDDS (Bureau of Developmental Disabilities Services) and to investigate injuries of unknown origin for 1 of 4 sampled clients (client #1). The governing body neglected to document and monitor injuries (scratches) sustained by client #2's self injurious behavior. The governing body neglected to develop and implement corrective action to protect client #1 from cellulitis (skin infection) after a history of cellulitis had been identified. Please see W122.</p> <p>2. The Governing Body failed to meet the Condition of Participation: Facility Staffing. The governing body failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) performed all aspects of the QIDP position for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and for 4 of 4 sampled clients (clients #5, #6, #7 and #8). The governing body failed to ensure there were a sufficient number of staff provided to meet the needs of for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and for 4 of 4 sampled clients (clients #5, #6, #7 and</p>			

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	<p>#8). The governing body failed to ensure the staff were trained to sufficiently, effectively and competently meet the health and programming needs for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and for 4 of 4 sampled clients (clients #5, #6, #7 and #8). Please see W158.</p> <p>3. The Governing Body failed to meet the Condition of Participation: Health Care Services. The governing body failed to ensure the RN had a system in place to document, monitor, and identify injuries of unknown origin and self injurious behaviors for 2 of 4 sampled clients (clients #1 and #2). The governing body failed to ensure the RN developed and implemented corrective action to protect client #1 from cellulitis (skin infection) after a history of cellulitis had been identified. The governing body failed to provide a system of medication storage that was sanitary, secure, and locked except during times of medication pass and the governing body failed to assure all medications were labeled and disposed of when expired or discontinued. Please see W318.</p> <p>4. The Governing Body failed to meet the Condition of Participation: Dietetic Services. The governing body failed to provide well balanced diets and modified specially prescribed diets (clients #1, #2,</p>			

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	<p>#3, #4, #5, #6, #7, and #8), failed to serve food in the form consistent with individual needs (clients #1 and #8), failed to utilize appropriate and/or adaptive dining equipment (clients #1, #2, #3, #4, #5, #6, #7, and #8), failed to encourage client #5 to eat at the table with peers instead of off of his lap tray, failed to supervise clients during meal times (clients #1, #2, #3, #4, #5, #6, #7, and #8), failed to provide a sufficient amount of food at meals to allow for second servings and to meet the nutritional needs for (clients #1, #2, #3, #4, #5, #6, #7, and #8) and failed to encourage clients' participation in the dining process (clients #1, #2, #3, #4, #5, #6, #7, and #8). Please see W459.</p> <p>5. The Governing Body failed to provide general policy, budget and operating direction over the group home where 4 of 4 sampled clients lived (clients #, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) by failing to ensure the home was maintained in good repair. Please see W104.</p> <p>9-3-1(a)</p>				

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W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the governing body failed to provide general policy, budget and operating direction over the group home where 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) lived by failing to ensure the home was maintained in good repair. The governing body neglected to implement its policy and procedures to prevent neglect and mistreatment for 2 of 4 sampled clients (clients #1 and #2). The governing body neglected to have a system in place to identify injuries of unknown origin, document them, report the unknown injuries to the administrator and to BDDS (Bureau of Developmental</p>	W 0104	<p>1. All of the noted repairs have been forwarded to the maintenance supervisor to address. All noted repairs will be scheduled to be completed as soon as possible.</p> <p>Program Coordinator will receive retraining to include completing weekly walkthroughs of the home to note any items that are in need of repair or replacement. If any items are noted the Program Coordinator will notify the Maintenance staff and/or QIDP as needed. If requests for repairs have not been completed or scheduled to be completed within a week, the Program Coordinator will follow up with the maintenance staff and/or QIDP to</p>	11/18/2015

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	<p>Disabilities Services) and to investigate injuries of unknown origin for 1 of 4 sampled clients (client #1). The governing body neglected to document and monitor injuries (scratches) sustained by client #2's self injurious behavior. The governing body neglected to develop and implement corrective action to protect client #1 from cellulitis (skin infection) after a history of cellulitis had been identified.</p> <p>Findings include:</p> <p>1. Observations of the group home where clients #1, #2, #3, #4, #5, #6, #7 and #8 lived was observed on 9/21/15 from 4:55 P.M. through 6:58 P.M. The front porch and area around the front door had cobwebs, and the front door had a Christmas wreath. The bedroom of clients #5 and #6 had splattered black spots on the ceiling and closet doors. The Kitchen cabinets had drawers and cabinet doors that were loose with worn finish and in need of replacement. The green painted walls in client #2's bedroom had a circular area above client #2's bed where the paint was worn off. The fence around the back yard had one of two doors which was unable to be opened from inside the fence. The fence also had screws and nails with the sharp ends exposed and sticking out 1/2 inch on the inside</p>		<p>determine the status of the repair. If the QIDP has not received any information regarding the status of the repair, the QIDP will speak with the Maintenance supervisor to determine the status of the repair. If the requested repairs have not been completed within 3 weeks of the request the QIDP will notify the Area Director so that further follow up can be completed as needed.</p> <p>Ongoing the Program Coordinator will complete walkthroughs of the home a minimum of weekly. Ongoing, the QIDP will complete an environmental review at least once monthly and the Area Director will complete an environmental assessment of the home at least quarterly. Any needed repairs or replacements will be reported and follow up on a minimum of weekly. If repairs are not completed within a timely manner the matter should be reported to the next level of the chain of command for follow up.</p> <p>Responsible Staff: Maintenance Staff, Program Coordinator, QIDP, Area Director</p> <p>2. Please refer to W149 3. Please refer to W154 4. Please refer to W157</p>				

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	<p>(towards the group home yard) of the fence, which posed a safety hazard.</p> <p>A confidential interview stated the kitchen cabinets were "very" old, and the cabinet doors did not function well.</p> <p>An interview was conducted with the Home Manager (HM) on 9/21/15 at 5:49 P.M. The HM indicated the kitchen cabinets were to be replaced soon, but she was not sure when. The HM indicated the fence was new, and she had not noticed the screw ends sticking out. The HM indicated the area above client #2's bed was from client #2 rubbing his head against the wall which caused the paint to rub off and get into client #2's hair.</p> <p>2. The governing body neglected to implement their policy Quality and Risk Management (prevention of abuse, neglect and mistreatment) by neglecting to have a system in place to identify injuries of unknown origin, document them, report unknown injuries to the administrator and to BDDS (Bureau of Developmental Disabilities Services) and to investigate injuries of unknown origin for 1 of 4 sampled clients (client #1). The governing body neglected to document and monitor injuries (scratches) sustained by client #2's self injurious behavior. The</p>			

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	<p>governing body neglected to develop and implement corrective action to protect client #1 from cellulitis (skin infection) after a history of cellulitis had been identified. Please see W149.</p> <p>3. The governing body failed to thoroughly investigate 1 of 1 incident involving staff to staff physical aggression which occurred at the home where 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) lived. Please see W154.</p> <p>4. The governing body failed to take appropriate corrective action for 2 of 4 sampled clients (clients #1 and #2) to protect client #1 from cellulitis (skin infection) after a history of cellulitis had been identified and to prevent recurrent injuries (scratches) sustained by client #2's self injurious behavior. Please see W157.</p> <p>9-3-1(a)</p>			

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W 0120 Bldg. 00	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based upon record review, interview and observation, for 1 of 4 sampled clients (clients #1), the outside services failed to document and report injuries of unknown origin to the facility.</p> <p>Findings include:</p> <p>During observations at day services on 9/22/15 from 11:25 AM until 12:15 PM, client #1 sat in a wheelchair without foot pedals. His feet were bare, and he had scratches on his forehead and along the length of his left shoulder blade and along the back of his neck. Client #1's ear was bruised on the front and back of the ear and he had a bruise across his knee cap on his right knee. Client #1's left knee had a scab 1/2 inch in diameter.</p> <p>Confidential interview #1 indicated there had been concerns about client #1's injuries and they were of unknown origin.</p> <p>The Adult Services Coordinator (ASC) at</p>	W 0120	<p>The Day Service supervisor completed a retraining with their staff about the need to ensure BDDS reportable incidents are reported to the appropriate parties timely so BDDS reports can be filed as needed.</p> <p>The QIDP will complete training with the Day Services supervisor on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents.</p> <p>Ongoing, the QIDP will complete observations at Day Services a minimum of monthly to ensure that Day Services are following all consumers ISP, BSP and program goals. Documentation will be completed for each visit and will be available for review.</p> <p>Responsible Party: Program Coordinator and QIDP</p>	11/18/2015

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W 0122 Bldg. 00	<p>day services #1 was interviewed on 9/22/15 at 11:35 AM. When asked about documentation of client #1's injuries, the ASC indicated she was not aware of their origin. When asked if the day services staff documented and reported the injuries to the facility, she indicated she would look for the documentation.</p> <p>The Director of Adult Services of day services #1 indicated on 9/22/15 at 12:40 PM, there should be ongoing documentation of client #1's injuries. There was no additional documentation of client #1's injuries found during the observations provided.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based upon observation, record review and interview, the facility failed to meet the Condition of Participation: Client Protections. The facility neglected to implement its policy and procedures to prevent neglect and mistreatment for 2 of 4 sampled clients (clients #1 and #2). The</p>			W 0122	<p>1. Please refer to W149 2. Please refer to W154 3. Please refer to W157</p>		11/18/2015

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	<p>facility neglected to have a system in place to identify injuries of unknown origin, document them, report the unknown injuries to the administrator and to BDDS (Bureau of Developmental Disabilities Services) and to investigate injuries of unknown origin for 1 of 4 sampled clients (client #1). The facility neglected to document and monitor injuries (scratches) sustained by client #2's self injurious behavior. The facility neglected to develop and implement corrective action to protect client #1 from cellulitis (skin infection) after a history of cellulitis had been identified.</p> <p>This noncompliance resulted in an IMMEDIATE JEOPARDY. The IMMEDIATE JEOPARDY began on 8/19/15. The Immediate Jeopardy was identified on 9/23/15 at 4:30 PM. The Area Director was notified of the Immediate Jeopardy on 9/23/15 at 4:55 PM.</p> <p>A plan of action from the facility to remove the immediate jeopardy, dated 9/24/15 was received on 9/28/15 at 5:27 P.M. An amendment to the plan of action to remove the IJ was received on 9/29/15 at 5:28 P.M. The plan indicated the following steps would be immediately implemented:</p>						

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	"The following actions and protective measures are in place or are in process to abate the immediate jeopardy in regards to client protections for [client #1]. As of 9/24/15 a line of sight supervision and body assessment protocol for [client #1] was implemented. The line of sight supervision will allow staff to monitor if there are any incidents of falls or situations that could cause potential injury and/or bruising. The body assessment protocol will allow staff to observe and document daily if [client #1] has any bruising and/or marks present that may have resulted from an injury and also if there is an injury present the form will allow staff to document if the injury has changed. The line of sight and body assessment protocol will ensure that protective measures are in place for [client #1] to reduce the possibility of unknown injury. This will also allow for staff to report bruises to management and therefore proceed with completing an investigation. Line of sight and body assessment protocol will remain in place for a minimum of 6 weeks. At the 6 week mark an IDT (interdisciplinary team) will be held to determine if the daily body			

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	<p>assessments still need to be completed.</p> <p>Verbal approval from the Guardian for the line of sight and body assessment protocol has been obtained. Written approval for the line of sight and body assessment protocols will be sent to the guardian through the mail based on the guardian's request.</p> <p>A body assessment protocol for all other consumers in the home has been implemented. Body assessments will be completed daily when staff are showering individuals for a minimum of 6 weeks.</p> <p>Guardian approval has been obtained for body assessments from all consumers' guardians.</p> <p>All staff on duty effective 9/24/15 responsible for implementing the line of sight and body assessment protocols have been trained or will be trained prior to working their scheduled shifts. Line of sight supervision will be assigned per the schedule developed by Indiana MENTOR management.</p> <p>Staff observations will be completed by Indiana MENTOR management a minimum of four times per week for a minimum of 6 weeks at varying times to ensure staff are implementing the line of</p>			

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	<p>sight and body assessment protocols for [client #1] and all other consumers appropriately. During this time all body assessments will be reviewed to ensure appropriate reporting has been completed. Management staff that may complete observations include, new/covering Program Nurse, Area Director, Regional Director, Quality Assurance Specialist, and other Area Directors that have been trained on the needs of the home."</p> <p>The IMMEDIATE JEOPARDY was removed on 9/30/15 at 1:00 P.M. based upon observations completed on 9/28/15 from 5:50 P.M. until 6:28 P.M., 9/29/15 from 5:33 P.M. until 6:09 P.M. and 9/30/15 from 7:15 A.M. until 7:52 A.M. of the plan's implementation in the group home. The body assessment form was present in the home during the observations conducted on 9/29/15 and 9/30/15. The HM (home manager) was interviewed on 9/29/15 at 5:48 P.M. and indicated she had been trained on completing the assessments and was giving the showers that evening to complete the assessments herself. The condition remains out of compliance to ensure the monitoring system remains effective over a period of time.</p>			

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	<p>Findings include:</p> <p>1. The facility neglected to implement their policy Quality and Risk Management (prevention of abuse, neglect and mistreatment) by neglecting to have a system in place to identify injuries of unknown origin, document them, report unknown injuries to the administrator and to BDDS (Bureau of Developmental Disabilities Services) and to investigate injuries of unknown origin for 1 of 4 sampled clients (client #1). The facility neglected to document and monitor injuries (scratches) sustained by client #2's self injurious behavior. The facility neglected to develop and implement corrective action to protect client #1 from cellulitis (skin infection) after a history of cellulitis had been identified. Please see W149.</p> <p>2. The facility failed to thoroughly investigate 1 of 1 incident involving staff to staff physical aggression which occurred at the home where 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) lived. Please see W154.</p> <p>3. The facility failed to take appropriate corrective action for 2 of 4 sampled clients (clients #1 and #2) to protect</p>				

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W 0137	<p>client #1 from cellulitis (skin infection) after a history of cellulitis had been identified and to prevent recurrent injuries (scratches) sustained by client #2's self injurious behavior. Please see W157.</p> <p>9-3-2(a)</p> <p>483.420(a)(12)</p>			

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Bldg. 00	<p>PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based upon observation and interview, the facility failed for 2 of 4 sampled clients (clients #2 and #4) and for 2 of 4 additional clients (clients #7 and #8) to ensure they wore clothing that fit appropriately and was in good condition.</p> <p>Findings include:</p> <p>During observations on 9/22/15 from 5:48 P.M. through 6:24 P.M. client #4 walked throughout the home with his jeans unzipped and open. At 5:38 P.M. client #8 stood up from the dining table and his brown sweat pants hung down exposing the entire back of his undergarments.</p> <p>During observations on 9/22/15 from 5:15 PM until 6:55 PM, client #2 wore shorts that hung down to mid calf and exposed his undergarments. Client #7 wore jeans that dragged on the floor and exposed his undergarments when he raised his arms.</p> <p>During observations on 9/24/15 from 4:38 P.M. until 6:12 P.M. client #7 wore light gray track pants. His pant legs were</p>	W 0137	<p>All direct care staff will receive retraining on client dignity including ensuring that all consumers are wearing weather appropriate clothing and clothing that fits appropriately.</p> <p>Program Coordinator and/or QIDP will complete observations a minimum of twice weekly for 4 weeks to ensure that all consumers are wearing weather appropriate clothing and clothing that fits appropriately. Ongoing, after the 4 weeks the Program Coordinator and/or QIDP will complete observations a minimum of weekly to ensure that all consumers are wearing weather appropriate clothing and clothing that fits appropriately.</p> <p>Responsible party; Program Coordinator, QIDP</p>	11/18/2015	

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W 0149 Bldg. 00	<p>both ripped at the ankles and hung down past both of his feet. Client #2's sweat pants kept sliding down and he had to pull them up frequently. There was a collection of belts, at least nine, hung on a hook beside the fireplace in the family room.</p> <p>During observations on 9/28/15 from 5:50 P.M. until 6:28 P.M. the collection of belts was hanging on a hook beside the fireplace in the family room.</p> <p>The Area Director was interviewed on 10/2/15 at 1:17 PM and indicated clients should wear clothing that fits and is in good repair. The AD indicated clients should wear their own belts.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit</p>				

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	<p>mistreatment, neglect or abuse of the client. Based on observation, record review and interview, the facility neglected to implement their policy Quality and Risk Management (prevention of abuse, neglect and mistreatment) by neglecting to have a system in place to identify injuries of unknown origin, document them, report unknown injuries to the administrator and to BDDS (Bureau of Developmental Disabilities Services) and to investigate injuries of unknown origin for 1 of 4 sampled clients (client #1's). The facility neglected to document and monitor injuries (scratches) sustained by client #2's self injurious behavior. The facility neglected to develop and implement corrective action to protect client #1 from cellulitis (skin infection) after a history of cellulitis had been identified.</p> <p>Findings include:</p> <p>During observations at day services on 9/22/15 from 11:25 AM until 12:15 PM, client #1 sat in a wheelchair without foot pedals. His feet were bare, and he had scratches on his forehead and along the length of his left shoulder blade and along the back of his neck. Client #1's ear was bruised on the front and back of the ear and he had a bruise across his knee cap on his right knee. Client #1's left</p>	W 0149	<p>1. Protocols have been developed for Client #1 to address his history of cellulitis and how staff should assist him with skin care.</p> <p>Client #1 Risk Management Plan has been updated to address the history of cellulitis and the increased risk of sores and bruising due to the cellulitis history.</p> <p>A wheelchair protocol has been developed for Client #1 that includes recommendations from the physician for Client #1 to use foot pedals to prevent him from dragging his feet to reduce possibility of injuries to his feet.</p> <p>Body Check assessments have been implemented for all consumers, including client #1. Staff are to complete a body assessment form daily when assisting consumers with showers to note any bruises, scratches or other injuries. Staff are to document notes on the size, shape, etc. of each mark noted on the body to determine if any changes are occurring. Staff are to notify the Program Coordinator, QIDP and/or Program Nurse if any new marks are observed or any changes to current bruises, scratches, etc. are observed to determine if further assessment needs to be</p>	11/18/2015			

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	<p>knee had a scab 1/2 inch in diameter.</p> <p>Confidential interview #1 indicated there had been concerns about client #1's injuries and they were of unknown origin.</p> <p>Client #1's record was reviewed on 9/22/15 at 2:25 PM. An annual physical examination on 11/4/14 indicated client #1 had foot contractures and used a wheelchair. An Indiana Mentor Medical Appointment Form dated 8/20/15 indicated client #1 was seen for foot care. Recommendations indicated "Trim nails and keep them short. Watch for signs of infection where there are open areas. Call for increased redness, swelling, drainage or fever. Use foot pedals to avoid feet dragging on the ground..." The form indicated client #1 could return to day program and was prescribed an ointment to be used twice daily for "irritant dermatitis."</p> <p>An Annual Healthcare Assessment dated 3/1/15 indicated client #1 was to use skid (gripper) socks and no shoes. The assessment did not address client #1's history of cellulitis or of his needs for skin care.</p> <p>A Risk Assessment and Plan dated 8/24/15 indicated client #1 was at risk for pressure sores/skin ulcers and client #1</p>		<p>made. Program Coordinator, QIDP and Area Director will review the body assessment forms to ensure that all new injuries or changes to injuries are being reported to determine if further evaluation is needed.</p> <p>Body checks are to be completed for each consumer daily at the time of undressing/shower. Daily body checks are to be completed for a minimum of 6 weeks in an attempt to prevent injuries of unknown origin from not being reported.</p> <p>After the initial 6 weeks, the QIDP, Program Coordinator, Area Director, Program Nurse and Quality Assurance Specialist will meet to review findings and determine the frequency that Body Assessments need to continue</p> <p>2. Client #2 Behavior Support Plan has been updated in include scratching himself as a specific targeted behavior.</p> <p>QIDP will receive retraining to include ensuring that all identified targeted behaviors observed for each consumer are specified in their Behavior Support Plan and interventions included for how staff are to monitor/prevent.</p>		

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	<p>"walked on his toes and the skin is very fragile in this area. After his shower, make sure his feet are dry before putting on socks. Monitor for skin breakdown and report to the nurse if any is suspected. He should wear socks when not sleeping." The Risk Plan indicated client #1 was not at risk for bruises or rashes.</p> <p>There was no evidence in the record of a health care protocol in client #1's Individual Support Plan to address the recommendations made by client #1's physician to use foot pedals to avoid dragging his feet. Nursing assessments dated 4/1/15 and 7/15/15 indicated client #1's skin was dry and intact. There was no evidence in the record of documentation of client #1's injuries, bruises or of monitoring their healing status by group home staff or the nurse.</p> <p>The Program Director (PD) and Area Director (AD) were interviewed on 9/22/15 at 4:15 PM. When asked about client #1's injuries, the PD indicated she was unaware of the injuries or their status of documentation. During the interview, the PD called the house manager who indicated to the PD client #1 had been taken to the doctor on 8/20/15 in regards to skin issues. The house manager indicated the current scratches, bruising</p>		<p>Body Check assessments have been implemented for all consumers, including client #1. Staff are to complete a body assessment form daily when assisting consumers with showers to note any bruises, scratches or other injuries. Staff are to document notes on the size, shape, etc. of each mark noted on the body to determine if any changes are occurring. Staff are to notify the Program Coordinator, QIDP and/or Program Nurse if any new marks are observed or any changes to current bruises, scratches, etc. are observed to determine if further assessment needs to be made. Program Coordinator, QIDP and Area Director will review the body assessment forms to ensure that all new injuries or changes to injuries are being reported to determine if further evaluation is needed.</p> <p>Body checks are to be completed for each consumer daily at the time of undressing/shower. Daily body checks are to be completed for a minimum of 6 weeks in an attempt to prevent injuries of unknown origin from not being reported.</p> <p>After the initial 6 weeks, the QIDP, Program Coordinator, Area</p>		

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	<p>and marks on client #1's body were a result of dermatitis. She indicated client #1 was to keep his nails trimmed short and staff were to watch for signs of infection such as increased redness, swelling and drainage. The PD indicated there was not a system in place to document healing of minor injuries, bruises or scratches. The AD stated, "We don't do body checks (unless there is a specific need) because of dignity", but indicated staff observe for injuries when they assist clients during showering. The AD indicated client #1 should be using foot pedals as recommended by the doctor and should be using socks to protect his feet. When asked how injuries to clients are documented, the AD indicated they are reported to BDDS if the incident meets the criteria or are to be documented on internal accident/injury reports. She indicated she would look for additional reports. No additional documentation of client #1's injuries were provided.</p> <p>An email dated 9/22/15 with attached pictures and documentation of client #1's injuries from the director of client #1's day services was reviewed on 9/23/15 at 8:00 AM. The pictures attached to an e-mail dated 5/7/15 indicated a linear bruise across client #1's hip and scratches across his torso. A hand written</p>		<p>Director, Program Nurse and Quality Assurance Specialist will meet to review findings and determine the frequency that Body Assessments need to continue.</p> <p>3. Please refer to W157</p>		

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	<p>document dated 8/18/15 indicated client #1 had 2 scabs and a rug burn on his left shoulder, left elbow 2 scabs, back of neck, 2 scratch marks, 1 scratch to the groin, 1 scratch to the left ear, back "sporadic bruising" and "red blotches," spine "4 rug burn (sic)," right knee "whole knee is scabbed...," left knee 3 scabs, right elbow, "red, 5 scrapes," left bicep "1 bruise," left thigh, "scratches, 1 scab," right neck, "rash or yeast infection," chest/stomach "sporadic scratches", right buttock "open sores, bed sores," left foot "dry skin, 1 scab on top, side and bottom," right foot, "1 scab on top needs medical attention, dry skin, scratch," right calf inside "several scratches...." A phone call note attached to the e-mail indicated the PD's name and the date 8/19/15 at 3:05 PM.</p> <p>The Director indicated on 9/23/15 at 10:52 AM, the PD had been made aware of the injuries to client #1 detailed in the documentation on 8/18/15 and of the pictures in the e-mail on 5/7/15.</p> <p>The facility's reportable incidents to BDDS and investigations were reviewed on 9/23/15 at 11:50 AM and included the following:</p> <p>A BDDS report dated 2/1/15 indicated client #1 had been taken to the ER for</p>			

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	<p>evaluation and treatment of his swollen left foot. Client #1 was diagnosed with cellulitis and admitted for antibiotic treatment. A follow up report dated 2/19/15 indicated client #1 remained in the hospital for treatment. A follow up report dated 4/6/15 indicated client #1 had completed antibiotics for cellulitis on 4/6/15 and the group home nurse and staff would monitor his condition.</p> <p>A report dated 5/30/15 indicated client #1 had been taken to the ER to evaluate a purplish rash on both arms and a bump on one eye. Evaluation did not determine the cause of the rash, but the doctor "hypothesized he could have been having a reaction to something, but he couldn't be certain. " Client #1 was released to go home, and advised to use the medication already prescribed for his skin. Client #1 was to visit his primary care physician if he was not improved in a week. The house manager advised on 8/31/15 client #1 had improved. Corrective action indicated client #1 would be monitored for his health and safety.</p> <p>A BDDS report dated 6/5/15 indicated client #1 was taken to the ER at the recommendation of the nurse to be evaluated for a red area with a small sore on his lower left leg. Client #1 was diagnosed with cellulitis and given a</p>			

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	<p>prescription for antibiotic treatment and released. Corrective action indicated the group home staff would monitor client #1 for health and safety, and the group home nurse would monitor client #1's leg for any changes.</p> <p>The group home nurse and AD were interviewed on 9/23/15 at 2:50 PM. She indicated client #1 should have used foot pedals as recommended by his physician and client #1 should be wearing socks. She indicated client #1's medication administration record included measures to wash client #1's feet twice daily and to monitor for skins of redness, swelling or discharge, but there was not a system to document or monitor scratches or bruises other than the reporting system. The group home nurse indicated she should have been notified of client #1's injuries. The AD indicated she was unaware of bruises or injuries to client #1 and should have been made aware of them. The nurse indicated the failure to follow recommendations to use foot pedals and keep client #1's feet covered placed him at risk for developing cellulitis. The AD indicated the failure to document and report injuries placed client #1 at risk for abuse, neglect and mistreatment.</p> <p>2. During observations at the group home on 9/21/15 from 4:55 P.M. until 6:58</p>			

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	<p>P.M., Client #2 had visible light red scratch marks on both sides of his face. At 5:59 P.M. Client #2 sat in the corner of the fenced-in backyard and bit at his left lower arm. There was a pink calloused area on this part of client #2's arm.</p> <p>Direct Care Staff (DCS) #3 was interviewed on 9/21/15 at 5:52 P.M. DCS #3 stated "He does it to himself."</p> <p>During observations at the group home on 9/22/15 from 6:18 A.M. until 8:02 A.M., Client #2 had scratch marks on both sides of his face. The scratches were dark red in color and there were more scratches, especially on the left side of his face.</p> <p>During observations at the group home on 9/22/15 from 5:20 P.M. until 6:48 P.M., Client #2's scratches on the sides of his face were deeper and dark red.</p> <p>During observations at day services on 9/23/15 from 10:45 A.M. until 12:35 P.M., client #2's scratches on the sides of his face appeared to have dried blood in some of the scratch marks due to the dark red/black color that was visible.</p> <p>A confidential interview stated "[client #2] has a few behaviors we are concerned</p>						

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	<p>about. His scratching at his face and biting at his arm usually occurs around meal time or whenever there is food around."</p> <p>Client #2's record was reviewed on 9/23/15 at 2:58 P.M. Client #2's record indicated he had an ISP (Individual Support Plan) dated 7/22/15. Client #2's ISP indicated he had the following diagnoses: profound mental retardation, seizure disorder, autism, self-injurious behaviors, atypical psychosis, expressive communication needs, and ataxia. Client #2's ISP indicated "will bite self if he is frustrated or angry, verbally redirect. Not able to self report injury, if he appears to be injured assess his body. He does not present risk for skin integrity issues."</p> <p>Client #2 had a BSP (behavior support plan) dated 5/29/15. The BSP indicated the following targeted behaviors: "disturbing others sleep, stereotypical behaviors, self-injurious behaviors (biting), taking others belongings, inappropriate sexual behaviors." Client #2's BSP did not include scratching as a targeted behavior. Client #2's record did not include any documentation of client #2's scratches on his face and the calloused area on his arm.</p> <p>The Program Director (PD) and Area Director (AD) were interviewed on</p>			

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	<p>9/22/15 at 4:15 PM. When asked about client #2's scratches, the PD indicated she was unaware of the injuries or their status of documentation. The PD indicated there was not a system in place to document healing of minor injuries, bruises or scratches. The AD stated, "We don't do body checks (unless there is a specific need) because of dignity", but indicated staff observe for injuries when they assist clients during showering. When asked how injuries to clients are documented, the AD indicated they are reported to BDDS if the incident meets the criteria or are to be documented on internal accident/injury reports. She indicated she would look for additional reports. No additional documentation of client #2's scratches was provided.</p> <p>The group home RN and the Area Director (AD) were interviewed on 9/23/15 at 2:50 P.M. The RN indicated the group home staff were to be checking all of the clients' skin daily and report any unusual findings to her. There was not a system of documentation or monitoring of scratches or bruises. The group home nurse indicated she should have been notified of client #2's scratches from his self injurious behaviors. The AD indicated she was unaware of client #2's scratches and should have been made aware of them. The AD indicated it was</p>						

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	<p>the facility policy to monitor, document and report all in client injuries.</p> <p>The facility's policy Quality and Risk Management dated 4/2011 was reviewed on 9/23/15 at 5:15 P.M. and indicated "Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying evaluating and reducing risk to which individuals are exposed... B.1. Alleged, suspected, or actual abuse, neglect, or exploitation of an individual. An incident in this category shall also be reported...as applicable. The provider shall suspend staff involved in an incident from duty pending investigation by the provider. This may include: ...e. Failure to provide appropriate supervision, care or training; ... 4...h. Injury to an individual when the origin or cause of the injury is unknown and could be indicative of abuse, neglect or exploitation; i. Injury to an individual when the origin or cause of the injury is unknown and the injury required medical evaluation or treatment. j. A significant injury to an individual, including; (1) A fracture; ... (4) Bruises larger then three inches in any direction or pattern of bruises or contusions regardless of size;</p>			

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	(5) Any occurrence of skin breakdown related to decubitus ulcer regardless of severity; (6) Contusions or lacerations which require more than basic first aid; (7) Any injury requiring more than first aid; (8) Any puncture wound penetrating the skin, including human or animal bites; or (9) Any pica ingestion requiring more than first aid. 1. A fall resulting in injury, regardless of severity of injury...p. Inadequate staff support for an individual, including inadequate supervision, with the potential for: (1) Significant harm or injury to an individual; or (2) Death of an individual; q. Inadequate medical support for an individual, including failure to obtain: 1. Necessary medical services; 2. Routine dental or physician services; ... 4. An incident shall be reported by a provider or an employee or agent who: (a) Is providing services to the individual at the time of the incident. (b). Becomes aware of or receives information about an alleged incident. 5. An initial report regarding an incident shall be submitted within twenty-four hours of: (a) the occurrence of the incident; or (b). the reporter becoming aware of or receiving information about an incident. The Program Director, who serves as the QMRP (Qualified Mental Retardation Professional), shall submit a follow-up report concerning the incident on the			

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	<p>BDDS's follow-up incident report form at the following times: (a). Within seven days of the date of the initial report; (b). Every seven days thereafter until the incident is resolved; (c). All information required to be submitted to the BDDS shall also be submitted to the provider of case management services to the individual... C. Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee. 1. Investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident."</p> <p>3. The facility failed to take appropriate corrective action for 2 of 4 sampled clients (clients #1 and #2) to protect client #1 from cellulitis (skin infection) after a history of cellulitis had been identified and to prevent recurrent injuries (scratches) sustained by client #2's self injurious behavior. Please see W157.</p> <p>9-3-2(a)</p>				

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W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.			

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	<p>Based on record review and interview, the facility failed to thoroughly investigate 1 of 1 incident involving staff to staff physical aggression which occurred at the home where 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) lived.</p> <p>Findings include:</p> <p>Facility records were reviewed on 9/21/15 at 3:24 P.M. including the Bureau of Developmental Disability Services (BDDS) reports. The BDDS reports indicated the following:</p> <p>-A BDDS report dated 5/29/15 for an incident on 5/28/15 indicated "At approximately 5:00 P.M. staff [name of direct care staff (DCS) #3] was assisting [client #3] and bumped into [DCS #8]. [DCS #8] got upset with [DCS #3] and started yelling at her and physically hitting her. [DCS #3] put her hands up to defend herself. During the altercation an earring was pulled out of [DCS #3's] ear causing it to bleed. A third staff (unnamed) broke up the two staff that were fighting. The police were called and [DCS #3] went to the emergency room to get her ear checked out. She was treated and released. All consumers were at home at the time and either visually</p>	W 0154	<p>The Program Director will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</p>	11/18/2015			

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	<p>witnessed the incident or heard the yelling from the other room. No clients were harmed or suffered any adverse effects from the staff altercation. The identified aggressor has separated employment from Indiana Mentor. The identified victim has been suspended pending an internal investigation. The Home Manager went to the home shortly after the incident occurred and checked with each consumer to make sure they were ok. Program Director will have face to face conversation with all other staff to ensure they feel safe and are aware that physical aggression with peers at work is not tolerated. All staff will receive retraining on workplace violence and getting along with others in the workplace."</p> <p>There were BDDS reports filled out as above for clients #1, #2, #3, #4, #5, #6, #7 and #8 indicating they were present in the home at the time of the staff to staff altercation.</p> <p>The internal investigation summary of investigation dated 6/1/15 was reviewed on 9/21/15 at 3:30 P.M. and indicated "The clients in the home were not interviewed either because they were in their bedrooms and did not see what happened or they were unable to answer questions about the incident."</p>						

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W 0157 Bldg. 00	<p>The facility investigation failed to address the discrepancy of the initial BDDS report and the investigation regarding the whereabouts of the clients during the altercation and what they may have seen and heard.</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) indicated on 9/28/15 at 3:18 P.M. that the clients had seen or heard some of the altercation, including the police being at the home and there were clients in the home who could have been interviewed.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview, the facility failed to take appropriate corrective action for 2 of 4 sampled clients (clients #1 and #2) to protect client #1 from cellulitis (skin infection) after a history of cellulitis had been identified and to prevent recurrent injuries (scratches) sustained by client</p>	W 0157	<p>1. A wheelchair protocol has been developed for Client #1 that includes recommendations from the physician for Client #1 to use foot pedals to prevent him from dragging his feet to reduce possibility of injuries to his feet.</p> <p>A cellulitis protocol has been developed for Client #1 to instruct</p>	11/18/2015

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	<p>#2's self injurious behavior.</p> <p>Findings include:</p> <p>During observations at day services on 9/22/15 from 11:25 AM until 12:15 PM, client #1 sat in a wheelchair without foot pedals. His feet were bare, and he had scratches on his forehead and along the length of his left shoulder blade and along the back of his neck. Client #1's ear was bruised on the front and back of the ear and he had a bruise across his knee cap on his right knee. Client #1's left knee had a scab 1/2 inch in diameter.</p> <p>Confidential interview #1 indicated there had been concerns about client #1's injuries and they were of unknown origin.</p> <p>Client #1's record was reviewed on 9/22/15 at 2:25 PM. An annual physical examination on 11/4/14 indicated client #1 had foot contractures and used a wheelchair. An Indiana Mentor Medical Appointment Form dated 8/20/15 indicated client #1 was seen for foot care. Recommendations indicated "Trim nails and keep them short. Watch for signs of infection where there are open areas. Call for increased redness, swelling, drainage or fever. Use foot pedals to avoid feet dragging on the ground..." The form indicated client #1 could return to day</p>		<p>staff about the signs and symptoms of cellulitis and what to look for on Client #1 person since he is at a high risk for the cellulitis to recur since he has had it previously.</p> <p>Program Nurse will receive retraining to include ensuring that all consumers that have identified medical needs such as wheelchair care, proper wheelchair positioning, etc. have appropriate protocols developed so staff are aware on how to monitor and prevent risks. In addition, training will also include ensuring that protocols are developed for any medical conditions that might be recurring to instruct staff for what to look for in order to get treatment prescribed as soon as possible. Ongoing the Program Nurse will review and update as needed, a minimum of quarterly, all consumer protocols to ensure the most accurate information is available to the staff. Program Nurse will also ensure that staff are trained as needed for any updates</p> <p>Body Check assessments have been implemented for all consumers, including client #1. Staff are to complete a body assessment form daily when assisting consumers with showers to note any bruises, scratches or other injuries. Staff are to document notes on the</p>				

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	<p>program and was prescribed an ointment to be used twice daily for "irritant dermatitis."</p> <p>An Annual Healthcare Assessment dated 3/1/15 indicated client #1 was to use skid (gripper) socks and no shoes. The assessment did not address client #1's history of cellulitis or of his needs for skin care.</p> <p>A Risk Assessment and Plan dated 8/24/15 indicated client #1 was at risk for pressure sores/skin ulcers and client #1 "walked on his toes and the skin is very fragile in this area. After his shower, make sure his feet are dry before putting on socks. Monitor for skin breakdown and report to the nurse if any is suspected. He should wear socks when not sleeping." The Risk Plan indicated client #1 was not at risk for bruises or rashes.</p> <p>There was no evidence in the record of a health care protocol in client #1's Individual Support Plan to address the recommendations made by client #1's physician to use foot pedals to avoid dragging his feet. Nursing assessments dated 4/1/15 and 7/15/15 indicated client #1's skin was dry and intact. There was no evidence in the record of documentation of client #1's injuries,</p>		<p>size, shape, etc. of each mark noted on the body to determine if any changes are occurring. Staff are to notify the Program Coordinator, QIDP and/or Program Nurse if any new marks are observed or any changes to current bruises, scratches, etc. are observed to determine if further assessment needs to be made. Program Coordinator, QIDP and Area Director will review the body assessment forms to ensure that all new injuries or changes to injuries are being reported to determine if further evaluation is needed.</p> <p>Body checks are to be completed for each consumer daily at the time of undressing/shower. Daily body checks are to be completed for a minimum of 6 weeks in an attempt to prevent injuries of unknown origin from not being reported.</p> <p>After the initial 6 weeks, the QIDP, Program Coordinator, Area Director, Program Nurse and Quality Assurance Specialist will meet to review findings and determine the frequency that Body Assessments need to continue.</p> <p>2. Client #2 Behavior Support Plan has been updated in include scratching himself as a specific targeted behavior.</p>				

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	<p>bruises or of monitoring their healing status by group home staff or the nurse.</p> <p>The Program Director (PD) and Area Director (AD) were interviewed on 9/22/15 at 4:15 PM. When asked about client #1's injuries, the PD indicated she was unaware of the injuries or their status of documentation. During the interview, the PD called the house manager who indicated to the PD client #1 had been taken to the doctor on 8/20/15 in regards to skin issues. The house manager indicated the current scratches, bruising and marks on client #1's body were a result of dermatitis. She indicated client #1 was to keep his nails trimmed short and staff were to watch for signs of infection such as increased redness, swelling and drainage. The PD indicated there was not a system in place to document healing of minor injuries, bruises or scratches. The AD stated, "We don't do body checks (unless there is a specific need) because of dignity", but indicated staff observe for injuries when they assist clients during showering. The AD indicated client #1 should be using foot pedals as recommended by the doctor and should be using socks to protect his feet. When asked how injuries to clients are documented, the AD indicated they are reported to BDDS if the incident meets the criteria or are to be</p>		<p>QIDP will receive retraining to include ensuring that all identified targeted behaviors observed for each consumer are specified in their Behavior Support Plan and interventions included for how staff are to monitor/prevent.</p> <p>Body Check assessments have been implemented for all consumers, including client #1. Staff are to complete a body assessment form daily when assisting consumers with showers to note any bruises, scratches or other injuries. Staff are to document notes on the size, shape, etc. of each mark noted on the body to determine if any changes are occurring. Staff are to notify the Program Coordinator, QIDP and/or Program Nurse if any new marks are observed or any changes to current bruises, scratches, etc. are observed to determine if further assessment needs to be made. Program Coordinator, QIDP and Area Director will review the body assessment forms to ensure that all new injuries or changes to injuries are being reported to determine if further evaluation is needed.</p> <p>Body checks are to be completed for each consumer daily at the time of undressing/shower. Daily body checks are to be completed for a minimum of 6 weeks in an</p>		

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	<p>documented on internal accident/injury reports. She indicated she would look for additional reports. No additional documentation of client #1's injuries were provided.</p> <p>An email dated 9/22/15 with attached pictures and documentation of client #1's injuries from the director of client #1's day services was reviewed on 9/23/15 at 8:00 AM. The pictures attached to an e-mail dated 5/7/15 indicated a linear bruise across client #1's hip and scratches across his torso. A hand written document dated 8/18/15 indicated client #1 had 2 scabs and a rug burn on his left shoulder, left elbow 2 scabs, back of neck, 2 scratch marks, 1 scratch to the groin, 1 scratch to the left ear, back "sporadic bruising" and "red blotches," spine "4 rug burn (sic)," right knee "whole knee is scabbed...," left knee 3 scabs, right elbow, "red, 5 scrapes," left bicep "1 bruise," left thigh, "scratches, 1 scab," right neck, "rash or yeast infection," chest/stomach "sporadic scratches", right buttock "open sores, bed sores," left foot "dry skin, 1 scab on top, side and bottom," right foot, "1 scab on top needs medical attention, dry skin, scratch," right calf inside "several scratches...." A phone call note attached to the e-mail indicated the PD's name and the date 8/19/15 at 3:05 PM.</p>		<p>attempt to prevent injuries of unknown origin from not being reported.</p> <p>After the initial 6 weeks, the QIDP, Program Coordinator, Area Director, Program Nurse and Quality Assurance Specialist will meet to review findings and determine the frequency that Body Assessments need to continue.</p> <p>Responsible Party: QIDP, Program Coordinator, Program Nurse</p>		

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	<p>The Director indicated on 9/23/15 at 10:52 AM, the PD had been made aware of the injuries to client #1 detailed in the documentation on 8/18/15 and of the pictures in the e-mail on 5/7/15.</p> <p>The facility's reportable incidents to BDDS and investigations were reviewed on 9/23/15 at 11:50 AM and included the following:</p> <p>A BDDS report dated 2/1/15 indicated client #1 had been taken to the ER for evaluation and treatment of his swollen left foot. Client #1 was diagnosed with cellulitis and admitted for antibiotic treatment. A follow up report dated 2/19/15 indicated client #1 remained in the hospital for treatment. A follow up report dated 4/6/15 indicated client #1 had completed antibiotics for cellulitis on 4/6/15 and the group home nurse and staff would monitor his condition.</p> <p>A report dated 5/30/15 indicated client #1 had been taken to the ER to evaluate a purplish rash on both arms and a bump on one eye. Evaluation did not determine the cause of the rash, but the doctor "hypothesized he could have been having a reaction to something, but he couldn't be certain." Client #1 was released to go home, and advised to use the medication</p>			

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	<p>already prescribed for his skin. Client #1 was to visit his primary care physician if he was not improved in a week. The house manager advised on 8/31/15 client #1 had improved. Corrective action indicated client #1 would be monitored for his health and safety.</p> <p>A BDDS report dated 6/5/15 indicated client #1 was taken to the ER at the recommendation of the nurse to be evaluated for a red area with a small sore on his lower left leg. Client #1 was diagnosed with cellulitis and given a prescription for antibiotic treatment and released. Corrective action indicated the group home staff would monitor client #1 for health and safety, and the group home nurse would monitor client #1's leg for any changes.</p> <p>The group home nurse and AD were interviewed on 9/23/15 at 2:50 PM. She indicated client #1 should have used foot pedals as recommended by his physician and client #1 should be wearing socks. She indicated client #1's medication administration record included measures to wash client #1's feet twice daily and to monitor for skins of redness, swelling or discharge, but there was not a system to document or monitor scratches or bruises other than the reporting system. The group home nurse indicated she should</p>			

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	<p>have been notified of client #1's injuries. The AD indicated she was unaware of bruises or injuries to client #1 and should have been made aware of them. The nurse indicated the failure to follow recommendations to use foot pedals and keep client #1's feet covered placed him at risk for developing cellulitis. The AD indicated the failure to document and report injuries placed client #1 at risk for abuse, neglect and mistreatment.</p> <p>2. During observations at the group home on 9/21/15 from 4:55 P.M. until 6:58 P.M., Client #2 had visible light red scratch marks on both sides of his face. At 5:59 P.M. Client #2 sat in the corner of the fenced-in backyard and bit at his left lower arm. There was a pink calloused area on this part of client #2's arm.</p> <p>Direct Care Staff (DCS) #3 was interviewed on 9/21/15 at 5:52 P.M. DCS #3 stated "He does it to himself."</p> <p>During observations at the group home on 9/22/15 from 6:18 A.M. until 8:02 A.M., Client #2 had scratch marks on both sides of his face. The scratches were dark red in color and there were more scratches, especially on the left side of his face.</p>			

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	<p>During observations at the group home on 9/22/15 from 5:20 P.M. until 6:48 P.M., Client #2's scratches on the sides of his face were deeper and dark red.</p> <p>During observations at day services on 9/23/15 from 10:45 A.M. until 12:35 P.M., client #2's scratches on the sides of his face appeared to have dried blood in some of the scratch marks due to the dark red/black color that was visible.</p> <p>A confidential interview stated "[client #2] has a few behaviors we are concerned about. His scratching at his face and biting at his arm usually occurs around meal time or whenever there is food around."</p> <p>Client #2's record was reviewed on 9/23/15 at 2:58 P.M. Client #2's record indicated he had an ISP (Individual Support Plan) dated 7/22/15. Client #2's ISP indicated he had the following diagnoses: profound mental retardation, seizure disorder, autism, self-injurious behaviors, atypical psychosis, expressive communication needs, and ataxia. Client #2's ISP indicated "will bite self if he is frustrated or angry, verbally redirect. Not able to self report injury, if he appears to be injured assess his body. He does not present risk for skin integrity issues." Client #2 had a BSP (behavior support</p>			

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	<p>plan) dated 5/29/15. The BSP indicated the following targeted behaviors: "disturbing others sleep, stereotypical behaviors, self-injurious behaviors (biting), taking others belongings, inappropriate sexual behaviors." Client #2's BSP did not include scratching as a targeted behavior. Client #2's record did not include any documentation of client #2's scratches on his face and the calloused area on his arm.</p> <p>The Program Director (PD) and Area Director (AD) were interviewed on 9/22/15 at 4:15 PM. When asked about client #2's scratches, the PD indicated she was unaware of the injuries.</p> <p>The group home RN and the Area Director (AD) were interviewed on 9/23/15 at 2:50 P.M. The RN indicated the group home staff were to be checking all of the clients' skin daily and report any unusual findings to her. The group home nurse indicated she should have been notified of client #2's scratches from his self injurious behaviors. The AD indicated she was unaware of client #2's scratches and should have been made aware of them. The AD indicated the specific self-injurious behaviors client #2 had should be addressed in his BSP and there should be safe guards in place to prevent clients #1 and #2 from injuring</p>				

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W 0158 Bldg. 00	<p>themselves.</p> <p>9-3-2(a)</p> <p>483.430 FACILITY STAFFING</p> <p>The facility must ensure that specific facility staffing requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Facility Staffing. The facility failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) performed all aspects of the QIDP position for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and for 4 of 4 sampled clients (clients #5, #6, #7 and #8). The facility failed to ensure there were a sufficient number of staff provided to meet the needs of 4 of 4 sampled clients (clients #1, #2, #3 and #4) and for 4 of 4 sampled clients (clients #5, #6, #7 and #8). The facility failed to ensure the staff were trained to sufficiently, effectively and competently meet the health, dining and behavior needs for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and for 4 of 4 sampled clients (clients #5, #6, #7 and #8).</p> <p>Findings include:</p>	W 0158	<ol style="list-style-type: none"> 1. Please refer to W159 2. Please refer to W186 3. Please refer to W189 4. Please refer to W191 5. Please refer to W192 	11/18/2015

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	<p>1. The Qualified Intellectual Disabilities Professional (QIDP) failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4), and for 4 additional clients (clients #5, #6, #7 and #8) to ensure plans were developed to address clients' needs and failed to coordinate and monitor program implementation across settings. The QIDP failed for 2 of 4 additional clients (clients #7 and #8) to ensure they wore clothing that fit appropriately and was in good condition. The QIDP failed to complete comprehensive functional assessments including physical therapy, occupational therapy, body positioning, and wheelchair/adaptive equipment usage for 1 of 4 sampled clients (client #1) and 1 of 4 additional clients (client #5). The QIDP failed to address the identified needs for 3 of 4 sampled clients (clients #1, #2 and #3) and for 2 of 4 additional clients (clients #5 and #7) in their Individual Support Plans (ISPs). The QIDP failed for 1 of 4 sampled clients (client #1), and one additional client (client #5), to identify specific instructions in the clients' ISPs (Individual Support Plans) to address their needs for positioning in their wheelchairs and of assisting client #5 in his needs to address contractures. The QIDP failed to assure the day program had all relevant plans for 1 of 4 sampled</p>			

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	<p>clients (client #2) and 1 of 4 additional clients (client #7). The QIDP failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) who are prescribed psychotropic medications to assist them with behavior control and/or symptoms of their diagnoses, to ensure the Human Rights Committee approved the restrictive plans only after the written informed consent of their guardians had been obtained. The QIDP failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and for 4 of 4 additional clients (clients #5, #6, #7 and #8) to promote dignity by failing to ensure they were well groomed and dressed appropriately. The QIDP failed to encourage and teach socially appropriate dining skills and to redirect socially inappropriate dining behaviors. The QIDP failed for 2 of 4 sampled clients (clients #1 and #2) to manage their inappropriate self-injurious behaviors (SIB) and to adequately protect them from repeated injuries. The QIDP implemented restrictive measures of denying clients accessibility to their clothing and closets for 2 of 4 sampled clients (clients #1 and #4) and 2 of 4 additional clients (clients #7 and #8) in absence of programming techniques. The QIDP failed to ensure all medications used for behavior control were incorporated into a plan (client #2). Please see W159.</p>			

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	<p>2. The facility failed to ensure there were sufficient staff to manage and supervise clients in accordance with their individual needs for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8). Please see W186.</p> <p>3. The facility failed to ensure staff received continuing training and were able to perform their duties for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) sufficiently, effectively and competently. Please see W189.</p> <p>4. The facility failed to train staff competently on the behavioral needs of 2 of 2 sampled clients (clients #1 and #2). Please see W191.</p> <p>5. The facility failed to train staff competently on the health needs of 1 of 4 sampled clients (client #1). Please see W192.</p> <p>9-3-3(a)</p>			

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W 0159 Bldg. 00	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based upon record review, observation and interview, the facility's Qualified Intellectual Disabilities Professional (QIDP) failed for 4 of sampled clients (clients #1, #2, #3 and #4), and for 4 additional clients (clients #5, #6, #7 and #8) to ensure plans were developed to address clients' needs and failed to coordinate and monitor program implementation across settings. The QIDP failed for 2 of 4 sampled clients (clients #2 and #4) and for 2 of 4 additional clients (clients #7 and #8) to ensure they wore clothing that fit appropriately and was in good condition. The QIDP neglected to document and monitor injuries (scratches) sustained by client #2's self injurious behavior, neglected to develop and implement</p>	W 0159	<ol style="list-style-type: none"> 1. The QIDP will receive retraining on group home and day service observation expectations. Group home observations are required a minimum of weekly. Day service observations are required a minimum of monthly. Training will include ensuring that documentation is available for review of QIDP visits both to the group home and day services. Ongoing, the QIDP will complete group home and day services observations as required above and provide documentation of visits to Area Director for review. 2. Please see W137 3. Please see W149 4. Please see W214 5. Please see W227 6. Please see W240 	11/18/2015

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	corrective action to protect client #1 from cellulitis (skin infection) after a history of cellulitis had been identified. The QIDP failed to develop and implement corrective action to address injuries of unknown source involving client #1 and self injurious behaviors involving client #2. The QIDP failed to complete comprehensive functional assessments including physical therapy, occupational therapy, body positioning, and wheelchair/adaptive equipment usage for 1 of 4 sampled clients (client #1) and 1 of 4 additional clients. The QIDP failed to address the identified needs for 3 of 4 sampled clients (clients #1, #2 and #3) and for 2 of 4 additional clients (clients #5 and #7) in their Individual Support Plans (ISP). The QIDP failed for 1 of 4 sampled clients (client #1), and one additional client (client #5), to identify specific instructions in the clients' ISPs (Individual Support Plans) to address their needs for positioning in their wheelchairs and of assisting client #5 in his needs to address contractures. The QIDP failed to assure the day program had all relevant plans for 1 of 4 sampled clients (client #2) and 1 of 4 additional clients (client #7). The QIDP failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) who are prescribed psychotropic medications to assist them with behavior control and/or symptoms of their		7. Please see W248 8. Please see W249 9. Please see W263 10. Please see W268 11. Please see W285 12. Please see W287 13. Please see W312				

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	<p>diagnoses, to ensure the Human Rights Committee approved the restrictive plans only after the written informed consent of their guardians had been obtained. The QIDP failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and for 4 of 4 additional client (clients #5, #6, #7 and #8) to promote dignity by failing to ensure they were well groomed and dressed appropriately to encourage and teach socially appropriate dining skills and to redirect socially inappropriate dining behaviors. The QIDP failed for 2 of 4 sampled clients (clients #1 and #2) to manage their inappropriate self-injurious behaviors (SIB) and to adequately protect them from repeated injuries. The QIDP implemented restrictive measures of denying clients accessibility to their clothing and closets for 2 of 4 sampled clients (clients #1 and #4) and 2 of 4 additional clients (clients #7 and #8) in absence of programming techniques. The QIDP failed for 1 of 4 sampled clients (client #2) who was prescribed psychotropic medications to assist him with behavior control and/or symptoms of his diagnoses to include the use of all prescribed psychotropic medications in his plan.</p> <p>Findings include:</p> <p>1. A record of QIDP (Qualified</p>			

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	<p>Intellectual Disabilities Professional) observations at the group home to observe for program implementation was reviewed on 9/29/15 at 11:56 AM. There was documentation the QIDP made visits to the group home on 8/31/15, 7/10/15, 6/26/15, 6/2/15, 5/15/15, 4/9/15, 3/17/15, 2/25/15, 1/29/15, 12/18/14, 10/28/14 and 10/21/14. There was no record of visits to the 4 day services clients #1, #2, #3, #4, #5, #6, #7 and #8 attended.</p> <p>The Area Director was interviewed on 9/29/15 at 10:45 AM and indicated the facility's expectation was for QIDP visits to the home to be once weekly.</p> <p>The Director of day services #1 was interviewed on 10/2/15 at 11:50 AM and indicated visits by the QIDP were occasional.</p> <p>The Director of day services #2 was interviewed on 9/23/15 at 10:47 A.M. and indicated the QIDP had visited the day program one time for a meeting (9/21/15) since 6/2015.</p> <p>2. The QIDP failed for 2 of 4 sampled clients (clients #2 and #4) and for 2 of 4 additional clients (clients #7 and #8) to ensure they wore clothing that fit appropriately and was in good condition. Please see W137.</p>			

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	<p>3. The QIDP neglected to document and monitor injuries (scratches) sustained by client #2's self injurious behavior, neglected to develop and implement corrective action to protect client #1 from cellulitis (skin infection) after a history of cellulitis had been identified. Please see W149.</p> <p>4. The QIDP failed to complete comprehensive functional assessments including physical therapy, occupational therapy, body positioning, and wheelchair/adaptive equipment usage for 1 of 4 sampled clients (client #1) and 1 of 4 additional clients (client #5). Please see W214.</p> <p>5. The QIDP failed to address the identified needs for 3 of 4 sampled clients (clients #1, #2 and #3) and for 2 of 4 additional clients (clients #5 and #7) in their Individual Support Plans (ISP). Please see W227.</p> <p>6. The QIDP failed for 1 of 4 sampled clients (client #1), and one additional client (client #5), to identify specific instructions in the clients' ISPs (Individual Support Plans) to address their needs for positioning in their wheelchairs and of assisting client #5 in his needs to address contractures. Please</p>			

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	<p>see W240.</p> <p>7. The QIDP failed to assure the day program had all relevant plans for 1 of 4 sampled clients (client #2) and 1 of 4 additional clients (client #7). Please see W248.</p> <p>8. The QIDP failed to ensure 4 of 4 sampled clients (clients #1, #2, #3 and #4) received a continuous active treatment program based on their individual needed services and interventions. Please see W249.</p> <p>9. The QIDP failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) who are prescribed psychotropic medications to assist them with behavior control and/or symptoms of their diagnoses, to ensure the Human Rights Committee approved the restrictive plans only after the written informed consent of their guardians had been obtained. Please see W263.</p> <p>10. The QIDP failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and for 4 of 4 additional clients (clients #5, #6, #7 and #8) to promote dignity by failing to ensure they were well groomed and dressed appropriately. The facility failed to promote dignity for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7</p>			

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	<p>and #8) by failing to encourage and teach socially appropriate dining skills and to redirect socially inappropriate dining behaviors. Please see W268.</p> <p>11. The QIDP failed for 2 of 4 sampled clients (clients #1 and #2) to manage their inappropriate self-injurious behaviors (SIB) and to adequately protect them from repeated injuries. Please see W285.</p> <p>12. The QIDP implemented restrictive measures of denying clients accessibility to their clothing and closets for 2 of 4 sampled clients (clients #1 and #4) and 2 of 4 additional clients (clients #7 and #8) in absence of programming techniques. Please see W287.</p> <p>13. The QIDP failed for 1 of 4 sampled clients (client #2) who was prescribed psychotropic medications to assist him with behavior control and/or symptoms of his diagnoses to include the use of all prescribed psychotropic medications in his plan. Please see W312.</p> <p>9-3-3(a)</p>			

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W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program			

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	<p>plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview, the facility failed to provide sufficient direct care staff to manage and supervise clients in accordance with their individual needs for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8).</p> <p>Findings include:</p> <p>During observations at the group home on 9/22/15 from 5:05 PM until 5:45 PM, clients #1, #2, #3, #4, #5, #6, #7, and #8 were in the dining room. Direct Support Staff (DSP) #1 and DSP #6 were the only staff in the home during the observation. Client #1 sat slumped in his wheelchair without a seat cushion or foot pedals/rests. Client #5 sat slumped with his head to one side in his wheelchair with a lap tray. DSP #6 prepared lasagna, creamed corn and green beans and poured them into the same bowl causing the food to run together. Client #8's food had chunks of pasta in the bowl. Client #1 ate his lasagna in bites 2 inches in diameter without redirection.</p>	W 0186	<p>The staff schedule has been revised to allow for 3 staff to be present at mealtimes to assist consumers. Direct care staff will receive retraining to include ensuring that medications are passed prior to mealtime so all staff present are available to assist during the meal. Direct care staff will receive retraining on ensuring that at least one staff is present in the dining room at all times to ensure consumers are following mealtime etiquette and are redirected as needed when behaviors occur.</p> <p>The Program Coordinator and/or QIDP will complete mealtime observations at least three times weekly for 4 weeks to ensure that consumers are being supervised during the meal, staff are redirecting consumers as needed when behaviors occur and ensuring that staff are passing medications prior to the meal to allow for all staff to assist with mealtimes.</p> <p>Ongoing after the 4 weeks the Program Coordinator and/or QIDP will complete mealtime observations at least twice weekly to ensure that consumers are being supervised during the meal,</p>	11/18/2015

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	<p>During observations on 9/22/15 between 5:20 P.M. and 6:05 P.M. including the evening meal. The clients were eating their evening meal from a bowl. The meal consisted of creamed corn, green beans, lasagna, lemonade and milk. The gallon of milk sat on the table, but was never opened or served to any of the clients. There were two staff working DCS #1 and #6. Client #2 completed his meal and went outside. DCS #1 followed client #2. There were no staff in the dining room with the remaining clients. Client #1 grabbed client #2's bowl and started to eat from it. Client #7 grabbed the lemonade pitcher and began to drink from the spout of the pitcher. Client #7 then grabbed some food from another client's bowl across the table and ate it. Client #7 stood up and went to client #5 and attempted to take client #5's bowl. Client #5 hit client #7 in the abdomen. Client #5 stated "He tried to take my bowl." DCS #1 was informed of what had occurred when he returned to the dining room. DCS #1 removed the lemonade and the contaminated food bowls. Other food was not provided for those clients other than client #1 was given a pot pie upon the surveyor's question if he (client #1) was "allowed second servings?"</p> <p>During observations on 9/25/15 from</p>		<p>staff are redirecting consumers as needed when behaviors occur and ensuring that staff are passing medications prior to the meal to allow for all staff to assist with mealtimes</p> <p>Responsible Party: Program Coordinator, QIDP</p>	

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	<p>7:10 AM until 8:20 AM, there were two staff in the home, DSPs #4 and #8. Clients #1, #2, #3, #4, #5, #6, #7 and #8 sat in the dining room unattended while DSPs #4 and #8 made breakfast in an adjacent kitchen upon arrival at the group home. Client #6 came to the table, sat down, then hit the table and was redirected by staff. Client #6 then raised his spoon as if he was about to throw it before being redirected by staff. DSP #8 then administered medications and DSP #4 finished preparing breakfast consisting of instant oatmeal, pancakes, milk and tea while the clients sat unattended in the dining room. DSP #4 brought individual portions of oatmeal and pancakes to the table after they were heated up one at a time. While DSP #4 prepared individual portions of microwave instant oatmeal and pancakes, client #2 made loud verbalizations and dug into his brief then wiped his hands on the table. Staff were not present in the room and did not observe his behavior. Client #1 slipped down in his wheelchair until his buttocks were on the edge of the seat unobserved by staff until he nearly slipped out of his seat. As the surveyor stepped toward client #1 to prevent his fall and notify staff of his position, DSP #4 came into the room to bring food to the table, saw client #1's position and repositioned him just as he began to slide out of his seat to</p>			

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	<p>the floor. Client #2 periodically yelled as DSP #4 prepared the food and slapped his head without redirection from staff who were not present to observe his behavior. Client #2 yelled out and stood up prior to being served breakfast, and DSP #4 stated, "I'm hurrying buddy." Client #2 ate his pancake in two bites then took client #6's pancake without staff present to observe. Client #7 ate his pancake with his hands, then took client #3's oatmeal and poured it into his bowl and ate it. Client #1's oatmeal in a bowl fell to the floor, but staff did not see the bowl fall. DSP #4 asked what happened to client #1's oatmeal and was told by the surveyor his bowl had fallen to the floor. DSP #4 was present to observe client #7 taking client #3's oatmeal and then left the clients in the dining room to prepare more oatmeal for clients #1 and #3. Client #8 ate a pancake ground into a grainy texture and client #6 pounded the table 5 times during the meal when staff were not present. Client #7 took client #2's remaining pancake and client #2 took client #1's pancake and ate it unobserved by staff who were not present. Client #6 hit the table again and client #7 took client #3's nutritional substitute and poured it into his glass. Client #1 did not receive a nutritional substitute and tried to eat from client #3's oatmeal bowl, then took a bite of food</p>			

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	<p>laying on the table top. Client #6 gave client #3 his tea and client #1 drank the tea after client #3 drank some of it.</p> <p>During confidential interview, the interview indicated two staff in the home during the morning and the breakfast meal were not adequate to address the clients' needs, especially if there were appointments scheduled and the clients needed to leave the home on time for the appointments.</p> <p>The Area Director (AD) was interviewed on 10/9/15 at 9:39 AM and indicated there were normally three staff working in the group home during morning and evening meals, and the facility was reviewing client schedules and staff deployment to ensure clients were not eating meals and receiving medication at the same time to provide more staff supervision at mealtimes.</p> <p>The Home Manager (HM), the Qualified Intellectual Disabilities Professional (QIDP) and the Area Director (AD) were interviewed on 9/28/15 at 3:18 P.M. When asked how many staff normally work at the group home during awake hours, the AD stated "It's 2-3 usually, it depends. Part of our plan is to have management in there more." The HM and the QIDP both shook their heads "no"</p>			

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W 0189 Bldg. 00	<p>when asked if even 4 staff were enough to meet the clients' needs at meal times. The AD was asked when she had last observed a meal at the group home and indicated it had been awhile.</p> <p>9-3-3(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, record review and interview, the facility failed to provide continuing training for the staff who worked with 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) to enable the staff to perform their duties effectively, efficiently and competently.</p> <p>Findings include:</p> <p>1. During observations at day services on 9/22/15 from 11:25 AM until 12:15 PM, client #1 sat in a wheelchair without foot</p>	W 0189	<p>1.The Day Service supervisor completed a retraining with their staff about the need to ensure BDDS reportable incidents are reported to the appropriate parties timely so BDDS reports can be filed as needed.</p> <p>The QIDP will complete training with the Day Services supervisor on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of</p>	11/18/2015

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	<p>pedals. His feet were bare, and he had scratches on his forehead and along the length of his left shoulder blade and along the back of his neck. Client #1's ear was bruised on the front and back of the ear and he had a bruise across his knee cap on his right knee. Client #1's left knee had a scab 1/2 inch in diameter.</p> <p>Confidential interview #1 indicated there had been concerns about client #1's injuries and they were of unknown origin.</p> <p>The Program Director (PD) and Area Director (AD) were interviewed on 9/22/15 at 4:15 PM. When asked about client #1's injuries, the PD indicated she was unaware of the injuries or their status of documentation. During the interview, the PD called the house manager who indicated to the PD client #1 had been taken to the doctor on 8/20/15 in regards to skin issues. The house manager indicated the current scratches, bruising and marks on client #1's body were a result of dermatitis. She indicated client #1 was to keep his nails trimmed short and staff were to watch for signs of infection such as increased redness, swelling and drainage. The PD indicated there was not a system in place to document healing of minor injuries, bruises or scratches. The AD stated, "We don't do body checks (unless there is a</p>		<p>reportable incidents.</p> <p>Ongoing, the QIDP will complete observations at Day Services a minimum of monthly to ensure that Day Services are following all consumers ISP, BSP and program goals. Documentation will be completed for each visit and will be available for review.</p> <p>A wheelchair protocol has been developed for Client #1 that includes recommendations from the physician for Client #1 to use foot pedals to prevent him from dragging his feet to reduce possibility of injuries to his feet.</p> <p>A cellulitis protocol has been developed for Client #1 to instruct staff about the signs and symptoms of cellulitis and what to look for on Client #1 person since he is at a high risk for the cellulitis to recur since he has had it previously.</p> <p>Body Check assessments have been implemented for all consumers, including client #1. Staff are to complete a body assessment form daily when assisting consumers with showers to note any bruises, scratches or other injuries. Staff are to document notes on the size, shape, etc. of each mark noted on the body to determine if any changes are occurring. Staff are to notify the Program Coordinator, QIDP and/or</p>		

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	<p>specific need) because of dignity", but indicated staff observe for injuries when they assist clients during showering. The AD indicated client #1 should be using foot pedals as recommended by the doctor and should be using socks to protect his feet. When asked how injuries to clients are documented, the AD indicated they are reported to BDDS (Bureau of Developmental Disabilities Services) if the incident meets the criteria or are to be documented on internal accident/injury reports. She indicated she would look for additional reports. No additional documentation of client #1's injuries were provided.</p> <p>The facility's reportable incidents to BDDS and investigations were reviewed on 9/23/15 at 11:50 AM and included the following:</p> <p>A BDDS report dated 2/1/15 indicated client #1 had been taken to the ER (emergency room) for evaluation and treatment of his swollen left foot. Client #1 was diagnosed with cellulitis and admitted for antibiotic treatment. A follow up report dated 2/19/15 indicated client #1 remained in the hospital for treatment. A follow up report dated 4/6/15 indicated client #1 had completed antibiotics for cellulitis on 4/6/15 and the group home nurse and staff would</p>		<p>Program Nurse if any new marks are observed or any changes to current bruises, scratches, etc. are observed to determine if further assessment needs to be made. Program Coordinator, QIDP and Area Director will review the body assessment forms to ensure that all new injuries or changes to injuries are being reported to determine if further evaluation is needed. Body checks are to be completed for each consumer daily at the time of undressing/shower. Daily body checks are to be completed for a minimum of 6 weeks in an attempt to prevent injuries of unknown origin from not being reported.</p> <p>2. The staff schedule has been revised to allow for 3 staff to be present at mealtimes to assist consumers. Direct care staff will receive retraining to include ensuring that medications are passed prior to mealtime so all staff present are available to assist during the meal. Direct care staff will receive retraining on ensuring that at least one staff is present in the dining room at all times to ensure consumers are following mealtime etiquette and are redirected as needed when behaviors occur.</p> <p>The Program Coordinator and/or QIDP will complete mealtime observations at least three times weekly for 4 weeks to ensure that</p>				

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	<p>monitor his condition.</p> <p>A report dated 5/30/15 indicated client #1 had been taken to the ER to evaluate a purplish rash on both arms and a bump on one eye. Evaluation did not determine the cause of the rash, but the doctor "hypothesized he could have been having a reaction to something, but he couldn't be certain. " Client #1 was released to go home, and advised to use the medication already prescribed for his skin. Client #1 was to visit his primary care physician if he was not improved in a week. The house manager advised on 8/31/15 client #1 had improved. Corrective action indicated client #1 would be monitored for his health and safety.</p> <p>A BDDS report dated 6/5/15 indicated client #1 was taken to the ER at the recommendation of the nurse to be evaluated for a red area with a small sore on his lower left leg. Client #1 was diagnosed with cellulitis and given a prescription for antibiotic treatment and released. Corrective action indicated the group home staff would monitor client #1 for health and safety, and the group home nurse would monitor client #1's leg for any changes.</p> <p>The group home nurse and AD were interviewed on 9/23/15 at 2:50 PM. She</p>		<p>consumers are being supervised during the meal, staff are redirecting consumers as needed when behaviors occur and ensuring that staff are passing medications prior to the meal to allow for all staff to assist with mealtimes.</p> <p>Ongoing after the 4 weeks the Program Coordinator and/or QIDP will complete mealtime observations at least twice weekly to ensure that consumers are being supervised during the meal, staff are redirecting consumers as needed when behaviors occur and ensuring that staff are passing medications prior to the meal to allow for all staff to assist with mealtimes</p> <p>Dining goals have been developed for each consumer for them to work on at mealtimes based on their abilities. All direct care staff will receive retraining on ensuring that all consumers dining goals and objectives are being run as directed.</p> <p>For 4 weeks the HM and/or QIDP will complete mealtime administration observations a minimum of three times weekly to ensure that direct care staff are running dining goals as directed.</p> <p>Ongoing after the 4 weeks the HM and/or QIDP will complete mealtime administration observations a minimum of three</p>		

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	<p>indicated client #1 should have used foot pedals as recommended by his physician and client #1 should be wearing socks. She indicated client #1's medication administration record included measures to wash client #1's feet twice daily and to monitor for skins of redness, swelling or discharge, but there was not a system to document or monitor scratches or bruises other than the reporting system. The group home nurse indicated she should have been notified of client #1's injuries. The AD indicated she was unaware of bruises or injuries to client #1 and should have been made aware of them. The nurse indicated the failure to follow recommendations to use foot pedals and keep client #1's feet covered placed him at risk for developing cellulitis. The AD indicated the failure to document and report injuries placed client #1 at risk for abuse, neglect and mistreatment.</p> <p>An Indiana Mentor Meeting Note dated 6/9/15 was reviewed on 9/29/15 at 12:58 PM and indicated, "Cellulitis is a bacterial infection. It is not contagious. Can be from scratches, etc....[Client #1] will always be a target for cellulitis. His PCP (primary care physician) says he will always be susceptible for cellulitis...look for small scratches, cuts, cracks, etc. *Wash his feet 2 times a day and apply ointment, clean socks. Staff will be</p>		<p>times weekly to ensure that direct care staff are running dining goals as directed.</p> <p>All direct care staff will receive retraining on mealtime protocols including ensuring that all consumers are receiving a sufficient amount of food as designated by the menu and the consumers diet orders. Training will include ensuring that extra portions are offered as designated by individual consumers diet orders. In addition, training will include ensuring that if an item on the menu is not conducive to preparing for consumers that have modified diet orders that appropriate substitutions are provided. All direct care staff will receive retraining to include ensuring that consumers are offered nutritional supplements as directed by the consumers PCP and/or dietician.</p> <p>The Program Coordinator and/or QIDP will complete mealtime observations at least three times weekly for 4 weeks to ensure that consumers are being offered sufficient amounts of food, are offered appropriate substitutions, staff are following diet orders and consumers are being offered their nutritional supplements as directed.</p> <p>Ongoing after the 4 weeks the Program Coordinator and/or</p>				

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	<p>trained in the signs of cellulitis and what to do." There was no evidence of staff training in the area of preventing client #1's cellulitis.</p> <p>During observations at the group home on 9/22/15 from 5:05 PM until 5:45 PM, client #1 sat slumped in his wheelchair without a seat cushion or foot pedals/rests. Client #5 sat slumped with his head to one side in his wheelchair with a lap tray. Clients #1, #2, #3, #4, #5, #6, #7, and #8 were in the dining room. Direct Support Staff (DSP) #1 and DSP #6 were the only staff in the home during the observation.</p> <p>DSP #6 was interviewed on 9/22/15 at 5:10 PM and stated client #1 "never" uses foot pedals/rests.</p> <p>DSP #6 was interviewed on 9/22/15 at 5:05 PM and stated "sometimes he scratches his arms," when asked about client #7's sore. She indicated the injury was documented on an injury form, but was unable to find the documentation.</p> <p>DSP #4 was interviewed on 9/22/15 at 8:45 AM and indicated client #1's foot pedals were in the garage and that he used his feet to propel himself in the wheelchair so he did not use foot pedals.</p>		<p>QIDP will complete mealtime observations at least twice weekly to ensure that consumers are being offered sufficient amounts of food, are offered appropriate substitutions, staff are following diet orders and consumers are being offered their nutritional supplements as directed.</p> <p>Dining plans have been created or updated for all consumers. All direct care still will receive retraining on every consumer's specific dining plan including each consumers specified diet orders. Retraining will include ensuring that staff are following all consumers diet orders including if consumers have modified diets such as mechanical soft and pureed.</p> <p>Staff will also receive retraining on how to prepare the specialized diets prescribed for each consumer. Previous Program Nurse is no longer working for Indiana Mentor. The new Program Nurse will receive retraining on ensuring that specified dining plans are developed for each consumer based on PCP and dietician recommendations. Training will include ensuring that dining plans are updated a minimum of annually at the ISP and more often as needed if any changes occur. Training will also include ensuring that all staff working in the home are trained on all</p>	

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	<p>2. During observations at the group home on 9/22/15 from 5:05 PM until 5:45 PM, clients #1, #2, #3, #4, #5, #6, #7, and #8 were in the dining room. Direct Support Staff (DSP) #1 and DSP #6 were the only staff in the home during the observation. Client #1 sat slumped in his wheelchair without a seat cushion or foot pedals/rests. Clients #1, #2, #3, #4, #5, #6, #7, and #8 were in the dining room. DSP #6 prepared lasagna, creamed corn and green beans and poured them into the same bowl causing the food to run together. Client #8's food had chunks of pasta in the bowl. Client #1 ate his lasagna in bites 2 inches in diameter without redirection.</p> <p>During observations on 9/22/15 between 5:20 P.M. and 6:05 P.M. including the evening meal. The clients were eating their evening meal from a bowl. The meal consisted of creamed corn, green beans, lasagna, lemonade and milk. The gallon of milk sat on the table, but was never opened or served to any of the clients. There were two staff working DCS #1 and #6. Client #2 completed his meal and went outside. DCS #1 followed client #2. There were no staff in the dining room with the remaining clients. client #1 grabbed client #2's bowl and started to eat from it. Client #7 grabbed the lemonade pitcher and began to drink</p>		<p>consumers specified dining plans.</p> <p>The Program Coordinator and/or QIDP will complete mealtime observations at least three times weekly for 4 weeks to ensure that staff are following all consumers prescribed diet orders and are preparing meals as directed by the specialized diets. Observations will also include ensuring that staff are following all aspects of consumers specified dining plans.</p> <p>Ongoing after the 4 weeks the Program Coordinator and/or QIDP will complete mealtime observations at least twice weekly to ensure that staff are following all consumers prescribed diet orders and are preparing meals as directed by the specialized diets. Observations will also include ensuring that staff are following all aspects of consumers specified dining plans.</p> <p>Responsible party: QIDP, Program Coordinator, Program Nurse</p>				

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	<p>from the spout of the pitcher. Client #7 then grabbed some food from another clients bowl across the table and ate it. Client #7 stood up and went to client #5 and attempted to take client #5's bowl. Client #5 hit client #7 in the abdomen. Client #5 stated "He tried to take my bowl." DCS #1 was informed of what had occurred when he returned to the dining room. DCS #1 removed the lemonade and the contaminated food bowls. Other food was not provided for those clients other than client #1 was given a pot pie upon the surveyor's question if he (client #1) was "allowed second servings?"</p> <p>DSP #6 was interviewed on 9/22/15 at 5:15 PM and indicated client #1 received a pureed diet. When the surveyor pointed out the chunks of food in client #1's bowl, DSP #6 took his bowl and clients #1 did not receive a liquid nutritional supplement during the meal. DSP #1 and #6 did not offer a second portion and DSP #6 began washing dishes after the meal.</p> <p>DSP #6 was interviewed on 9/22/15 at 5:37 P.M. When asked what menu was followed for the evening meal DSP #6 stated "We didn't go by the menu."</p> <p>DSP #6 was interviewed again on</p>			

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	<p>9/22/15 at 5:40 PM. When asked if the clients liked to have their food mixed together into a bowl, she stated, "They're eating it." When asked about additional food for client #1, DSP #6 indicated she had more food for him.</p> <p>During observations on 9/25/15 from 7:10 AM until 8:20 AM, there were two staff in the home, DSPs #4 and #8. Clients #1, #2, #3, #4, #5, #6, #7 and #8 sat in the dining room unattended while DSPs #4 and #8 made breakfast in an adjacent kitchen upon arrival at the group home. Client #6 came to the table, sat down, then hit the table and was redirected by staff. Client #6 then raised his spoon as if he was about to throw it before being redirected by staff. DSP #8 then administered medications and DSP #4 finished preparing breakfast consisting of instant oatmeal, pancakes, milk and tea while the clients sat unattended in the dining room. DSP #4 brought individual portions of oatmeal and pancakes to the table after they were heated up one at a time. While DSP #4 prepared individual portions of microwave instant oatmeal and pancakes, client #2 made loud verbalizations and dug into his brief then wiped his hands on the table. Staff were not present in the room and did not observe his behavior. Client #1 slipped down in his wheelchair until his buttocks</p>				

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	<p>were on the edge of the seat unobserved by staff until he nearly slipped out of his seat. As the surveyor stepped toward client #1 to prevent his fall and notify staff of his position, DSP #4 came into the room to bring food to the table, saw client #1's position and repositioned him just as he began to slide out of his seat to the floor. Client #2 periodically yelled as DSP #4 prepared the food and slapped his head without redirection from staff who were not present to observe his behavior. Client #2 yelled out and stood up prior to being served breakfast, and DSP #4 stated, "I'm hurrying buddy." Client #2 ate his pancake in two bites then took client #6's pancake without staff present to observe. Client #7 ate his pancake with his hands, then took client #3's oatmeal and poured it into a his bowl and ate it. Client #1's oatmeal in a bowl fell to the floor, but staff did not see the bowl fall. DSP #4 asked what happened to client #1's oatmeal and was told by the surveyor his bowl had fallen to the floor. DSP #4 was present to observe client #7 taking client #3's oatmeal and then left the clients in the dining room to prepare more oatmeal for clients #1 and #3. Client #8 ate a pancake ground into a grainy texture and client #6 pounded the table 5 times during the meal when staff were not present. Client #7 took client #2's remaining pancake and client #2</p>			

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	<p>took client #1's pancake and ate it unobserved by staff who were not present. Client #6 hit the table again and client #7 took client #3's nutritional substitute and poured it into his glass. Client #1 did not receive a nutritional substitute and tried to eat from client #3's oatmeal bowl, then took a bite of food laying on the table top. Client #6 gave client #3 his tea and client #1 drank the tea after client #3 drank some of it.</p> <p>During confidential interview, the interview indicated two staff in the home during the morning during the breakfast meal were not adequate to address the clients' needs, especially if there were appointments scheduled and the clients needed to leave the home on time for the appointments.</p> <p>Client #1's records were reviewed on 9/22/15 at 2:25 PM. Client #1's nutritional assessments indicated the following: An assessment dated 10/15/14 indicated client #1 was "underweight" for his height and had a body mass index of 18.5. The assessment indicated goals to "increase weight...Noted [liquid nutritional supplement] was recommended in the past. No order noted at this time. Add [liquid nutritional supplement] TID (three times daily) to promote weight gain." An assessment</p>			
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	<p>dated 1/6/15 indicated "...Noted RN aware of [liquid nutritional supplement] recommend (sic) at last visit. Per staff, supplement is not on MAR (medication administration record). Recommend [liquid nutritional supplement] TID added to MAR to help with wt (weight) gain...." An assessment dated 6/10/15 indicated "...Still recommend supplement of [liquid nutritional supplement] BID (twice daily)-0 orders noted yet...Reg (regular) high cal (calorie) soft diet and 2 c (cups) of fortified cereal every morning. Rec (recommend) add oral nutrition supplement morning and evening HS (bedtime)." Client #1's physician's orders dated 9/1/15 failed to indicate a liquid nutritional supplement.</p> <p>Client #2's record was reviewed on 9/23/15 at 2:58 P.M. Client #2's Physician's Orders(PO) dated for 9/2015 indicated client #2 was to have Boost (nutritional supplement) 1 can 4 times a day. Regular high fiber diet, 2 cups of [name] cereal daily at breakfast. Client #2's Nutritional Assessment dated 6/10/2015 indicated "CBW (current body weight) 124 pounds BMI (body mass index) 17.8 below by 3.8%... though considered underweight for height (70 inches)...recommend to offer extra portions at meal times. Goal to increase weight by 2 pounds next quarter." Client</p>			

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	<p>#2's Individual Support Plan (ISP) dated 7/22/15 indicated client #2's "desired body weight was 160-178 pounds."</p> <p>Client #3's record was reviewed on 9/22/15 at 2:28 P.M. Client #3's Physician's Orders dated for 9/2015 indicated client #3 was to have a "soft high calorie diet, with 8 ounces of Ensure (nutritional supplement) four times a day to increase albumin, may have (nutritional supplement) at meals." Client #3's nutritional assessment dated 6/10/15 indicated "73 pounds, BMI 14.7 (underweight) 12% loss between Feb. (February) 2015 - May 2015, spoke with staff, reports client went to nursing home during this period and did not eat well in the unfamiliar environment. Client returned mid (middle) of May ... Spoke with staff and recommend to add ice cream to ensure for added carb/fats...." Client #3's ISP dated 5/14/15 indicated client #3's desired weight was 106-130 pounds. Client #3's 9/2015 MAR did not indicate current weight. The nutrition assessment completed indicated "Weight for July, 2015 80 pounds."</p> <p>Client #4's record was reviewed on 9/28/15 at 2:15 P.M. Client #4's ISP dated 3/19/15 indicated he was to have a "regular soft diet, mechanical, Boost twice daily." Client #4's MAR for 9/2015</p>			

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	<p>did not indicate current weight. His ISP indicated his weight was "138 pounds and he was 65.5 inches tall. His ideal body weight range was 126-167."</p> <p>Client #5's record was reviewed on 9/28/15 at 12:35 P.M. Client #5's PO dated for 9/2015 indicated client #5 was prescribed a regular low fat, low cholesterol, NCS (no concentrated sweets) diet with Boost once daily.</p> <p>Client #6's record was reviewed on 9/29/15 at 3:28 P.M. Client #6's PO dated for 9/2015 indicated he was prescribed a "regular, no extra portions" diet.</p> <p>Client #7's record was reviewed on 9/29/15 at 3:47 P.M. Client #7's PO dated for 9/2015 indicated he was prescribed a "regular, no extra portions" diet.</p> <p>Client #8's record was reviewed on 9/22/15 at 2:29 P.M. Client #8's PO dated for 9/2015 indicated he was to have a "pureed diet, may have extra portions."</p> <p>The Area Director (AD) and group home nurse were interviewed on 9/23/15 at 2:50 PM and indicated clients should be offered all food groups as listed on the menu and diets should be prepared to the prescribed consistency. The group home nurse indicated she thought client #1 was</p>			

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	<p>receiving a nutritional supplement. The AD indicated she had checked with the group home manager and the manager indicated she had not been made aware of the need for client #1 to receive a nutritional supplement and the supplement was not on client #1's physician's orders or MAR. She indicated there was not a definition of what a high calorie diet should consist of to be considered a high calorie diet, but that staff knew the clients were to receive seconds when on a high calorie diet. She stated staff "have a list" of what constituted a high calorie diet.</p> <p>There was no evidence of a list of high calorie diet for staff to use to provide for clients or of training on signs and symptoms of cellulitis for client #1 for staff working in the group home. There was no evidence of staff training in regards to documentation of client injuries provided.</p> <p>The Area Director (AD) was interviewed on 10/9/15 at 9:39 AM and indicated there was no evidence of staff training for client #1's cellulitis, for clients' high calorie diets or of documenting clients' injuries.</p> <p>The Home Manager (HM), the Qualified Intellectual Disabilities Professional</p>			

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	<p>(QIDP) and the Area Director (AD) were interviewed on 9/28/15 at 3:18 P.M. When asked how many staff normally work at the group home during awake hours. The AD stated "It's 2-3 usually, it depends. Part of our plan is to have management in there more." The HM and the QIDP both shook their heads "no" when asked if even 4 staff were enough to meet the clients' needs at meal times. The AD was asked when she had last observed a meal at the group home and indicated it had been awhile. The AD indicated all staff were trained initially at their time of hire and as needed.</p> <p>Staff training records were reviewed on 9/29/15 at 12:31 P.M. and included training on initial orientation to the facility, skin integrity, medical emergencies, utility emergencies, seizure protocol for client #1 and work place violence. There was no additional evidence that the staff had been trained on the clients' dietary and nutritional needs, menu substitutions, dining plans, client supervision at meal times and supervision of clients with self injurious behaviors or food stealing behaviors.</p> <p>9-3-3(a)</p>			

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W 0191 Bldg. 00	<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 on observation, record review and interview, the facility failed to train staff competently on the behavioral needs of 2 of 2 sampled clients (clients #1 and #2).</p> <p>Findings include:</p> <p>During observations at the group home on 9/21/15 from 4:55 P.M. until 6:58 P.M., Client #2 had visible light red scratch marks on both sides of his face. At 5:59 P.M. Client #2 sat in the corner of the fenced-in backyard and bit at his left lower arm. There was a pink calloused area on this part of client #2's arm.</p>	W 0191	<p>The staff schedule has been revised to allow for 3 staff to be present at mealtimes to assist consumers. Direct care staff will receive retraining to include ensuring that medications are passed prior to mealtime so all staff present are available to assist during the meal. Direct care staff will receive retraining on ensuring that at least one staff is present in the dining room at all times to ensure consumers are following mealtime etiquette and are redirected as needed when behaviors occur.</p> <p>The Program Coordinator and/or QIDP will complete mealtime observations at least three times weekly for 4 weeks to ensure that</p>	11/18/2015

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	<p>Direct Care Staff (DCS) #3 was interviewed on 9/21/15 at 5:52 P.M. DCS #3 stated "He does it to himself."</p> <p>During observations at the group home on 9/22/15 from 6:18 A.M. until 8:02 A.M., Client #2 had scratch marks on both sides of his face. The scratches were dark red in color and there were more scratches, especially on the left side of his face.</p> <p>During observations at the group home on 9/22/15 from 5:20 P.M. until 6:48 P.M., Client #2's scratches on the sides of his face were deeper and dark red.</p> <p>During observations at day services on 9/23/15 from 10:45 A.M. until 12:35 P.M., client #2's scratches on the sides of his face appeared to have dried blood in some of the scratch marks due to the dark red/black color that was visible.</p> <p>A confidential interview stated "[client #2] has a few behaviors we are concerned about. His scratching at his face and biting at his arm usually occurs around meal time or whenever there is food around."</p> <p>During observations on 9/25/15 from 7:10 AM until 8:20 AM, there were two staff in the home, DSPs #4 and #8.</p>		<p>consumers are being supervised during the meal, staff are redirecting consumers as needed when behaviors occur and ensuring that staff are passing medications prior to the meal to allow for all staff to assist with mealtimes.</p> <p>Ongoing after the 4 weeks the Program Coordinator and/or QIDP will complete mealtime observations at least twice weekly to ensure that consumers are being supervised during the meal, staff are redirecting consumers as needed when behaviors occur and ensuring that staff are passing medications prior to the meal to allow for all staff to assist with mealtimes</p> <p>Responsible Party: Program Coordinator, QIDP</p>				

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	<p>Clients #1, #2, #3, #4, #5, #6 #7 and #8 sat in the dining room unattended while DSPs #4 and #8 made breakfast in an adjacent kitchen upon arrival at the group home. Client #6 came to the table, sat down, then hit the table and was redirected by staff. Client #6 then raised his spoon as if he was about to throw it before being redirected by staff. DSP #8 then administered medications and DSP #4 finished preparing breakfast consisting of instant oatmeal, pancakes, milk and tea while the clients sat unattended in the dining room. DSP #4 brought individual portions of oatmeal and pancakes to the table after they were heated up one at a time. While DSP #4 prepared individual portions of microwave instant oatmeal and pancakes, client #2 made loud verbalizations and dug into his brief then wiped his hands on the table. Staff were not present in the room and did not observe his behavior. Client #2 periodically yelled as DSP #4 prepared the food and slapped his head without redirection from staff who were not present to observe his behavior. Client #2 yelled out and stood up prior to being served breakfast, and DSP #4 stated, "I'm hurrying buddy." Client #2 ate his pancake in two bites then took client #6's pancake without staff present to observe. Client #7 ate his pancake with his hands, then took client #3's oatmeal and poured</p>			

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	<p>it into a his bowl and ate it. Client #1's oatmeal in a bowl fell to the floor, but staff did not see the bowl fall. DSP #4 asked what happened to client #1's oatmeal and was told by the surveyor his bowl had fallen to the floor. DSP #4 was present to observe client #7 taking client #3's oatmeal and then left the clients in the dining room to prepare more oatmeal for clients #1 and #3. Client #6 pounded the table 5 times during the meal when staff were not present. Client #7 took client #2's remaining pancake and client #2 took client #1's pancake and ate it unobserved by staff who were not present. Client #6 hit the table again and client #7 took client #3's nutritional substitute and poured it into his glass. Client #1 tried to eat from client #3's oatmeal bowl, then took a bite of food laying on the table top. Client #6 gave client #3 his tea and client #1 drank the tea after client #3 drank some of it.</p> <p>Client #1's records were reviewed on 9/22/15 at 2:25 PM. Client #1's Behavior Support Plan (BSP) dated May, 2015 indicated target objectives of aggressive outbursts, inappropriate nudity, taking others' belongings without permission and disrupting others' sleep. Proactive interventions indicated in part, "Consistent communication is incredibly important to minimize problems and</p>			
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	<p>prevent unwanted behaviors...Staff report that the preferred activities of client include: watching television, listening to music, dining out and shopping. Therefore all of these should be provided as positive reinforcement for appropriate behavior...[Client #1] should be given choices regarding the order he needs to complete tasks or the types of tasks he needs to complete during a given period of time, to give him increased control over his environment. When possible, give client time to let him know what activities he is expected to engage in with advanced notice. When client is kept active and monitored he displays fewer inappropriate behaviors...Active treatment goals seeking to address opportunities for client to increase display incompatible behaviors and/or independence and/or daily living skills will be developed and implemented with him. Goals may include, increased use of eating utensils, increased verbal communication, and receiving positive reinforcement of buying items of choice when working on ISP goals."</p> <p>Client #2's record was reviewed on 9/23/15 at 2:58 P.M. Client #2's record indicated he had an ISP (Individual Support Plan) dated 7/22/15. Client #2's ISP indicated he had the following diagnoses: profound mental retardation,</p>			

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	<p>seizure disorder, autism, self-injurious behaviors, atypical psychosis, expressive communication needs, and ataxia. Client #2's ISP indicated "will bite self if he is frustrated or angry, verbally redirect. Not able to self report injury, if he appears to be injured assess his body. He does not present risk for skin integrity issues." Client #2 had a BSP (behavior support plan) dated 5/29/15. The BSP indicated the following targeted behaviors: "disturbing others sleep, stereotypical behaviors, self-injurious behaviors (biting), taking others belongings, inappropriate sexual behaviors." Client #2's BSP did not include scratching as a targeted behavior. Client #2's record did not include any documentation of client #2's scratches on his face and the calloused area on his arm.</p> <p>Staff training records were reviewed on 9/29/15 at 12:31 P.M. and included training on initial orientation to the facility, skin integrity, medical emergencies, utility emergencies, seizure protocol for client #1 and work place violence. There was no additional evidence that the staff had been trained on the clients' behavioral needs, client supervision at meal times and supervision of clients with self injurious behaviors or food stealing behaviors.</p>			

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W 0192 Bldg. 00	<p>The Home Manager (HM), the Qualified Intellectual Disabilities Professional (QIDP) and the Area Director (AD) were interviewed on 9/28/15 at 3:18 P.M. When asked how many staff normally work at the group home during awake hours. The AD stated "It's 2-3 usually, it depends. Part of our plan is to have management in there more." The HM and the QIDP both shook their heads "no" when asked if even 4 staff were enough to meet the clients' needs at meal times. The AD was asked when she had last observed a meal at the group home and indicated it had been awhile. The AD indicated all staff were trained initially at their time of hire and as needed.</p> <p>9-3-3(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' health needs. Based on observation, record review and interview, the facility failed to train staff competently on the health needs of 1 of 4 sampled clients (client #1).</p>	W 0192	A cellulitis protocol been developed for Client #1 to address his history of cellulitis and how staff should assist him with skin care. The protocol also	11/18/2015

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	<p>Findings include:</p> <p>During observations at day services on 9/22/15 from 11:25 AM until 12:15 PM, client #1 sat in a wheelchair without foot pedals. His feet were bare, and he had scratches on his forehead and along the length of his left shoulder blade and along the back of his neck. Client #1's ear was bruised on the front and back of the ear and he had a bruise across his knee cap on his right knee. Client #1's left knee had a scab 1/2 inch in diameter.</p> <p>Confidential interview #1 indicated there had been concerns about client #1's injuries and they were of unknown origin.</p> <p>Client #1's record was reviewed on 9/22/15 at 2:25 PM. An annual physical examination on 11/4/14 indicated client #1 had foot contractures and used a wheelchair. An Indiana Mentor Medical Appointment Form dated 8/20/15 indicated client #1 was seen for foot care. Recommendations indicated "Trim nails and keep them short. Watch for signs of infection where there are open areas. Call for increased redness, swelling, drainage or fever. Use foot pedals to avoid feet dragging on the ground...." The form indicated client #1 could return to day program and was prescribed an ointment</p>		<p>instructs staff about the signs and symptoms of cellulitis and what to look for on Client #1 person since he is at a high risk for the cellulitis to recur since he has had it previously.</p> <p>Client #1 Risk Management Plan has been updated to address the history of cellulitis and the increased risk of sores and bruising due to the cellulitis history.</p> <p>Program Nurse will receive retraining to include ensuring that all consumers that have identified risks such as cellulitis have appropriate protocols developed so staff are aware on how to monitor and prevent risks. Ongoing the Program Nurse will review and update as needed, a minimum of quarterly, all consumer protocols to ensure the most accurate information is available to the staff. Program Nurse will also ensure that staff are trained as needed for any updates.</p> <p>Responsible Party: Program Nurse, QIDP</p>		

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	<p>to be used twice daily for "irritant dermatitis." An Annual Healthcare Assessment dated 3/1/15 indicated client #1 was to use skid (gripper) socks and no shoes. The assessment did not address client #1's history of cellulitis or of his needs for skin care. A Risk Assessment and Plan dated 8/24/15 indicated client #1 was at risk for pressure sores/skin ulcers and client #1 "walked on his toes and the skin is very fragile in this area. After his shower, make sure his feet are dry before putting on socks. Monitor for skin breakdown and report to the nurse if any is suspected. He should wear socks when not sleeping." The Risk Plan indicated client #1 was not at risk for bruises or rashes. There was no evidence in the record of a health care protocol in client #1's Individual Support Plan) to address the recommendations made by client #1's physician to use foot pedals to avoid dragging his feet. Nursing assessments dated 4/1/15 and 7/15/15 indicated client #1's skin was dry and intact. There was no evidence in the record of documentation of client #1's injuries, bruises or of monitoring their healing status by group home staff or the nurse.</p> <p>The Program Director (PD) and Area Director (AD) were interviewed on 9/22/15 at 4:15 PM. When asked about</p>			

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	<p>client #1's injuries, the PD indicated she was unaware of the injuries or their status of documentation. During the interview, the PD called the house manager who indicated to the PD client #1 had been taken to the doctor on 8/20/15 in regards to skin issues. The house manger indicated the current scratches, bruising and marks on client #1's body were a result of dermatitis. She indicated client #1 was to keep his nails trimmed short and staff were to watch for signs of infection such as increased redness, swelling and drainage. The PD indicated there was not a system in place to document healing of minor injuries, bruises or scratches. The AD stated, "We don't do body checks (unless there is a specific need) because of dignity", but indicated staff observe for injuries when they assist clients during showering. The AD indicated client #1 should be using foot pedals as recommended by the doctor and should be using socks to protect his feet. When asked how injuries to clients are documented, the AD indicated they are reported to BDDS (Bureau of Developmental Disabilities Services) if the incident meets the criteria or are to be documented on internal accident/injury reports. She indicated she would look for additional reports. No additional documentation of client #1's injuries were provided.</p>			

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	<p>An email dated 9/22/15 with attached pictures and documentation of client #1's injuries from the director of client #1's day services was reviewed on 9/23/15 at 8:00 AM. The pictures attached to an e-mail dated 5/7/15 indicated a linear bruise across client #1's hip and scratches across his torso. A hand written document dated 8/18/15 indicated client #1 had 2 scabs and a rug burn on his left shoulder, left elbow 2 scabs, back of neck, 2 scratch marks, 1 scratch to the groin, 1 scratch to the left ear, back "sporadic bruising" and "red blotches," spine "4 rug burn (sic)," right knee "whole knee is scabbed...," left knee 3 scabs, right elbow, "red, 5 scrapes," left bicep "1 bruise," left thigh, "scratches, 1 scab," right neck, "rash or yeast infection," chest/stomach "sporadic scratches", right buttock "open sores, bed sores," left foot "dry skin, 1 scab on top, side and bottom," right foot, "1 scab on top needs medical attention, dry skin, scratch," right calf inside "several scratches...." A phone call note attached to the e-mail indicated the PD's name and the date 8/19/15 at 3:05 PM.</p> <p>The Director indicated on 9/23/15 at 10:52 AM, the PD had been made aware of the injuries to client #1 detailed in the documentation on 8/18/15 and of the</p>			

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	<p>pictures in the e-mail on 5/7/15.</p> <p>The facility's reportable incidents to BDDS and investigations were reviewed on 9/23/15 at 11:50 AM and included the following:</p> <p>A BDDS report dated 2/1/15 indicated client #1 had been taken to the ER (emergency room) for evaluation and treatment of his swollen left foot. Client #1 was diagnosed with cellulitis and admitted for antibiotic treatment. A follow up report dated 2/19/15 indicated client #1 remained in the hospital for treatment. A follow up report dated 4/6/15 indicated client #1 had completed antibiotics for cellulitis on 4/6/15 and the group home nurse and staff would monitor his condition.</p> <p>A report dated 5/30/15 indicated client #1 had been taken to the ER to evaluate a purplish rash on both arms and a bump on one eye. Evaluation did not determine the cause of the rash, but the doctor "hypothesized he could have been having a reaction to something, but he couldn't be certain. " Client #1 was released to go home, and advised to use the medication already prescribed for his skin. Client #1 was to visit his primary care physician if he was not improved in a week. The house manager advised on 8/31/15 client</p>				

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	<p>#1 had improved. Corrective action indicated client #1 would be monitored for his health and safety.</p> <p>A BDDS report dated 6/5/15 indicated client #1 was taken to the ER at the recommendation of the nurse to be evaluated for a red area with a small sore on his lower left leg. Client #1 was diagnosed with cellulitis and given a prescription for antibiotic treatment and released. Corrective action indicated the group home staff would monitor client #1 for health and safety, and the group home nurse would monitor client #1's leg for any changes.</p> <p>The group home nurse and AD were interviewed on 9/23/15 at 2:50 PM. She indicated client #1 should have used foot pedals as recommended by his physician and client #1 should be wearing socks. She indicated client #1's medication administration record included measures to wash client #1's feet twice daily and to monitor for skins of redness, swelling or discharge, but there was not a system to document or monitor scratches or bruises other than the reporting system. The group home nurse indicated she should have been notified of client #1's injuries. The AD indicated she was unaware of bruises or injuries to client #1 and should have been made aware of them. The</p>			

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	<p>nurse indicated the failure to follow recommendations to use foot pedals and keep client #1's feet covered placed him at risk for developing cellulitis. The AD indicated the failure to document and report injuries placed client #1 at risk for abuse, neglect and mistreatment.</p> <p>An Indiana Mentor Meeting Note dated 6/9/15 was reviewed on 9/29/15 at 12:58 PM and indicated, "Cellulitis is a bacterial infection. It is not contagious. Can be from scratches, etc...[Client #1] will always be a target for cellulitis. His PCP (primary care physician) says he will always be susceptible for cellulitis...look for small scratches, cuts, cracks, etc. *Wash his feet 2 times a day and apply ointment, clean socks. Staff will be trained in the signs of cellulitis and what to do."</p> <p>The Area Director (AD) and group home nurse were interviewed on 9/23/15 at 2:50 PM and indicated staff had been trained on cellulitis and what to do to help prevent reoccurrence of cellulitis</p> <p>There was no evidence of staff training on signs and symptoms of cellulitis for staff working in the group home provided.</p> <p>9-3-3(a)</p>			

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W 0214 Bldg. 00	<p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>Based on observation, record review and interview, the facility failed to complete comprehensive functional assessments including physical therapy, occupational therapy, body positioning, and wheelchair/adaptive equipment usage for 1 of 4 sampled clients (client #1) and 1 of 4 additional clients (client #5).</p> <p>Findings include:</p> <p>Observations were conducted on 9/21/15 between 4:38 P.M. and 6:12 P.M. Client #5 was in a custom wheelchair with lap tray. He had on a soiled chest harness. A soiled wrist/hand brace on his right arm. His feet dangled from the wheelchair. There were no foot pedals on his chair. At the meal at 5:29 P.M. Client #5 ate his meal from a high sided divided plate placed on top of the tray table of his wheelchair. He was slumped over in his wheelchair with his head bent down</p>	W 0214	<p>A wheelchair protocol has been developed for Client #1. Protocol includes ensuring that foot pedals are on the wheelchair to prevent Client #1 from slipping down in his seat. Protocol also includes need to ensure that Client #1 seat cushion is present. Protocol also clarifies how staff are to assist Client #1 with positioning in his wheelchair</p> <p>A wheelchair protocol has been developed for Client #5. Protocol includes how staff are to assist Client #5 with positioning in his wheelchair and cleaning the wheelchair daily.</p> <p>A protocol has also been developed to instruct staff about how to assist Client #5 in caring for his contracture in his right hand. Protocol includes assisting Client #5 with opening his hand and assisting him with cleaning</p>	11/18/2015

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	<p>toward his plate. He utilized a straw when drinking.</p> <p>During observations at the group home on 9/22/15 from 5:05 PM until 5:45 PM, client #1 sat slumped in his wheelchair without a seat cushion or foot pedals/rests. Client #5 sat slumped with his head to one side in his wheelchair with a lap tray.</p> <p>During observations on 9/22/15 between 5:20 P.M. and 6:05 P.M. Client #5 was in his wheelchair, no chest harness, no wrist/hand brace, no foot pedals on the chair. He did not utilize a straw. He was slumped over to the right with his head bent down and nearly touching his bowl of food.</p> <p>DSP #6 was interviewed on 9/22/15 at 5:10 PM and stated client #1 "never" uses foot pedals/rests.</p> <p>A confidential interview indicated client #5 had always eaten from his wheelchair lap tray, even though he could stand to pivot during transfer.</p> <p>During observations on 9/25/15 from 7:10 AM until 8:20 AM, client #1 sat in a wheelchair without foot pedals or a seat cushion. Client #1 slipped down in his wheelchair until his buttocks was on the</p>		<p>the inside of his hand daily to prevent any odor.</p> <p>All Direct Care staff have received retraining all of these protocols.</p> <p>Program Nurse will receive retraining to include ensuring that all consumers that have identified medical needs such as wheelchair care, proper wheelchair positioning, etc. have appropriate protocols developed so staff are aware on how to monitor and prevent risks. Ongoing the Program Nurse will review and update as needed, a minimum of quarterly, all consumer protocols to ensure the most accurate information is available to the staff. Program Nurse will also ensure that staff are trained as needed for any updates.</p> <p>Program Coordinator will contact the company that Client #1 wheelchair came from to obtain a copy of the wheelchair evaluation. If the evaluation cannot be located a new wheelchair evaluation will be scheduled.</p> <p>An PT/OT evaluation will be scheduled for Client #5 for an assessment to evaluate is mobility needs to determine if there are any additional supports recommended. Once an evaluation is completed, an IDT meeting will be held to review</p>		

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	<p>edge of the seat unobserved by staff until he nearly slipped out of his seat. As the surveyor stepped toward client #1 to prevent his fall and notify staff of his position, DSP #4 came into the room to bring food to the table, saw client #1's position and repositioned him just as he began to slide out of his seat to the floor.</p> <p>DSP #4 was interviewed on 9/22/15 at 8:45 AM and indicated client #1's foot pedals were in the garage and that he used his feet to propel himself in the wheelchair so he did not use foot pedals.</p> <p>Client #1's records were reviewed on 9/22/15 at 2:25 PM. An annual physical examination dated 11/4/14 indicated client #1 had flexion contractures and used a wheelchair. There was no evidence of a wheelchair evaluation in client #1's record.</p> <p>Client #5's record was reviewed on 9/28/15 at 12:36 P.M. Client #5's medical appointment form dated 3/25/2008 indicated he was "fitted for new braces -AFO (ankle/foot orthotic brace) and WHFO (wrist/hand orthotic brace)" and client #5 was to "wear them 8 hours a day or when up." Client #5's Individual Support Plan (ISP) dated 10/15/14 indicated client #5 had not had an OT/PT (Occupational/Physical Therapy)</p>		<p>recommendations and make any necessary changes and/or modifications based on Client #5 needs.</p> <p>QIDP and Program Coordinator will receive retraining that includes the need to ensure that all consumers receive appropriate assessments to evaluate the need for any adaptive equipment and/or modifications as needed.</p> <p>The Area Director will review the next 3 ISPs submitted by this QIDP to ensure that all necessary assessments have been completed and/or scheduled to evaluate each client's abilities as needed.</p> <p>Ongoing, the QIDP will ensure that all consumers receive appropriate assessments to evaluate the need for any adaptive equipment and/or modifications as needed.</p> <p>Responsible Staff: Program Coordinator, QIDP, Area Director</p>				

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W 0227 Bldg. 00	<p>assessment in the past year.</p> <p>The group home nurse was interviewed on 9/23/15 at 2:50 PM. She indicated client #1 had a wheelchair evaluation and had a specialized wheelchair ordered. She indicated client #1 positioned himself in his wheelchair and should be using a wheelchair with foot pedals. She indicated client #1 had recently started using a wheelchair due to the contractures in his feet. No additional evidence of a wheelchair evaluation for client #1's needs in positioning/mobility was provided.</p> <p>The QIDP and AD were interviewed on 9/28/15 at 3:18 P.M. and both indicated client #5 had not had an OT, PT or positioning evaluation in years. They indicated they did not know of any type of positioning schedule, or when he should wear his braces or chest harness.</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the</p>			

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	<p>client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, record review and interview, the facility failed to address the identified needs for 3 of 4 sampled clients (clients #1, #2 and #3) and for 2 of 4 additional clients (clients #5 and #7) in their Individual Support Plans (ISP).</p> <p>Findings include:</p> <p>Observations were conducted on 9/21/15 between 4:38 P.M. and 6:12 P.M. Client #5 was in a custom wheelchair with lap tray. He had on a soiled chest harness. A soiled wrist/hand brace on his right arm. His feet dangled from the wheelchair. There were no foot pedals on his chair. At the meal at 5:29 P.M. Client #5 ate his meal from a high sided divided plate placed on top of the tray table of his wheelchair. He was slumped over in his wheelchair with his head bent down toward his plate. He utilized a straw when drinking. Client #2's bedroom had a white circular area above his bed where the green paint was missing.</p> <p>An interview was conducted with the Home Manager (HM) on 9/21/15 at 5:49 P.M. The HM indicated the worn off green paint area above client #2's bed was from client #2 rubbing his head against</p>	W 0227	<p>A wheelchair protocol has been developed for Client #5. Protocol includes how staff are to assist Client #5 with positioning in his wheelchair and cleaning the wheelchair daily.</p> <p>A protocol has also been developed to instruct staff about how to assist Client #5 in caring for his contracture in his right hand. Protocol includes assisting Client #5 with opening his hand and assisting him with cleaning the inside of his hand daily to prevent any odor.</p> <p>All Direct Care staff have received retraining all of these protocols.</p> <p>Program Nurse will receive retraining to include ensuring that all consumers that have identified medical needs such as wheelchair care, proper wheelchair positioning, etc. have appropriate protocols developed so staff are aware on how to monitor and prevent risks. Ongoing the Program Nurse will review and update as needed, a minimum of quarterly, all consumer protocols to ensure the most accurate information is available to the staff. Program</p>	11/18/2015	

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	<p>the wall which caused the paint to rub off and get into client 2's hair.</p> <p>During observations on 9/22/15 between 5:20 P.M. and 6:05 P.M. Client #5 was in his wheelchair, no chest harness, no wrist/hand brace, no foot pedals on the chair. He did not utilize a straw when drinking. He was slumped over to the right with his head bent down nearly touching his bowl of food.</p> <p>During observations at the group home on 9/22/15 from 5:05 PM until 5:45 PM, client #1 sat slumped in his wheelchair without a seat cushion or foot pedals/rests. Client #5 sat slumped with his head to one side in his wheelchair with a lap tray. Client #1 ate his lasagna in bites 2 inches in diameter.</p> <p>Observations at the day program where clients #2 and #7 attend were conducted on 9/23/15 from 10:45 A.M. through 12:35 P.M. including observations of the program area, lunch area and gym. Clients #2 and #7 were seated together at lunch time at a separate table from their peers. One day program staff remained seated with them throughout their meal. Clients #2 and #7 had their lunches cut up. They were the last ones served in the room. The day program staff gave them each one bite of their lunch at a time. The</p>		<p>Nurse will also ensure that staff are trained as needed for any updates.</p> <p>QIDP, Program Coordinator, Behavior Specialist have held meetings with Client #2 Day Program to address behavioral concerns. Client #2 Behavior Support Plan has been updated to reflect any changes recommended by the IDT.</p> <p>Day Program staff have received copies of Client #2 updated Behavior Support Plan and have been trained on the updates.</p> <p>The QIDP will receive retraining to review the need to ensure that once consumers ISP, RMAP and/or BSPs are created or updated that they are forwarded to consumers' individual Day Service programs as needed.</p> <p>Ongoing, when completed or received, the QIDP will forward copies of updated ISP, RMAP and BSP to consumers appropriate service providers. The Area Director will communicate with other day service providers a minimum of quarterly to review if updated copies of any paperwork have not been received. The staff schedule has been revised to allow for 3 staff to be present at mealtimes to assist consumers. Direct care staff will receive retraining to include</p>				

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	<p>staff encouraged them to finish chewing what was in their mouths before they received another bite. Once both clients #2 and #7 had completed their meal, they left the room with the staff and went to the gym to participate in other activities.</p> <p>A confidential interview stated, "I have not been told of any specific BSPs. These are the plans we have for them. I have been trained on these plans. Monday we had a meeting with the Group Home Manager (HM) and the QIDP (qualified intellectual disabilities professional). They told us how they (clients #2 and #7) are at home and how to work with them. They were running from room to room at day program and person to person taking their food from them. Last Friday (9/18/15) [client #2] dug into his brief and had feces on his hand. Before we could catch him he ran into another classroom where they had just made brownies and grabbed brownies out of the pan with his soiled hand. We had him go home that day and asked for a meeting before he could return to day program. We had the meeting on Monday (9/21/15). We developed the dining plan ourselves yesterday, we had to do something. It is not a formal plan. So far it has worked well, but they (clients #2 and #7) are basically one-on-one at day program. The group home brought in a</p>		<p>ensuring that medications are passed prior to mealtime so all staff present are available to assist during the meal. Direct care staff will receive retraining on ensuring that at least one staff is present in the dining room at all times to ensure consumers are following mealtime etiquette and are redirected as needed when behaviors occur.</p> <p>The Program Coordinator and/or QIDP will complete mealtime observations at least three times weekly for 4 weeks to ensure that consumers are being supervised during the meal, staff are redirecting consumers as needed when behaviors occur and ensuring that staff are passing medications prior to the meal to allow for all staff to assist with mealtimes.</p> <p>Ongoing after the 4 weeks the Program Coordinator and/or QIDP will complete mealtime observations at least twice weekly to ensure that consumers are being supervised during the meal, staff are redirecting consumers as needed when behaviors occur and ensuring that staff are passing medications prior to the meal to allow for all staff to assist with mealtimes</p> <p>Dining goals have been developed for each consumer for them to work on at mealtimes based on their abilities. All direct</p>		

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	<p>lot of snacks. We give them a snack every two hours or so, or when they seem to be hungry. Although they said [client #7] shouldn't gain any weight, but that [client #2] needs to have double portions at mealtimes."</p> <p>During observations on 9/25/15 from 7:10 AM until 8:20 AM, there were two staff in the home, DSPs #4 and #8. Clients #1, #2, #3, #4, #5, #6, #7 and #8 sat in the dining room unattended while DSPs #4 and #8 made breakfast in an adjacent kitchen upon arrival at the group home. Client #7 ate his pancake with his hands, then took client #3's oatmeal and poured it into a his bowl and ate it. DSP #4 was present to observe client #7 taking client #3's oatmeal and then left the clients in the dining room to prepare more oatmeal for clients #1 and #3. Client #7 took client #2's remaining pancake and client #2 took client #1's pancake and ate it unobserved by staff who were not present. Client #6 hit the table again and client #7 took client #3's nutritional substitute and poured it into his glass. Client #1 tried to eat from client #3's oatmeal bowl, then took a bite of food laying on the table top. Client #6 gave client #3 his tea and client #1 drank the tea after client #3 drank some of it. Client #2 had 6 scratches 1/2 inches or less on the left side of his face, 1 scratch</p>		<p>care staff will receive retraining on ensuring that all consumers dining goals and objectives are being run as directed.</p> <p>For 4 weeks the HM and/or QIDP will complete mealtime administration observations a minimum of three times weekly to ensure that direct care staff are running dining goals as directed.</p> <p>Ongoing after the 4 weeks the HM and/or QIDP will complete mealtime administration observations a minimum of three times weekly to ensure that direct care staff are running dining goals as directed.</p> <p>Responsible Party: QIDP, Program Nurse, Program Coordinator</p>		

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	<p>at the left top of his forehead and 1/2 inch scratch at the top of his forehead/scalp area. Client #2's nails were soiled and he had a calloused area 6 inches in length across his left forearm. Client #2 had a green substance on the back of his head and top of his head in a balding area of his scalp. Client #4 had a 1 inch long by 1/4 inch bruise under his right eye. While DSP #4 prepared individual portions of microwave instant oatmeal and pancakes, client #2 made loud verbalizations and dug into his brief then wiped his hands on the table. Client #2 periodically yelled as DSP #4 prepared the food and slapped his head without redirection from staff who were not present to observe his behavior. Client #2 yelled out and stood up prior to being served breakfast, and DSP #4 stated, "I'm hurrying buddy." Client #2 ate his pancake in two bites then took client #6's pancake without staff present to observe. Client #7 ate his pancake with his hands, then took client #3's oatmeal and poured it into a his bowl and ate it. Client #1's oatmeal in a bowl fell to the floor, but staff did not see the bowl fall. DSP #4 asked what happened to client #1's oatmeal and was told by the surveyor his bowl had fallen to the floor. DSP #4 was present to observe client #7 taking client #3's oatmeal and then left the clients in the dining room to prepare more oatmeal for clients #1 and #3.</p>			

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	<p>Client #6 pounded the table 5 times during the meal when staff were not present. Client #7 took client #3's nutritional substitute and poured it into his glass. Client #1 did not receive a nutritional substitute and tried to eat from client #3's oatmeal bowl, then took a bite of food laying on the table top. Client #6 gave client #3 his tea and client #1 drank the tea after client #3 drank some of it. Clients #1, #2, #3, #4 #5, #6, #7 and #8 were unshaven.</p> <p>Client #1's records were reviewed on 9/22/15 at 2:25 PM. An Individual Support Plan dated 3/19/15 failed to address in a goals or programs client #1's needs in dining, to address his needs for staff supervision, bite size, taking other's food or of his needs for utensils and tableware.</p> <p>Client #2's record was reviewed on 9/23/15 at 2:58 P.M. Client #2's ISP dated 7/22/15 failed to address in a goal or program his needs for staff supervision, or his needs for utensils and tableware. His Behavior Support Plan (BSP) dated 5/2015 failed to address his identified needs of stealing other peoples' food, rubbing his head against his bedroom wall, scratching himself to point of injury, and hitting himself on his head.</p>			

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	<p>Client #3's record was reviewed on 9/22/15 at 2:28 P.M. Client #3's ISP dated 5/14/15 failed to address the need for staff supervision during dining to assist him in protecting his food from being taken by others and his needs for utensils and tableware.</p> <p>Client #5's record was reviewed on 9/28/15 at 12:35 P.M. Client #5's ISP dated 10/15/14 failed to address his need for staff supervision during meal times to prevent others from trying to take his food or of his needs for utensils and tableware. The ISP failed to address his need for proper body positioning during dining, when he was to utilize his braces and how his chest harness and braces were to be cleaned and maintained in a sanitary and dignified condition.</p> <p>Client #7's record was reviewed on 9/29/15 at 3:47 P.M. Client #7's ISP dated 10/22/14 failed to address his needs for staff supervision, or of his needs for utensils and tableware. His ISP failed to address his identified needs of stealing other peoples' food.</p> <p>The Area Director (AD) and group home nurse were interviewed on 9/23/15 at 2:50 PM. The AD indicated it was the nurse's responsibility to develop dining plans. The group home nurse indicated</p>			

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W 0240 Bldg. 00	<p>there were no plans for the clients in the home to address their dining needs except for what type of diet each client was to receive. The RN indicated she knew of no positioning schedule for client #5 or how his braces were to be cleaned and maintained.</p> <p>The QIDP and AD were interviewed on 9/28/15 at 3:18 P.M. and both indicated the clients' identified needs should be addressed in their plans. The QIDP indicated she was aware of the behaviors of stealing food some of the clients had.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #1), and one additional client (client #5), to identify specific instructions in the clients' ISP (Individual Support Plan) to address their needs for positioning in their wheelchairs and of assisting client #5 in his needs to address contractures.</p> <p>Findings include:</p>	W 0240	<p>A wheelchair protocol has been developed for Client #1. Protocol includes ensuring that foot pedals are on the wheelchair to prevent Client #1 from slipping down in his seat. Protocol also includes need to ensure that Client #1 seat cushion is present. Protocol also clarifies how staff are to assist Client #1 with positioning in his wheelchair</p> <p>A wheelchair protocol has been developed for Client #5. Protocol</p>	11/18/2015			

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	<p>During observations at the group home on 9/22/15 from 5:05 PM until 5:45 PM, client #1 sat slumped in his wheelchair without a seat cushion or foot pedals/rests. Client #5 sat slumped with his head to one side in his wheelchair with a lap tray.</p> <p>DSP #6 was interviewed on 9/22/15 at 5:10 PM and stated client #1 "never" uses foot pedals/rests.</p> <p>During observations on 9/25/15 from 7:10 AM until 8:20 AM, client #1 sat in a wheelchair without foot pedals. Client #1 slipped down in his wheelchair until his buttocks were on the edge of the seat unobserved by staff until he nearly slipped out of his seat. As the surveyor stepped toward client #1 to prevent his fall and notify staff of his position, DSP #4 came into the room to bring food to the table, saw client #1's position and repositioned him just as he began to slide out of his seat to the floor. Client #5 sat in his wheelchair and ate his breakfast using his wheelchair lap top for a table.</p> <p>During observations on 9/24/15 from 4:33 P.M. until 6:19 P.M. Client #5 was observed sitting in his wheelchair with his lap tray. Client #5 did not have his chest harness, leg braces, foot pedals or wrist/hand AFO on. Client #5's right</p>		<p>includes how staff are to assist Client #5 with positioning in his wheelchair and cleaning the wheelchair daily.</p> <p>A protocol has been developed for Client #5 to specify how staff are to assist him with care of his ankle and wrist braces. Protocol includes ensuring that the braces are cleaned daily.</p> <p>A protocol has also been developed to instruct staff about how to assist Client #5 in caring for his contracture in his right hand. Protocol includes assisting Client #5 with opening his hand and assisting him with cleaning the inside of his hand daily to prevent any odor.</p> <p>All Direct Care staff have received retraining all of these protocols.</p> <p>Program Nurse will receive retraining to include ensuring that all consumers that have identified medical needs such as wheelchair care, proper wheelchair positioning, etc. have appropriate protocols developed so staff are aware on how to monitor and prevent risks. Ongoing the Program Nurse will review and update as needed, a minimum of quarterly, all consumer protocols to ensure the most accurate information is</p>		

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	<p>hand was tightly contracted. At 4:55 P.M. client #5 stated "I need someone to help me open it (hand) up for me. They do it sometimes." There was a noticeable odor coming from client #5's contracted hand. Client #5 indicated his hand felt better when it was opened up.</p> <p>A confidential interview stated "His hand smells really bad sometimes. It takes a lot of cleaning to get the odor to leave. I don't know if some people are not washing his hand for him or not."</p> <p>DSP #4 was interviewed on 9/25/15 at 8:45 AM and indicated client #1's foot pedals were in the garage and that he used his feet to propel himself in the wheelchair so he did not use foot pedals.</p> <p>Client #1's records were reviewed on 9/22/15 at 2:25 PM. An annual physical examination dated 11/4/14 indicated client #1 had flexion contractures and used a wheelchair. Client #1's Individual Support Plan dated 3/19/15 indicated client #1 used a wheelchair "prn (as needed)." There was no evidence of specific instruction in regards to wheelchair positioning and use of foot pedals.</p> <p>Client #5's record was reviewed on 9/28/15 at 12:36 P.M. Client #5's medical</p>		<p>available to the staff. Program Nurse will also ensure that staff are trained as needed for any updates.</p> <p>Responsible party: QIDP, Program Nurse</p>	

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	<p>appointment form dated 3/25/2008 indicated he was "fitted for new braces -AFO (ankle/foot orthotic brace) and WHFO (wrist/hand orthotic brace)" and client #5 was to "wear them 8 hours a day or when up." Client #5's Individual Support Plan (ISP) dated 10/15/14 indicated client #5 had not had an OT/PT (Occupational/Physical Therapy) assessment in the past year.</p> <p>The group home nurse was interviewed on 9/23/15 at 2:50 PM. She indicated client #1 positioned himself in his wheelchair and should be using a wheelchair with food pedals. She indicated client #1 had recently started using a wheelchair due to the contractures in his feet. No additional evidence of staff instructions in client #1's ISP for how to assist client #1 for his needs in mobility and wheelchair use was provided.</p> <p>The Area Director (AD) was interviewed on 10/9/15 at 9:39 AM and indicated there was no evidence of instructions for staff to address client #1's needs for using his wheelchair.</p> <p>The AD, Home Manager (HM) and the Qualified Intellectual Disabilities Professional (QIDP) were interviewed on 9/28/15 at 3:18 P.M. The HM indicated</p>			

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W 0248 Bldg. 00	<p>she was aware of the odor from client #5's hand. The AD, HM and QIDP indicated they did not have a protocol in place to address client #5's wearing his braces, cleaning his braces, or how to assist him with care of the contracted right hand (cleaning, tension release, extension exercises, etc.).</p> <p>9-3-4(a)</p> <p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on observation, record review and interview, the facility failed to assure the day program had all relevant plans for 1 of 4 sampled clients (client #2) and 1 of 4 additional clients (client #7).</p> <p>Findings include:</p>	W 0248	<p>The QIDP will forward copies of all consumers ISP, RMAP and BSP to all appropriate service providers.</p> <p>The QIDP will receive retraining to review the need to ensure that once consumers ISP, RMAP and/or BSPs are created or updated that they are forwarded</p>	11/18/2015

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	<p>Observations at the day program where clients #2 and #7 attend were conducted on 9/23/15 from 10:45 A.M. through 12:35 P.M. including observations of the program area, lunch area and gym. Clients #2 and #7 were seated together at lunch time at a separate table from their peers. One day program staff remained seated with them throughout their meal. Clients #2 and #7 had their lunches cut up. They were the last ones served in the room. The day program staff gave them each one bite of their lunch at a time. Staff encouraged them to finish chewing what was in their mouths before they received another bite. Once both clients #2 and #7 had completed their meal, they left the room with the staff and went to the gym to participate in other activities.</p> <p>At 12:20 P.M. on 9/23/15 Client records maintained at the day program were reviewed. For client #2 there was an Individual Support Plan (ISP) dated 2013, a high risk plan dated 10/22/14, no behavior support plan and no dining plan to review. For client #7 there was an ISP dated 2013, no behavior support plan and a high risk plan dated 7/22/13.</p> <p>A confidential interview stated, "I have not been told of any specific BSPs. These are the plans we have for them. I have been trained on these plans. Monday we</p>		<p>to consumers' individual Day Service programs as needed.</p> <p>Ongoing, when completed or received, the QIDP will forward copies of updated ISP, RMAP and BSP to consumers appropriate service providers. The Area Director will communicate with other day service providers a minimum of quarterly to review if updated copies of any paperwork have not been received.</p> <p>Responsible staff: QIDP, Area Director</p>				

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	<p>had a meeting with the Group Home Manager (HM) and the QIDP (qualified intellectual disabilities professional). They told us how they (clients #2 and #7) are at home and how to work with them. They were running from room to room and person to person taking their food from them. Last Friday (9/18/15) [client #2] dug into his brief and had feces on his hand. Before we could catch him he ran into another classroom where they had just made brownies and grabbed brownies out of the pan with his soiled hand. We had him go home that day and asked for a meeting before he could return to day program. We had the meeting on Monday (9/21/15). We developed the dining plan ourselves yesterday, we had to do something. So far it has worked well, but they are basically one-on-one here at day program. The group home brought in a lot of snacks. We give them a snack every two hours or so, or when they seem to be hungry. Although they said [client #7] shouldn't gain any weight, but that [client #2] needs to have double portions at mealtimes."</p> <p>An interview was conducted with the QIDP on 9/28/15 at 3:18 P.M. The QIDP stated, "We meet with the staff on Monday. They are to try to give them a snack." The QIDP indicated the day</p>			

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W 0249 Bldg. 00	<p>program should have copies of the clients' ISPs and BSPs.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview, the facility failed to ensure 4 of 4 sampled clients (clients #1, #2, #3 and #4) received a continuous active treatment program based on their individual needed services and interventions, and the facility failed to assure 3 of 3 sampled clients observed receiving their medications were encouraged to work on their self administration of medication objectives. (clients #3, #4 and #1).</p> <p>Findings include:</p> <p>1. Observations were conducted on</p>	W 0249	<p>1. Dining goals have been developed for each consumer for them to work on at mealtimes based on their abilities. All direct care staff will receive retraining on ensuring that all consumers dining goals and objectives are being run as directed.</p> <p>For 4 weeks the HM and/or QIDP will complete mealtime administration observations a minimum of three times weekly to ensure that direct care staff are running dining goals as directed.</p> <p>Ongoing after the 4 weeks the HM and/or QIDP will complete mealtime administration</p>	11/18/2015	

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	<p>9/21/15 between 4:55 P.M. and 6:58 P.M. including the evening meal at 5:29 P.M. The evening meal provided was spaghetti with meat sauce, whole kernel corn, tossed salad, choice of two salad dressings and iced tea or milk. There were four staff working in the home, the Home Manager (HM), Direct Care Staff (DCS) #1, #2 and #3. Client #1 was not offered salad or a substitution, not provided with more than one glass of beverage, or offered second helpings. Client #2 was not offered more than one beverage or second helpings, Client #3 was not offered corn, salad or a substitution for them, more than one beverage or second helpings, Client #4 was not offered salad or a substitution and not offered more than one beverage. Other than the mealtime activities the clients did not work on goals.</p> <p>During observations at the group home on 9/22/15 from 5:05 PM until 5:45 PM, clients #1, #2, #3, #4, #5, #6, #7, and #8 were in the dining room. Direct Support Staff (DSP) #1 and DSP #6 were the only staff in the home during the observation. Client #1 sat slumped in his wheelchair without a seat cushion or foot pedals/rests. Client #5 sat slumped with his head to one side in his wheelchair with a lap tray. Clients #1, #2, #3, #4, #5, #6, #7, and #8 were in the dining room.</p>		<p>observations a minimum of three times weekly to ensure that direct care staff are running dining goals as directed.</p> <p>All direct care staff will receive retraining on mealtime protocols including ensuring that all consumers are receiving a sufficient amount of food as designated by the menu and the consumers diet orders. Training will include ensuring that extra portions are offered as designated by individual consumers diet orders. In addition, training will include ensuring that if an item on the menu is not conducive to preparing for consumers that have modified diet orders that appropriate substitutions are provided. All direct care staff will receive retraining to include ensuring that consumers are offered nutritional supplements as directed by the consumers PCP and/or dietician.</p> <p>The Program Coordinator and/or QIDP will complete mealtime observations at least three times weekly for 4 weeks to ensure that consumers are being offered sufficient amounts of food, are offered appropriate substitutions, staff are following diet orders and consumers are being offered their nutritional supplements as directed.</p> <p>Ongoing after the 4 weeks the</p>		

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	<p>DSP #6 prepared lasagna, creamed corn and green beans and poured them into the same bowl causing the food to run together. Client #8's food had chunks of pasta in the bowl. Client #1 ate his lasagna in bites 2 inches in diameter without redirection.</p> <p>During observations on 9/22/15 between 5:20 P.M. and 6:05 P.M. including the evening meal. The clients were eating their evening meal from a bowl. The meal consisted of creamed corn, green beans, lasagna, lemonade and milk. The gallon of milk sat on the table, but was never opened or served to any of the clients. There were two staff working DCS #1 and #6. Client #2 completed his meal and went outside. DCS #1 followed client #2. There were no staff in the dining room with the remaining clients. Client #1 grabbed client #2's bowl and started to eat from it. Client #7 grabbed the lemonade pitcher and began to drink from the spout of the pitcher. Client #7 then grabbed some food from another client's bowl across the table and ate it. Client #7 stood up and went to client #5 and attempted to take client #5's bowl. Client #5 hit client #7 in the abdomen. Client #5 stated "He tried to take my bowl." DCS #1 was informed of what had occurred when he returned to the dining room. DCS #1 removed the</p>		<p>Program Coordinator and/or QIDP will complete mealtime observations at least twice weekly to ensure that consumers are being offered sufficient amounts of food, are offered appropriate substitutions, staff are following diet orders and consumers are being offered their nutritional supplements as directed.</p> <p>Dining plans have been created or updated for all consumers. All direct care still will receive retraining on every consumer's specific dining plan including each consumers specified diet orders. Retraining will include ensuring that staff are following all consumers diet orders including if consumers have modified diets such as mechanical soft and pureed.</p> <p>Staff will also receive retraining on how to prepare the specialized diets prescribed for each consumer. Previous Program Nurse is no longer working for Indiana Mentor. The new Program Nurse will receive retraining on ensuring that specified dining plans are developed for each consumer based on PCP and dietician recommendations. Training will include ensuring that dining plans are updated a minimum of annually at the ISP and more often as needed if any changes occur. Training will also include ensuring that all staff working in</p>				

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	<p>lemonade and the contaminated food bowls. Other food was not provided for those clients other than client #1 was given a pot pie upon the surveyor's question if he (client #1) was "allowed second servings?" Other than the mealtime activities the clients did not work on goals.</p> <p>Observations were conducted on 9/24/15 between 4:38 P.M. and 6:12 P.M. There were four staff working the HM, DCS #1, #2 and #4. The evening meal was served at 5:29 P.M. The clients were served tater tot casserole, spinach salad, 2 choices of salad dressing, cooked carrots, cantaloupe, tea, milk. The clients were offered at least three servings of casserole and carrots. The clients did not grab at each others plates or the serving bowls. Clients #2, #3, #4 and #8 each were given a can of chocolate ensure (nutritional supplement). Client #8's meal was pureed, client #1's, #3's and #4's foods were mashed to a soft consistency with a fork. Other than the mealtime activities the clients did not work on goals.</p> <p>During observations on 9/25/15 from 7:10 AM until 8:20 AM, there were two staff in the home, DSPs #4 and #8. Clients #1, #2, #3, #4, #5, #6, #7 and #8 sat in the dining room unattended while DSPs #4 and #8 made breakfast in an</p>		<p>the home are trained on all consumers specified dining plans.</p> <p>The Program Coordinator and/or QIDP will complete mealtime observations at least three times weekly for 4 weeks to ensure that staff are following all consumers prescribed diet orders and are preparing meals as directed by the specialized diets. Observations will also include ensuring that staff are following all aspects of consumers specified dining plans.</p> <p>Ongoing after the 4 weeks the Program Coordinator and/or QIDP will complete mealtime observations at least twice weekly to ensure that staff are following all consumers prescribed diet orders and are preparing meals as directed by the specialized diets. Observations will also include ensuring that staff are following all aspects of consumers specified dining plans.</p> <p>2. All direct care staff will receive retraining on ensuring that all consumers medication goals and objectives are being run as directed.</p> <p>For 4 weeks the HM and/or Program director will complete medication administration observations a minimum of three times weekly to ensure that direct care staff are running medication goals as directed.</p>				

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	<p>adjacent kitchen upon arrival at the group home. DSP #8 prepared instant oatmeal by tearing open 2 packages and added milk without measuring the amount. DSP #8 poured sugar coated cereal with marshmallow bits and milk into a bowl for client #4 without measuring the amount. DSP #8 then administered medications and DSP #4 finished preparing breakfast for clients #1, #2, #3, #4, #5, #6, #7 and #8 consisting of instant oatmeal, pancakes, milk and tea. DSP #4 brought individual portions of oatmeal and pancakes to the table after they were heated up one at a time. Client #2 yelled out and stood up prior to being served breakfast, and DSP #4 stated, "I'm hurrying buddy." Client #1's oatmeal in a bowl fell to the floor, but staff did not see the bowl fall and client #7 ate client #3's oatmeal. DSP #4 asked what happened to client #1's oatmeal and was told by the surveyor his bowl had fallen to the floor. DSP #4 left the clients in the dining room to prepare more oatmeal for clients #1 and #3. Client #8 ate a pancake ground into a grainy texture that was prepared and placed in front of him. Client #1 did not receive a liquid nutritional supplement during the breakfast meal.</p> <p>Client #1's records were reviewed on 9/22/15 at 2:25 PM. An Individual Support Plan (ISP) dated 3/15/15</p>		<p>Ongoing after the 4 weeks the HM and/or Program director will complete medication administration observations a minimum of twice weekly to ensure that direct care staff are running medication goals as directed.</p> <p>All direct care staff will receive retraining on infection control and universal precautions including encouraging clients to wash their hands and/or use hand sanitizer prior to medication administration. Training will also include ensuring that staff are washing their own hands or using hand sanitizer prior to assisting clients with their medications.</p> <p>Program Coordinator and/or QIDP will complete medication administration observations at least twice per week for four weeks to ensure that all staff are encouraging clients to wash their hands and/or use hand sanitizer prior to medication administration as well as ensuring staff are washing their own hands or using hand sanitizer prior to assisting clients with their medications.</p> <p>Ongoing, the Program Coordinator and/or QIDP will complete medication administration observations at least twice per week to ensure that all staff are encouraging clients to wash their hands and/or</p>				

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	<p>indicated objectives to make a punch one of his medications from a bubble pack, point to choice between two drinks, make a purchase and hand money to the cashier, brush his gums or swab gums, wash both arms, turn washing machine on, take dishes to the sink and use the restroom. Client #1's Behavior Support Plan (BSP) dated May, 2015 indicated target objectives of aggressive outbursts, inappropriate nudity, taking others' belongings without permission and disrupting others' sleep. Proactive interventions indicated in part, "Consistent communication is incredibly important to minimize problems and prevent unwanted behaviors...Staff report that the preferred activities of client include: watching television, listening to music, dining out and shopping. Therefore all of these should be provided as positive reinforcement for appropriate behavior...[Client #1] should be given choices regarding the order he needs to complete tasks or the types of tasks he needs to complete during a given period of time, to give him increased control over his environment. When possible, give client time to let him know what activities he is expected to engage in with advanced notice. When client is kept active and monitored he displays fewer inappropriate behaviors...Active treatment goals seeking to address</p>		<p>use hand sanitizer prior to medication administration as well as ensuring staff are washing their own hands or using hand sanitizer prior to assisting clients with their medications.</p> <p>Responsible Party: Program Coordinator, QIDP</p>				

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	<p>opportunities for client to increase display incompatible behaviors and/or independence and/or daily living skills will be developed and implemented with him. Goals may include, increased use of eating utensils, increased verbal communication, and receiving positive reinforcement of buying items of choice when working on ISP goals."</p> <p>Client #2's record was reviewed on 9/23/15 at 2:58 P.M. Client #2's Physician's Orders (PO) dated for 9/2015 indicated client #2 was to have Boost (nutritional supplement) 1 can 4 times a day. Regular high fiber diet, 2 cups of [name] cereal daily at breakfast. Client #2's Nutritional Assessment dated 6/10/2015 indicated "CBW (current body weight) 124 pounds BMI (body mass index) 17.8 below by 3.8%... though considered underweight for height (70 inches)...recommend to offer extra portions at meal times. Goal to increase weight by 2 pounds next quarter." Client #2's Individual Support Plan (ISP) dated 7/22/15 indicated client #2's "desired body weight was 160-178 pounds." Client #2's ISP goals indicated "punch out medication, participate in leisure activity, at evening meal offered choice of two drinks will indicate his choice, choose a quarter, brush his teeth, wash his body, take clean laundry out of dryer,</p>				

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	<p>use the restroom every two hours."</p> <p>Client #3's record was reviewed on 9/22/15 at 2:28 P.M. Client #3's Physician's Orders dated for 9/2015 indicated client #3 was to have a "soft high calorie diet, with 8 ounces of Ensure (nutritional supplement) four times a day to increase albumin, may have at meals." Client #3's nutritional assessment dated 6/10/15 indicated "73 pounds, BMI 14.7 (underweight) 12% loss between Feb. (February) 2015 - May 2015 spoke with staff, reports, client went to nursing home during this period and did not eat well in the unfamiliar environment. Client returned mid (middle) of May ... Spoke with staff, and recommend to add ice cream to ensure for added carb/fats...." Client #3's ISP dated 5/14/15 indicated client #3's desired weight was 106-130 pounds. Client #3's 9/2015 MAR did not indicate current weight. Weight for July, 2015 as indicated on the nutritional assessment was 80 pounds. Client #3's ISP indicated the following goals "punch out medication, gesture to drink of choice from two offered, choose a quarter from a dime and a quarter, swab his gums, wash his upper body, take laundry from washer put into dryer, press button on food processor, use restroom and use napkin."</p> <p>Client #4's record was reviewed on</p>			

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	<p>9/28/15 at 2:15 P.M. Client #4's ISP dated 3/19/15 indicated he was to have a "regular soft diet, mechanical, Boost twice daily. Client #4's MAR for 9/2015 did not indicate current weight. His ISP indicated his weight was "138 pounds and he was 65.5 inches tall. His ideal body weight range was 126-167." Client #4's ISP indicated the following goals "punch out one of his medications, choose between two drinks offered, participate in a recreational activity, choose the quarter from a group of coins, brush his teeth and gums, wash both of his arms, turn on the washing machine and use the restroom."</p> <p>The Area Director (AD) was interviewed on 10/9/15 at 9:39 AM and indicated the clients' ISP goals and interventions should be implemented.</p> <p>2. Observation of the 7:00 A.M. medication pass was conducted on 9/22/15.</p> <p>At 6:50 A.M. Client #3 was moved into the medication area of the kitchen and a room divider was placed around the area to offer privacy during the medication pass. Client #3 did not cleanse his hands prior to the medication pass. Client #3 was administered 1 tablet of Levothyroxine (thyroid supplement)</p>			
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	<p>50mg (milligrams). The tablet was administered in a spoon full of pudding by direct care staff (DCS) #4.</p> <p>At 6:55 A.M. Client #4 was assisted in walking to the medication area in the kitchen. Client #4 did not cleanse his hands prior to the medication pass. Client #4 was administered 1 Thera-M tablet (vitamin supplement). Client #4 held the medication cup up to his mouth placing the pill into his mouth and then drank a glass of water. Client #4 received 4 squirts of Acetic Acid (ear drops) 2% in his right ear by DCS #4. Client #4 had Econazole Nitrate (lotion) applied bilaterally to his feet. by DCS #4. Client #4 and DCS #4 then went to the restroom where client #4 had Chlorhexidine Rinse (oral rinse) .05% applied to his mouth with a soft brush by DCS #4.</p> <p>At 7:11 A.M. Client #1 was moved into the medication area of the kitchen. Client #1 did not wash his hands prior to the medication pass. Client #1 was administered 1 tablet Thera-M, Folic Acid (supplement) 1mg, Ferrous Sulfate Sulfate (iron) 324mg, 2 capsules of Phenytoin Sodium (seizures) 100mg, and 2 tablets Levetiracetam (seizures) 500mg. Client #1's medications were crushed (Phenytoin capsules opened) and placed into a medication cup of pudding. Client</p>			

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	<p>#1 fed himself his medications with hand over hand assistance from DCS #4.</p> <p>During observations at the group home on 9/25/15 at 7:10 AM until 8:20 AM, client #1 received medications at 7:30 AM, but did not punch out his medications from a pill pack.</p> <p>Client #3's Individual Support Plan (ISP) dated 5/14/15 was reviewed on 9/22/15 at 2:28 P.M. and indicated he had the following self medication objective: "Punch-out one of his medications from bubble pack at each medication pass."</p> <p>Client #4's ISP dated 3/19/15 was reviewed on 9/28/15 at 2:15 P.M. and indicated he had the following self medication objective: "Daily at each medication pass, with hand over hand assist will punch one of his medications from the bubble pack, into the medication cup."</p> <p>Client #1's ISP dated 3/15/15 was reviewed on 9/22/15 at 2:25 P.M. and indicated he had the following self medication objective: "Punch-out one of his medications from bubble pack at each medication pass."</p> <p>Interviews were conducted with the Home Manager (HM), Qualified</p>			

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	<p>Intellectual Disabilities Professional (QIDP) and the Area Director (AD) on 9/28/15 at 3:18 P.M. When asked when the clients were to work on their self administration of medication goals the AD and QIDP stated "During Meds. (medication pass)."</p> <p>The Area Director (AD) was interviewed on 10/9/15 at 9:39 AM and indicated client #1's, #3's and #4's ISP objectives in self administration should be implemented.</p> <p>9-3-4(a)</p>						
W 0263 Bldg. 00	<p>483.440(f)(3)(ii) PROGRAM MONITORING & 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. Based on record review and interview, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) who are prescribed psychotropic medications to</p>	W 0263	The QIDP will receive retraining on ensuring that consumers' guardians or Health Care Representatives are notified of any additions or changes to	11/18/2015			

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	<p>assist them with behavior control and/or symptoms of their diagnoses, to ensure the Human Rights Committee approved the restrictive plans only after the written informed consent of their guardians had been obtained.</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 9/22/15 at 2:25 PM. Client #1's Behavior Support Plan (BSP) dated May, 2015 indicated target objectives of aggressive outbursts, inappropriate nudity, taking others' belongings without permission and disrupting others' sleep. The plan included the use of Zyprexa (mood stabilizer) 10 mg (milligrams) and physical interventions/restraint. Client #1's guardian signed consent for the plan on 7/28/15 and the facility's human rights committee (HRC) signed approval on 6/10/15.</p> <p>Client #2's records were reviewed on 9/23/15 at 2:58 P. M. Client #2's BSP dated May, 2015 indicated target objectives of stereotypical behaviors, self-injurious behaviors, taking others' belongings, inappropriate sexual behavior and disturbing others' sleep. The plan included the use of Klonopin (anti-anxiety) 2mg twice a day for Autism, Olanzapine (anti-psychotic)</p>		<p>consumers' psychotropic medications and any additions or changes to consumers Behavior Support plans. The QIDP will also receive retraining on ensuring that consumer guardians and/or Health Care Representatives review and approve any changes or updates to psychotropic medications and/or Behavior Support plans prior to their implementation.</p> <p>For the next 3 months, the QIDP will provide documentation to the Area Director that consumers' guardians or Health Care Representatives have received notification of any changes to psychotropic medications and Behavior Support Plans and have approved any changes. After the 3 month period, the Area Director will review the documentation that guardians or Health Care Representatives are receiving updated copies of consumers BSPs a minimum of quarterly to ensure that these requirements continue to be met.</p> <p>Responsible Party: QIDP, Area Director</p>				

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	<p>10mg every morning and 20mg every evening for anxiety. Client #2's Physician's Orders (PO) dated for 9/2015 indicated he was also prescribed Paxil (anti-depressant) 40mg at HS (bedtime). Paxil was not included in his plan. Client #2's guardian signed consent for the plan on 9/3/15 and the facility's human rights committee (HRC) signed approval on 6/10/15.</p> <p>Client #3's records were reviewed on 9/22/15 at 2:28 P. M. Client #3's BSP dated May, 2015 indicated target objectives of self-injurious behaviors, inappropriate sexual behavior and incontinence. The plan included the use of Thioridazine (psychosis) 50mg twice a day for behavior control and Benztropine (side effects) 0.5mg every morning Client #3's guardian signed consent for the plan on 7/28/15 and the facility's human rights committee (HRC) signed approval on 6/10/15.</p> <p>Client #4's records were reviewed on 9/28/15 at 2:15 P. M. Client #4's Behavior Support Plan (BSP) dated May, 2015 indicated target objectives of physical aggression, property destruction, inappropriate urination/defecation and hiding items. The plan included the use of Nortriptyline (anti-depressant) 20mg at HS (bedtime), and Abilify</p>			

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W 0268 Bldg. 00	<p>(anti-depressant) 15mg at HS and physical intervention. Client #4's guardian signed consent for the plan on 7/28/15 and the facility's HRC signed approval on 6/10/15.</p> <p>The Area Director (AD) was interviewed on 10/9/15 at 9:39 AM and indicated the facility's HRC should not approve plans prior to guardian consent.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based upon observation and interview, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and for 4 of 4 additional clients (clients #5, #6, #7 and #8) to promote dignity by failing to ensure they were well groomed and dressed appropriately. The facility failed to promote dignity for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) by failing to encourage and teach socially appropriate dining skills and to redirect socially inappropriate dining behaviors.</p> <p>Findings included:</p>	W 0268	<p>1. All direct care staff will receive retraining on client dignity including ensuring that all consumers are wearing weather appropriate clothing and clothing that fits appropriately. Training will also include ensuring that all consumers are shaved a minimum of every other day, if not daily and nails are trimmed a minimum of weekly or more often as needed.</p> <p>Program Coordinator and/or QIDP will complete observations a minimum of three times weekly for 4 weeks to ensure that all consumers are wearing weather appropriate clothing, clothing that fits appropriately, are shaved and</p>	11/18/2015			

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	<p>1. During observations on 9/21/15 from 4:55 P.M. until 6:58 P.M. Clients #1, #4, #5, #6 and #8 had long unkempt hair which hung down past their ears and/or eyebrows. Clients #1, #4, #6 and #8 were taken for haircuts after the evening meal. At 6:18 P.M. client #5 was observed to have a darkened wet area on his gray sweat pants, indicating he had been incontinent. Client #5 was not assisted into changing into dry clothing during the observation.</p> <p>During observations on 9/22/15 from 5:48 P.M. through 6:24 P.M. client #4 walked throughout the home with his jeans unzipped and open. At 5:38 P.M. client #8 stood up from the dining table and his brown sweat pants hung down exposing the entire back of his undergarments.</p> <p>During observations on 9/22/15 from 5:15 PM until 5:45 PM, client #5 wore jeans that dragged on the floor and exposed his undergarments when he raised his arms.</p> <p>During observations on 9/24/15 from 4:38 P.M. until 6:12 P.M., client #5's hair was long. There was a red substance on his face, around his mouth and on his wrist/hand brace. Client #5 was in need of a shave.</p>		<p>nails are trimmed. Ongoing, after the 4 weeks the Program Coordinator and/or QIDP will complete observations a minimum of twice weekly to ensure that all consumers are wearing weather appropriate clothing, clothing that fits appropriately all consumers are shaved and nails are trimmed.</p> <p>2. Clothing protectors have been obtained for consumers that have a tendency to have excess food spillage at mealtimes to protect their clothing.</p> <p>Staff will receive retraining on mealtime preparation including following the menu and not mixing multiple foods together on consumers plates.</p> <p>Staff also will receive retraining about redirecting consumers from eating food off the table and stealing other consumers food.</p> <p>The staff schedule has been revised to allow for 3 staff to be present at mealtimes to assist consumers. Direct care staff will receive retraining to include ensuring that medications are passed prior to mealtime so all staff present are available to assist during the meal. Direct care staff will receive retraining on ensuring that at least one staff is present in the dining room at all times to ensure consumers are</p>				

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	<p>During observations on 9/25/15 from 7:10 AM until 8:20 AM, client #2's nails were soiled and he had green substance on the back of his head and top of his head in a balding area of his scalp. Clients #1, #2, #3, #4, #5, #6, #7 and #8 were unshaven.</p> <p>During observations on 9/28/15 from 5:50 P.M. until 6:28 P.M. client #2 had a green substance on the back of his head.</p> <p>The Area Director was interviewed on 10/2/15 at 1:17 PM and indicated clients should be well groomed and their clothing should be in good condition.</p> <p>2. Observations were conducted on 9/21/15 between 4:55 P.M. and 6:58 P.M. including the evening meal at 5:29 P.M. There were four staff working, the Home Manager (HM), Direct Care Staff (DCS) #1, #2 and #3. DCS #1 and DCS #2 set the table. The staff prepared the meal (spaghetti with meat sauce, corn, salad, two salad dressings, tea and milk) and put the items on the table. The clients were offered choice of tea or milk. The clients were assisted in serving themselves hand-over-hand. Client #5 was served spaghetti with meat sauce, and whole kernel corn. His plate was placed on top of his tray table. Client #5</p>		<p>following mealtime etiquette and are redirected as needed when behaviors occur.</p> <p>The Program Coordinator and/or QIDP will complete mealtime observations at least three times weekly for 4 weeks to ensure that consumers are being supervised during the meal, staff are redirecting consumers as needed when behaviors occur and ensuring that staff are passing medications prior to the meal to allow for all staff to assist with mealtimes.</p> <p>Ongoing after the 4 weeks the Program Coordinator and/or QIDP will complete mealtime observations at least twice weekly to ensure that consumers are being supervised during the meal, staff are redirecting consumers as needed when behaviors occur and ensuring that staff are passing medications prior to the meal to allow for all staff to assist with mealtimes</p> <p>Responsible Party: QIDP, Program Coordinator</p>				

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	<p>ate with his left hand due to the contractures of his right hand. Client #5 ate his meal with considerable spillage of food onto his clothing and tray table. Towards the end of the meal Direct Care Staff (DCS) #3 scraped all of client #3's food together on his plate mixing it all together for him to eat the remaining foods. After the meal clients #2 and #7 took their plate to the kitchen sink.</p> <p>During observations at the group home on 9/22/15 from 5:05 PM until 5:45 PM, client #1 sat slumped in his wheelchair without a seat cushion or foot pedals/rests. Client #5 sat slumped with his head to one side in his wheelchair with a lap tray. Clients #1, #2, #3, #4, #5, #6, #7, and #8 were in the dining room. Direct Support Staff (DSP) #1 and DSP #6 were the only staff in the home during the observation. DSP #6 prepared lasagna, creamed corn and green beans which were poured into the same bowl causing the food to run together.</p> <p>During observations on 9/22/15 between 5:20 P.M. and 6:05 P.M. including the evening meal. The clients were eating their evening meal from a bowl. The meal consisted of creamed corn, green beans, lasagna, lemonade and milk. The gallon of milk sat on the table, but was never opened or served to any of the</p>				

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	<p>clients. There were two staff working, DCS #2 and #6. Client #2 completed his meal and went outside. DCS #2 followed client #2. There were no staff in the dining room with the remaining clients. Client #1 grabbed client #2's bowl and started to eat from it. Client #7 grabbed the lemonade pitcher and began to drink from the spout of the pitcher. Client #7 then grabbed some food from another client's bowl across the table and ate it. Client #7 stood up and went to client #5 and attempted to take client #5's bowl. Client #5 hit client #7 in the abdomen. Client #5 stated "He tried to take my bowl." DCS #2 was informed of what had occurred when he returned to the dining room. DCS #2 removed the lemonade and the contaminated food bowls. Other food was not provided for those clients other than client #1 was given a pot pie upon the surveyor's question if he (client #1) was "allowed second servings?"</p> <p>DSP #6 was interviewed on 9/22/15 at 5:40 PM. When asked if the clients liked to have their food mixed together into a bowl, she stated, "They're eating it."</p> <p>Client #5 was interviewed on 9/22/15 at 5:50 P.M. When asked if he would like to have his food not mixed together he stated, "I reckon."</p>			

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	<p>During observations on 9/25/15 from 7:10 AM until 8:20 AM, there were two staff in the home, DSPs #4 and #8. Clients #1, #2, #3, #4, #5, #6 #7 and #8 sat in the dining room unattended while DSPs #4 and #8 made breakfast in an adjacent kitchen upon arrival at the group home. Client #7 ate his pancake with his hands, then took client #3's oatmeal and poured it into a his bowl and ate it. DSP #4 was present to observe client #7 taking client #3's oatmeal and then left the clients in the dining room to prepare more oatmeal for clients #1 and #3. Client #7 took client #2's remaining pancake and client #2 took client #1's pancake and ate it unobserved by staff who were not present. Client #6 hit the table again and client #7 took client #3's nutritional substitute and poured it into his glass. Client #1 tried to eat from client #3's oatmeal bowl, then took a bite of food laying on the table top. Client #6 gave client #3 his tea and client #1 drank the tea after client #3 drank some of it.</p> <p>The Area Director and the group home nurse were interviewed on 9/23/15 at 2:50 PM. When asked about the clients' food being mixed up together, the nurse stated, "It's not supposed to be like that."</p> <p>The Area Director (AD) was interviewed</p>			
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W 0285 Bldg. 00	<p>on 10/9/15 at 9:39 AM and when asked if staff should have promoted dignity by redirecting clients from eating food off of the table top and stealing others' food, she stated, "Yes."</p> <p>9-3-5(a)</p> <p>483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. Based on observation, record review and interview, the facility failed for 2 of 4 sampled clients (clients #1 and #2) to manage their self-injurious behaviors (SIB) and to adequately protect them from repeated injuries.</p> <p>Findings include:</p> <p>During observations at the group home on 9/21/15 from 4:55 P.M. until 6:58 P.M., Client #2 had visible light red scratch marks on both sides of his face. At 5:59 P.M. Client #2 sat in the corner of the fenced-in backyard and bit at his left lower arm. There was a pink calloused area on this part of client #2's arm.</p> <p>Direct Care Staff (DCS) #3 was</p>	W 0285	<p>Client #2 Behavior Support Plan has been updated in include scratching himself as a specific targeted behavior.</p> <p>QIDP will receive retraining to include ensuring that all identified targeted behaviors observed for each consumer are specified in their Behavior Support Plan and interventions included for how staff are to monitor/prevent.</p> <p>Body Check assessments have been implemented for all consumers, including client #1. Staff are to complete a body assessment form daily when assisting consumers with showers to note any bruises, scratches or other injuries. Staff are to document notes on the size, shape, etc. of each mark noted on the body to determine if any changes are occurring. Staff</p>	11/18/2015	

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	<p>interviewed on 9/21/15 at 5:52 P.M. DCS #3 stated "He does it to himself."</p> <p>During observations at day services on 9/22/15 from 11:25 AM until 12:15 PM, client #1 sat in a wheelchair without foot pedals. His feet were bare, and he had scratches on his forehead and along the length of his left shoulder blade and along the back of his neck. Client #1's ear was bruised on the front and back of the ear and he had a bruise across his knee cap on his right knee. Client #1's left knee had a scab 1/2 inch in diameter.</p> <p>Confidential interview #1 indicated there had been concerns about client #1's injuries and they were of unknown origin.</p> <p>DSP #6 was interviewed on 9/22/15 at 5:05 PM and stated "sometimes he scratches his arms," when asked about client #2's sore. She indicated the injury was documented on an injury form, but was unable to find the documentation.</p> <p>During observations at the group home on 9/22/15 from 6:18 A.M. until 8:02 A.M., Client #2 had scratch marks on both sides of his face. The scratches were dark red in color and there were more scratches, especially on the left side of his face.</p>		<p>are to notify the Program Coordinator, QIDP and/or Program Nurse if any new marks are observed or any changes to current bruises, scratches, etc. are observed to determine if further assessment needs to be made. Program Coordinator, QIDP and Area Director will review the body assessment forms to ensure that all new injuries or changes to injuries are being reported to determine if further evaluation is needed.</p> <p>Body checks are to be completed for each consumer daily at the time of undressing/shower. Daily body checks are to be completed for a minimum of 6 weeks in an attempt to prevent injuries of unknown origin from not being reported.</p> <p>After the initial 6 weeks, the QIDP, Program Coordinator, Area Director, Program Nurse and Quality Assurance Specialist will meet to review findings and determine the frequency that Body Assessments need to continue.</p> <p>Responsible party: Program Coordinator, QIDP, Area Director, Program Nurse</p>		

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	<p>During observations at the group home on 9/22/15 from 5:20 P.M. until 6:48 P.M., Client #2's scratches on the sides of his face were deeper and dark red.</p> <p>During observations at day services on 9/23/15 from 10:45 A.M. until 12:35 P. M., client #2's scratches on the sides of his face appeared to have dried blood in some of the scratch marks due to the dark red/black color that was visible.</p> <p>A confidential interview stated "[client #2] has a few behaviors we are concerned about. His scratching at his face and biting at his arm usually occurs around meal time or whenever there is food around."</p> <p>Client #1's records were reviewed on 9/22/15 at 2:25 PM. Client #1's Behavior Support Plan (BSP) dated May, 2015 indicated target objectives of aggressive outbursts, inappropriate nudity, taking others' belongings without permission and disrupting others' sleep. Proactive interventions indicated in part, "Consistent communication is incredibly important to minimize problems and prevent unwanted behaviors...Staff report that the preferred activities of client include: watching television, listening to music, dining out and shopping. Therefore all of these should be provided</p>			

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	<p>as positive reinforcement for appropriate behavior...[Client #1] should be given choices regarding the order he needs to complete tasks or the types of tasks he needs to complete during a given period of time, to give him increased control over his environment. When possible, give client time to let him know what activities he is expected to engage in with advanced notice. When client is kept active and monitored he displays fewer inappropriate behaviors...Active treatment goals seeking to address opportunities for client to increase display incompatible behaviors and/or independence and/or daily living skills will be developed and implemented with him. Goals may include, increased use of eating utensils, increased verbal communication, and receiving positive reinforcement of buying items of choice when working on ISP goals."</p> <p>Client #2's record was reviewed on 9/23/15 at 2:58 P.M. Client #2's record indicated he had an ISP (Individual Support Plan) dated 7/22/15. Client #2's ISP indicated he had the following diagnoses: profound mental retardation, seizure disorder, autism, self-injurious behaviors, atypical psychosis, expressive communication needs, and ataxia. Client #2's ISP indicated "will bite self if he is frustrated or angry, verbally redirect. Not</p>			

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	<p>able to self report injury, if he appears to be injured assess his body. He does not present risk for skin integrity issues." Client #2 had a BSP (behavior support plan) dated 5/29/15. The BSP indicated the following targeted behaviors: "disturbing others sleep, stereotypical behaviors, self-injurious behaviors (biting), taking others belongings, inappropriate sexual behaviors." Client #2's BSP did not include scratching as a targeted behavior. Client #2's record did not include any documentation of client #2's scratches on his face and the calloused area on his arm.</p> <p>The Program Director (PD) and Area Director (AD) were interviewed on 9/22/15 at 4:15 PM. When asked about client #1's injuries, the PD indicated she was unaware of the injuries or their status of documentation. During the interview, the PD called the house manager who indicated to the PD client #1 had been taken to the doctor on 8/20/15 in regards to skin issues. The house manager indicated the current scratches, bruising and marks on client #1's body were a result of dermatitis. She indicated client #1 was to keep his nails trimmed short and staff were to watch for signs of infection such as increased redness, swelling and drainage. The PD indicated there was not a system in place to</p>			

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	<p>document healing of minor injuries, bruises or scratches. The AD stated, "We don't do body checks (unless there is a specific need) because of dignity", but indicated staff observe for injuries when they assist clients during showering. The AD indicated client #1 should be using foot pedals as recommended by the doctor and should be using socks to protect his feet. When asked how injuries to clients are documented, the AD indicated they are reported to BDDS (Bureau of Developmental Disabilities Services) if the incident meets the criteria or are to be documented on internal accident/injury reports. She indicated she would look for additional reports. No additional documentation of client #1's injuries were provided.</p> <p>The group home RN and the Area Director (AD) were interviewed on 9/23/15 at 2:50 P.M. The RN indicated the group home staff were to be checking all of the clients' skin daily and report any unusual findings to her. The group home nurse indicated she should have been notified of client #2's scratches from his self injurious behaviors. The AD indicated she was unaware of client #2's scratches and should have been made aware of them. The AD indicated the specific self-injurious behaviors client #2 had should be addressed in his BSP and</p>			

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W 0287 Bldg. 00	<p>there should be safe guards in place to prevent clients #1 and #2 from injuring themselves.</p> <p>9-3-5(a)</p> <p>483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used for the convenience of staff.</p> <p>Based on observation, record review and interview, the facility implemented restrictive measures of denying clients accessibility to their clothing and closets for 2 of 4 sampled clients (clients #1 and</p>	W 0287	<p>The broken dressers have been removed from Client #1 and #4 closets. The debris has also been removed from the closets and clothing has been put back into the closets.</p> <p>The bed in Client #7 and #8 room</p>	11/18/2015

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	<p>#4) and 2 of 4 additional clients (clients #7 and #8) in absence of programming techniques.</p> <p>Findings include:</p> <p>Observations of the group home where clients #1, #4, #7 and #8 lived were conducted on 9/22/15 between 5:20 P.M. and 6:05 P.M. including each of the client's bedrooms.</p> <p>In the bedroom of clients #1 and #4 there were two closets. Each of the closets had a chest of drawers which had been placed inside the closets. There were no drawers and some of the drawer ledges were missing. Client #1's closet had a pair of sandals, two plastic hangers, broken window blinds and an unlabeled tube of Santyl (prescription wound care ointment) a bottle (2/3 full) of Sodium Chloride (saline) 0.9%, an unwound piece of gauze wrap, a pair of blunt edge scissors and debris. Client #4's closet had a pair of sandals, a stuffed teddy bear, a small plastic tote bag and debris. There was no clothing in either client #1's or client #4's closet.</p> <p>In the bedroom of clients #7 and #8 there was a walk-in closet. Client #8's bed was pushed up horizontally against the door of the closet. The door could only be</p>		<p>has been moved so it does not block the closet.</p> <p>Program Coordinator and QIDP will receive retraining to include ensuring that no restrictive measures, such as not allowing the consumers access to their clothing and closets, is implemented without restrictions being noted in consumers Behavior Support Plans.</p> <p>Program Coordinator and QIDP met with the Behavior Specialist assigned to the home and have been directed to track any adverse behavior regarding Client #4 clothing destruction on the behavior tracking so it can be added to the BSP as a targeted behavior if needed and interventions can be added to the Behavior Support Plan.</p> <p>For the next 3 months, the Area Director will review all of this QIDP Behavior Support Plans to ensure any restrictive measures that are being implemented in the home are noted in each client's Behavior Support Plan as needed.</p> <p>Responsible Party: QIDP, Program Coordinator, Area Director</p>				

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	<p>opened by either moving client #8's bed or reaching across client #8's bed. The door opened very hard. Inside the closet there were clothing and blankets piled 2 feet high covering the floor. The only bare space of the closet floor was the angle from where the door had pushed the items away as it was opened.</p> <p>Client #1's records were reviewed on 9/22/15 at 2:25 PM. Client #1's Behavior Support Plan (BSP) dated May, 2015 indicated target objectives of aggressive outbursts, inappropriate nudity, taking others' belongings without permission and disrupting others' sleep. Proactive interventions indicated in part, "Consistent communication is incredibly important to minimize problems and prevent unwanted behaviors...Staff report that the preferred activities of client include: watching television, listening to music, dining out and shopping. Therefore all of these should be provided as positive reinforcement for appropriate behavior...[Client #1] should be given choices regarding the order he needs to complete tasks or the types of tasks he needs to complete during a given period of time, to give him increased control over his environment. When possible, give client time to let him know what activities he is expected to engage in with advanced notice. When client is kept</p>				

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	<p>active and monitored he displays fewer inappropriate behaviors...Active treatment goals seeking to address opportunities for client to increase display incompatible behaviors and/or independence and/or daily living skills will be developed and implemented with him. Goals may include, increased use of eating utensils, increased verbal communication, and receiving positive reinforcement of buying items of choice when working on ISP (individual support plan) goals."</p> <p>Client #4's record was reviewed on 9/28/15 at 2:15 P.M. and indicated client #4 had an ISP dated 3/19/15 and a BSP dated 5/2015. Client #4's BSP indicated the following targeted behaviors, physical assault, property destruction, incontinence, hiding items and mood stability. Staff were to supervise client #4 at all times and provide necessary intervention and or prompting to engage in acceptable behaviors. Staff report that the preferred activities of client include: watching television, listening to music, dining out and shopping. Therefore all of these should be provided as positive reinforcement for appropriate behavior... [Client #4] should be given choices regarding tasks or the types of tasks he needs to complete during a given period of time, to give him increased control</p>			

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	<p>over his environment. When possible, give client time to let him know what activities he is expected to engage in with advanced notice. When client is kept active and monitored he displays fewer inappropriate behaviors...." Client #4's BSP did not include the restriction of having his clothing and personal items removed from his room and closet.</p> <p>An interview was conducted with Direct Care Staff (DCS) #2 on 9/21/15 at 6:47 P.M. DCS #2 indicated he did not know why the medication and other medical items were inside the closet. DCS #2 indicated clients #1 and #4 had inappropriate behaviors with their belongings and clothing and that was why their personal items and clothing were kept in another area of the home.</p> <p>An interview was conducted with the Home Manager (HM), Qualified Intellectual Disabilities Professional (QIDP) and Area Director (AD) on 9/28/15 at 3:18 P.M. The HM stated, "Their (clients #1 and #4) clothes are kept in another part of the house, so they won't ruin them. [Client #8's] bed is pushed up against the closet door "so other clients can not get to their (clients #7's and #8's) clothing." The QIDP stated "Yes, they should have access to their belongings. No, I don't believe having</p>			

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	<p>their (clients #1's and #4's) clothing removed from their bedroom is a part of their plan." The AD stated, "They should all have access to their own belongings and if restrictive measures are used then they need to be part of an approved plan."</p> <p>9-3-5(a)</p>				
W 0312 Bldg. 00	<p>483.450(e)(2) DRUG USAGE</p> <p>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 record review and interview, the facility failed for 1 of 4 sampled clients (client #2) who was prescribed psychotropic medications to assist him</p>	W 0312	<p>The QIDP will ensure that the use Client #3 Paxil for depression is added into Client #3 BSP.</p> <p>The QIDP will receive retraining</p>	11/18/2015	

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	<p>with behavior control and/or symptoms of his diagnoses to include the use of all prescribed psychotropic medications in his plan.</p> <p>Findings include:</p> <p>Client #2's records were reviewed on 9/23/15 at 2:58 P. M. Client #2's BSP dated May, 2015 indicated target objectives of stereotypical behaviors, self-injurious behaviors, taking others' belongings, inappropriate sexual behavior and disturbing others' sleep. The plan included the use of Klonopin (anti-anxiety) 2mg (milligrams) twice a day for Autism, Olanzapine (anti-psychotic) 10mg every morning and 20mg every evening for anxiety. Client #2's Physician's Orders (PO) dated for 9/2015 indicated he was also prescribed Paxil (anti-depressant) 40mg at HS. Paxil was not included in his plan.</p> <p>The Area Director (AD) was interviewed on 10/9/15 at 9:39 AM and indicated client #2's use of Paxil for depression should be included in his plan.</p> <p>9-3-5(a)</p>		<p>including the need to ensure that all medications to control behaviors and any restrictive practices are included in consumers BSP's and appropriate approvals by Guardian and HRC are obtained.</p> <p>For the next 3 months, the Area Director will review all of this QIDP Behavior Support Plans to ensure any medications to control behaviors and any restrictive measures are incorporated into them.</p> <p>Responsible Party: QIDP, Area Director</p>		

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W 0318 Bldg. 00	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based upon observation, record review and interview, the facility failed to meet the Condition of Participation: Health Care Services. The RN failed to have a system in place to document, monitor, and identify injuries of unknown origin and self injurious behaviors for 2 of 4 sampled clients (clients #1 and #2). The RN failed to develop and implement corrective action to protect client #1 from cellulitis (skin infection) after a history of cellulitis had been identified. The facility's health care services failed to provide a system of medication storage that was sanitary, secure, and locked except during times of medication pass, and the facility failed to assure all medications were labeled and disposed of when expired or discontinued.</p> <p>Findings include:</p> <p>1. The facility nurse failed to provide nursing services in accordance with the needs of 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) including but not limited to injuries, positioning and evaluations, diets, menus and dining plans. Please see W331.</p>			W 0318	<ol style="list-style-type: none"> 1. Please refer to W331 2. Please refer to W337 3. Please refer to W381 4. Please refer to W382 5. Please refer to W390 6. Please refer to W391 		11/18/2015

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	<p>2. The facility nurse failed to provide a storage system for medications which insured medications were maintained under proper conditions of sanitation for 2 of 4 sampled clients (clients #4 and #1). Please see W377.</p> <p>3. The facility nurse failed to assure all medications and medical supplies for 1 of 4 sampled clients (client #3) were secured. Please see W381.</p> <p>4. The facility nurse failed to assure all drugs and biologicals were locked except when being prepared for administration for 2 of 4 sampled clients (clients #1 and #4). Please see W382.</p> <p>5. The facility nurse failed to have a system to insure contaminated/outdated/expired medications were removed in a timely manner from the facility for 1 of 4 sampled clients (client #4). Please see W390.</p> <p>6. The facility nurse failed to assure all medications were labeled for 1 of 4 sampled clients (client #3). Please see W391.</p> <p>9-3-6(a)</p>			

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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 on observation, record review and interview, the facility nurse failed to provide nursing services in accordance with the needs of 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) including but not limited to injuries, positioning and evaluations, diets, menus and dining plans.</p> <p>Findings include:</p> <p>During observations at day services on 9/22/15 from 11:25 AM until 12:15 PM, client #1 sat in a wheelchair without foot pedals. His feet were bare, and he had scratches on his forehead and along the length of his left shoulder blade and</p>	W 0331	<p>1. A wheelchair protocol has been developed for Client #1 that includes recommendations from the physician for Client #1 to use foot pedals to prevent him from dragging his feet to reduce possibility of injuries to his feet.</p> <p>A cellulitis protocol has been developed for Client #1 to instruct staff about the signs and symptoms of cellulitis and what to look for on Client #1 person since he is at a high risk for the cellulitis to recur since he has had it previously.</p> <p>Program Nurse will receive retraining to include ensuring that all consumers that have identified medical needs such as wheelchair care, proper</p>	11/18/2015			

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	<p>along the back of his neck. Client #1's ear was bruised on the front and back of the ear and he had a bruise across his knee cap on his right knee. Client #1's left knee had a scab 1/2 inch in diameter.</p> <p>Confidential interview #1 indicated there had been concerns about client #1's injuries and they were of unknown origin.</p> <p>Client #1's record was reviewed on 9/22/15 at 2:25 PM. An annual physical examination on 11/4/14 indicated client #1 had foot contractures and used a wheelchair. An Indiana Mentor Medical Appointment Form dated 8/20/15 indicated client #1 was seen for foot care. Recommendations indicated "Trim nails and keep them short. Watch for signs of infection where there are open areas. Call for increased redness, swelling, drainage or fever. Use foot pedals to avoid feet dragging on the ground..." The form indicated client #1 could return to day program and was prescribed an ointment to be used twice daily for "irritant dermatitis." An Annual Healthcare Assessment dated 3/1/15 indicated client #1 was to use skid (gripper) socks and no shoes. The assessment did not address client #1's history of cellulitis or of his needs for skin care. A Risk Assessment and Plan dated 8/24/15 indicated client #1 was at risk for pressure sores/skin</p>		<p>wheelchair positioning, etc. have appropriate protocols developed so staff are aware on how to monitor and prevent risks. In addition, training will also include ensuring that protocols are developed for any medical conditions that might be recurring to instruct staff for what to look for in order to get treatment prescribed as soon as possible. Ongoing the Program Nurse will review and update as needed, a minimum of quarterly, all consumer protocols to ensure the most accurate information is available to the staff. Program Nurse will also ensure that staff are trained as needed for any updates</p> <p>Body Check assessments have been implemented for all consumers, including client #1. Staff are to complete a body assessment form daily when assisting consumers with showers to note any bruises, scratches or other injuries. Staff are to document notes on the size, shape, etc. of each mark noted on the body to determine if any changes are occurring. Staff are to notify the Program Coordinator, QIDP and/or Program Nurse if any new marks are observed or any changes to current bruises, scratches, etc. are observed to determine if further assessment needs to be made. Program Coordinator, QIDP and Area Director will</p>	

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	<p>ulcers and client #1 "walked on his toes and the skin is very fragile in this area. After his shower, make sure his feet are dry before putting on socks. Monitor for skin breakdown and report to the nurse if any is suspected. He should wear socks when not sleeping." The Risk Plan indicated client #1 was not at risk for bruises or rashes. There was no evidence in the record of a health care protocol in client #1's Individual Support Plan to address the recommendations made by client #1's physician to use foot pedals to avoid dragging his feet. Nursing assessments dated 4/1/15 and 7/15/15 indicated client #1's skin was dry and intact. There was no evidence in the record of documentation of client #1's injuries, bruises or of monitoring their healing status by group home staff or the nurse.</p> <p>The Program Director (PD) and Area Director (AD) were interviewed on 9/22/15 at 4:15 PM. When asked about client #1's injuries, the PD indicated she was unaware of the injuries or their status of documentation. During the interview, the PD called the house manager who indicated to the PD client #1 had been taken to the doctor on 8/20/15 in regards to skin issues. The house manager indicated the current scratches, bruising and marks on client #1's body were a</p>		<p>review the body assessment forms to ensure that all new injuries or changes to injuries are being reported to determine if further evaluation is needed.</p> <p>Body checks are to be completed for each consumer daily at the time of undressing/shower. Daily body checks are to be completed for a minimum of 6 weeks in an attempt to prevent injuries of unknown origin from not being reported.</p> <p>After the initial 6 weeks, the QIDP, Program Coordinator, Area Director, Program Nurse and Quality Assurance Specialist will meet to review findings and determine the frequency that Body Assessments need to continue.</p> <p>2. Program Coordinator will contact the company that Client #1 wheelchair came from to obtain a copy of the wheelchair evaluation. If the evaluation cannot be located a new wheelchair evaluation will be scheduled.</p> <p>An PT/OT evaluation will be scheduled for Client #5 for an assessment to evaluate is mobility needs to determine if there are any additional supports recommended. Once an evaluation is completed, an IDT</p>		

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	<p>result of dermatitis. She indicated client #1 was to keep his nails trimmed short and staff were to watch for signs of infection such as increased redness, swelling and drainage. The PD indicated there was not a system in place to document healing of minor injuries, bruises or scratches. The AD stated, "We don't do body checks (unless there is a specific need) because of dignity", but indicated staff observe for injuries when they assist clients during showering. The AD indicated client #1 should be using foot pedals as recommended by the doctor and should be using socks to protect his feet. When asked how injuries to clients are documented, the AD indicated they are reported to BDDS (Bureau of Developmental Disabilities Services) if the incident meets the criteria or are to be documented on internal accident/injury reports. She indicated she would look for additional reports. No additional documentation of client #1's injuries were provided.</p> <p>An email dated 9/22/15 with attached pictures and documentation of client #1's injuries from the director of client #1's day services was reviewed on 9/23/15 at 8:00 AM. The pictures attached to an e-mail dated 5/7/15 indicated a linear bruise across client #1's hip and scratches across his torso. A hand written</p>		<p>meeting will be held to review recommendations and make any necessary changes and/or modifications based on Client #5 needs.</p> <p>QIDP and Program Coordinator will receive retraining that includes the need to ensure that all consumers receive appropriate assessments to evaluate the need for any adaptive equipment and/or modifications as needed.</p> <p>The Area Director will review the next 3 ISPs submitted by this QIDP to ensure that all necessary assessments have been completed and/or scheduled to evaluate each client's abilities as needed.</p> <p>Ongoing, the QIDP will ensure that all consumers receive appropriate assessments to evaluate the need for any adaptive equipment and/or modifications as needed</p> <p>3. All direct care staff will receive retraining on mealtime protocols including ensuring that all consumers are receiving a sufficient amount of food as designated by the menu and the consumers diet orders. Training will include ensuring that extra portions are offered as designated by individual</p>				

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	<p>document dated 8/18/15 indicated client #1 had 2 scabs and a rug burn on his left shoulder, left elbow 2 scabs, back of neck, 2 scratch marks, 1 scratch to the groin, 1 scratch to the left ear, back "sporadic bruising" and "red blotches," spine "4 rug burn (sic)," right knee "whole knee is scabbed...", left knee 3 scabs, right elbow, "red, 5 scrapes," left bicep "1 bruise," left thigh, "scratches, 1 scab," right neck, "rash or yeast infection," chest/stomach "sporadic scratches", right buttock "open sores, bed sores," left foot "dry skin, 1 scab on top, side and bottom," right foot, "1 scab on top needs medical attention, dry skin, scratch," right calf inside "several scratches...." A phone call note attached to the e-mail indicated the PD's name and the date 8/19/15 at 3:05 PM.</p> <p>The Director indicated on 9/23/15 at 10:52 AM, the PD had been made aware of the injuries to client #1 detailed in the documentation on 8/18/15 and of the pictures in the e-mail on 5/7/15.</p> <p>The facility's reportable incidents to BDDS and investigations were reviewed on 9/23/15 at 11:50 AM and included the following:</p> <p>A BDDS report dated 2/1/15 indicated client #1 had been taken to the ER</p>		<p>consumers diet orders. In addition, training will include ensuring that if an item on the menu is not conducive to preparing for consumers that have modified diet orders that appropriate substitutions are provided. All direct care staff will receive retraining to include ensuring that consumers are offered nutritional supplements as directed by the consumers PCP and/or dietician.</p> <p>The Program Coordinator and/or QIDP will complete mealtime observations at least three times weekly for 4 weeks to ensure that consumers are being offered sufficient amounts of food, are offered appropriate substitutions, staff are following diet orders and consumers are being offered their nutritional supplements as directed.</p> <p>Ongoing after the 4 weeks the Program Coordinator and/or QIDP will complete mealtime observations at least twice weekly to ensure that consumers are being offered sufficient amounts of food, are offered appropriate substitutions, staff are following diet orders and consumers are being offered their nutritional supplements as directed.</p> <p>Dining plans have been created or updated for all consumers. All direct care still will receive</p>		

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	<p>(emergency room) for evaluation and treatment of his swollen left foot. Client #1 was diagnosed with cellulitis and admitted for antibiotic treatment. A follow up report dated 2/19/15 indicated client #1 remained in the hospital for treatment. A follow up report dated 4/6/15 indicated client #1 had completed antibiotics for cellulitis on 4/6/15 and the group home nurse and staff would monitor his condition.</p> <p>A report dated 5/30/15 indicated client #1 had been taken to the ER to evaluate a purplish rash on both arms and a bump on one eye. Evaluation did not determine the cause of the rash, but the doctor "hypothesized he could have been having a reaction to something, but he couldn't be certain. " Client #1 was released to go home, and advised to use the medication already prescribed for his skin. Client #1 was to visit his primary care physician if he was not improved in a week. The house manager advised on 8/31/15 client #1 had improved. Corrective action indicated client #1 would be monitored for his health and safety.</p> <p>A BDDS report dated 6/5/15 indicated client #1 was taken to the ER at the recommendation of the nurse to be evaluated for a red area with a small sore on his lower left leg. Client #1 was</p>		<p>retraining on every consumer's specific dining plan including each consumers specified diet orders. Retraining will include ensuring that staff are following all consumers diet orders including if consumers have modified diets such as mechanical soft and pureed.</p> <p>Staff will also receive retraining on how to prepare the specialized diets prescribed for each consumer. Previous Program Nurse is no longer working for Indiana Mentor. The new Program Nurse will receive retraining on ensuring that specified dining plans are developed for each consumer based on PCP and dietician recommendations. Training will include ensuring that dining plans are updated a minimum of annually at the ISP and more often as needed if any changes occur. Training will also include ensuring that all staff working in the home are trained on all consumers specified dining plans.</p> <p>The Program Coordinator and/or QIDP will complete mealtime observations at least three times weekly for 4 weeks to ensure that staff are following all consumers prescribed diet orders and are preparing meals as directed by the specialized diets. Observations will also include ensuring that staff are following all aspects of consumers</p>				

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	<p>diagnosed with cellulitis and given a prescription for antibiotic treatment and released. Corrective action indicated the group home staff would monitor client #1 for health and safety, and the group home nurse would monitor client #1's leg for any changes.</p> <p>The group home nurse and AD were interviewed on 9/23/15 at 2:50 PM. She indicated client #1 should have used foot pedals as recommended by his physician and client #1 should be wearing socks. She indicated client #1's medication administration record included measures to wash client #1's feet twice daily and to monitor for skins of redness, swelling or discharge, but there was not a system to document or monitor scratches or bruises other than the reporting system. The group home nurse indicated she should have been notified of client #1's injuries. The AD indicated she was unaware of bruises or injuries to client #1 and should have been made aware of them. The nurse indicated the failure to follow recommendations to use foot pedals and keep client #1's feet covered placed him at risk for developing cellulitis. The AD indicated the failure to document and report injuries placed client #1 at risk for abuse, neglect and mistreatment.</p> <p>An Indiana Mentor Meeting Note dated</p>		<p>specified dining plans.</p> <p>Ongoing after the 4 weeks the Program Coordinator and/or QIDP will complete mealtime observations at least twice weekly to ensure that staff are following all consumers prescribed diet orders and are preparing meals as directed by the specialized diets. Observations will also include ensuring that staff are following all aspects of consumers specified dining plans</p> <p>Program Nurse has clarified on the menu what constitutes a high calorie diet. Staff have been trained on clarifications. Program Nurse will receive retraining to include ensuring that all diet orders and menus are clarified for staff to implement.</p> <p>Responsible Party: QIDP, Program Coordinator, Program Nurse.</p>		

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	<p>6/9/15 was reviewed on 9/29/15 at 12:58 PM and indicated, "Cellulitis is a bacterial infection. It is not contagious. Can be from scratches, etc....[Client #1] will always be a target for cellulitis. His PCP (primary care physician) says he will always be susceptible for cellulitis...look for small scratches, cuts, cracks, etc. *Wash his feet 2 times a day and apply ointment, clean socks. Staff will be trained in the signs of cellulitis and what to do."</p> <p>2. Observations were conducted on 9/21/15 between 4:38 P.M. and 6:12 P.M. Client #5 was in a custom wheelchair with lap tray. He had on a soiled chest harness. A soiled wrist/hand brace on his right arm. His feet dangled from the wheelchair. There were no foot pedals on his chair. At the meal at 5:29 P.M. Client #5 ate his meal from a high sided divided plate placed on top of the tray table of his wheelchair. He was slumped over in his wheelchair with his head bent down toward his plate. He utilized a straw when drinking.</p> <p>A confidential interview indicated client #5 had always eaten from his wheelchair lap tray, even though he could stand to pivot during transfer.</p> <p>During observations at the group home</p>			

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	<p>on 9/22/15 from 5:05 PM until 5:45 PM, client #1 sat slumped in his wheelchair without a seat cushion or foot pedals/rests. Client #5 sat slumped with his head to one side in his wheelchair with a lap tray.</p> <p>During observations on 9/22/15 between 5:20 P.M. and 6:05 P.M. Client #5 was in his wheelchair, no chest harness, no wrist/hand brace, no foot pedals on the chair. He did not utilize a straw. He was slumped over to the right with his head bent down and nearly touching his bowl of food.</p> <p>During observations on 9/25/15 from 7:10 AM until 8:20 AM, client #1 sat in a wheelchair without foot pedals or a seat cushion. Client #1 slipped down in his wheelchair until his buttocks were on the edge of the seat unobserved by staff until he nearly slipped out of his seat. As the surveyor stepped toward client #1 to prevent his fall and notify staff of his position, DSP #4 came into the room to bring food to the table, saw client #1's position and repositioned him just as he began to slide out of his seat to the floor.</p> <p>DSP #4 was interviewed on 9/25/15 at 8:45 AM and indicated client #1's foot pedals were in the garage and that he used his feet to propel himself in the</p>				

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	<p>wheelchair so he did not use foot pedals.</p> <p>Client #1's records were reviewed on 9/22/15 at 2:25 PM. An annual physical examination dated 11/4/14 indicated client #1 had flexion contractures and used a wheelchair. There was no evidence of a wheelchair evaluation in client #1's record.</p> <p>Client #5's record was reviewed on 9/28/15 at 12:36 P.M. Client #5's medical appointment form dated 3/25/2008 indicated he was "fitted for new braces -AFO (ankle/foot orthotic brace) and WHFO (wrist/hand orthotic brace)" and Client #5 was to "wear them 8 hours a day or when up." Client #5's Individual Support Plan (ISP) dated 10/15/14 indicated client #5 had not had an OT/PT assessment (Occupational Therapy/Physical Therapy) in the past year.</p> <p>The group home nurse was interviewed on 9/23/15 at 2:50 PM. She indicated client #1 had a wheelchair evaluation and had a specialized wheelchair ordered. She indicated client #1 positioned himself in his wheelchair and should be using a wheelchair with food pedals. She indicated client #1 had recently started using a wheelchair due to the contractures in his feet. No additional</p>			

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	<p>evidence of a wheelchair evaluation for client #1's needs in positioning/mobility was provided. The Nurse indicated client #5 had always eaten off of his lap tray and that he had not had a recent OT/PT assessment or evaluations of his braces.</p> <p>The QIDP and AD were interviewed on 9/28/15 at 3:18 P.M. and both indicated client #5 had not had an OT, PT or positioning evaluation in years. They indicated they did not know of any type of positioning schedule, or when he should wear his braces or chest harness.</p> <p>3. Observations were conducted on 9/21/15 between 4:55 P.M. and 6:58 P.M. including the evening meal at 5:29 P.M. The evening meal provided was spaghetti with meat sauce, whole kernel corn, tossed salad, choice of two salad dressings and iced tea or milk. There were four staff working in the home, the Home Manager (HM), Direct Care Staff (DCS) #1, #2 and #3. Client #1 was not offered salad or a substitution, not provided with more than one glass of beverage, or offered second helpings. Client #2 was not offered more than one beverage or second helpings. Client #3 was not offered corn, salad or a substitution for them, more than one beverage or second helpings. Client #4 was not offered salad or a substitution</p>			

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	<p>and not offered more than one beverage.</p> <p>The Menu dated Fall 2015 Week 2, for the meal was reviewed on 9/21/15 at 5:47 p.m. and indicated "1 cup Italian spaghetti (1 cup pasta) with 3 ounces meat, 1/2 cup cooked squash, 1 cup tossed salad with 1 tablespoon dressing, 1 slice french bread with 1 teaspoon margarine, 1 cup milk and coffee or tea."</p> <p>During observations at the group home on 9/22/15 from 5:05 PM until 5:45 PM, clients #1, #2, #3, #4, #5, #7, and #8 were in the dining room. Direct Support Staff (DSP) #1 and DSP #6 were the only staff in the home during the observation. DSP #6 prepared lasagna, creamed corn and green beans and poured into the same bowl causing the food to run together. The bowls of food were prepared in the adjacent kitchen by staff #6 and lined up on the counter before she placed the bowls in front of the clients seated at the dining room table. Client #8's food had chunks of pasta in the bowl. Client #1 ate his lasagna in bites 2 inches in diameter without redirection.</p> <p>During observations on 9/22/15 between 5:20 P.M. and 6:05 P.M. the clients were eating their evening meal from a bowl. The meal consisted of creamed corn, green beans, lasagna, lemonade and milk.</p>			

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	<p>The gallon of milk sat on the table, but was never opened or served to any of the clients. There were two staff working DCS #1 and #6. Client #2 completed his meal and went outside. DCS #1 followed client #2. There were no staff in the dining room with the remaining clients. Client #1 grabbed client #2's bowl and started to eat from it. Client #7 grabbed the lemonade pitcher and began to drink from the spout of the pitcher. Client #7 then grabbed some food from another clients bowl across the table and ate it. Client #7 stood up and went to client #5 and attempted to take client #5's bowl. Client #5 hit client #7 in the abdomen. Client #5 stated "He tried to take my bowl." DCS #1 was informed of what had occurred when he returned to the dining room. DCS #1 removed the lemonade and the contaminated food bowls. Other food was not provided for those clients other than client #1 was given a pot pie upon the surveyor's question if he (client #1) was "allowed second servings?"</p> <p>DSP #6 was interviewed on 9/22/15 at 5:15 PM and indicated client #1 received a pureed diet. When the surveyor pointed out the chunks of food in client #1's bowl, DSP #6 took his bowl and client #1 did not receive a liquid nutritional supplement during the meal. DSP #1 and</p>			

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	<p>#6 did not offer a second portion and DSP #6 began washing dishes after the meal.</p> <p>DSP #6 was again interviewed on 9/22/15 at 5:37 P.M. When asked what menu was followed for the evening meal DSP #6 stated "We didn't go by the menu."</p> <p>DSP #6 was again interviewed again on 9/22/15 at 5:40 PM. When asked about additional food for client #1, DSP #6 indicated she had more food for him. DSP #6 took a pot pie out of the freezer and began to warm it up.</p> <p>Observations were conducted on 9/24/15 between 4:38 P.M. and 6:12 P.M. There were four staff working the HM, DCS #1, #2 and #4. The evening meal was served at 5:29 P.M. The clients were served tater tot casserole, spinach salad, 2 choices of salad dressing, cooked carrots, cantaloupe, tea, milk. The clients were offered at least three servings of casserole and carrots. The clients did not grab at each others' plates or the serving bowls. Clients #2, #3, #4 and #8 each were given a can of chocolate ensure (nutritional supplement). Client #8's meal was pureed and client #1's, #3's and #4's foods were mashed to a soft consistency with a fork.</p>			

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	<p>During observations on 9/25/15 from 7:10 AM until 8:20 AM, there were two staff in the home, DSPs #4 and #8. Clients #1, #2, #3, #4, #5, #7 and #8 sat in the dining room unattended while DSPs #4 and #8 made breakfast in an adjacent kitchen upon arrival at the group home. DSP #8 prepared instant oatmeal by tearing open 2 packages and added milk without measuring the amount. DSP #8 poured sugar coated cereal with marshmallow bits and milk into a bowl for client #4 without measuring the amount. DSP #8 then administered medications and DSP #4 finished preparing breakfast for clients #1, #2, #3, #4, #5, #6, #7 and #8 consisting of instant oatmeal, pancakes, milk and tea. DSP #4 brought individual portions of oatmeal and pancakes to the table after they were heated up one at a time. Client #2 yelled out and stood up prior to being served breakfast, and DSP #4 stated, "I'm hurrying buddy." Client #1's oatmeal in a bowl fell to the floor, but staff did not see the bowl fall and client #7 ate client #3's oatmeal. DSP #4 asked what happened to client #1's oatmeal and was told by the surveyor his bowl had fallen to the floor. DSP #4 left the clients in the dining room to prepare more oatmeal for clients #1 and #3. Client #8 ate a pancake ground into a grainy texture that was prepared and placed in front of him. Client #1 did</p>			

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	<p>not receive a liquid nutritional supplement during the breakfast meal.</p> <p>The menu, dated Fall 2015 Week 2, was reviewed on 9/25/15 at 8:15 AM and indicated 1/2 cup of orange juice, 1/2 cup asst (assorted) hot cereal, 1-2 pancakes, 1 tsp (teaspoon) of margarine/syrup and 1 cup of skim milk/coffee/tea.</p> <p>DSP #4 was interviewed on 9/25/15 at 8:15 AM and when asked about juice as indicated on the menu, indicated the orange juice was frozen and therefore not served at the meal. She indicated client #1 did not receive a nutritional supplement.</p> <p>DSP #4 was interviewed again on 9/25/15 at 8:20 AM. She indicated there was no fortified cereal in the house and indicated the nurse had not provided the cereal to give to client #1.</p> <p>Client #1's records were reviewed on 9/22/15 at 2:25 PM. Client #1's nutritional assessments indicated the following: An assessment dated 10/15/14 indicated client #1 was "underweight" for his height and had a body mass index of 18.5. The assessment indicated goals to "increase weight...Noted [liquid nutritional supplement] was recommended in the past. No order noted</p>			

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	<p>at this time. Add [liquid nutritional supplement] TID (three times daily) to promote weight gain." An assessment dated 1/6/15 indicated "...Noted RN aware of [liquid nutritional supplement] recommend (sic) at last visit. Per staff, supplement is not on MAR (medication administration record). Recommend [liquid nutritional supplement] TID added to MAR to help with wt (weight) gain...." An assessment dated 6/10/15 indicated "...Still recommend supplement of [liquid nutritional supplement] BID (twice daily)-0 orders noted yet...Reg (regular) high cal (calorie) soft diet and 2 c (cups) of fortified cereal every morning. Rec (recommend) add oral nutrition supplement morning and evening HS (bedtime)." Client #1's physician's orders dated 9/1/15 failed to indicate a liquid nutritional supplement.</p> <p>Client #2's record was reviewed on 9/23/15 at 2:58 P.M. Client #2's Physician's Orders (PO) dated for 9/2015 indicated client #2 was to have Boost (nutritional supplement) 1 can 4 times a day. Regular high fiber diet, 2 cups of [name] cereal daily at breakfast. Client #2's Nutritional Assessment dated 6/10/2015 indicated "CBW (current body weight) 124 pounds BMI (body mass index) 17.8 below by 3.8%... though considered underweight</p>			

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	<p>for height (70 inches)...recommend to offer extra portions at meal times. Goal to increase weight by 2 pounds next quarter." Client #2's Individual Support Plan (ISP) dated 7/22/15 indicated client #2's "desired body weight was 160-178 pounds."</p> <p>Client #3's record was reviewed on 9/22/15 at 2:28 P.M. Client #3's Physician's Orders dated for 9/2015 indicated client #3 was to have a "soft high calorie diet, with 8 ounces of Ensure (nutritional supplement) four times a day to increase albumin, may have at meals." Client #3's nutritional assessment dated 6/10/15 indicated "73 pounds, BMI 14.7 (underweight) 12% loss between Feb. (February) 2015 - May 2015 spoke with staff, reports, client went to nursing home during this period and did not eat well in the unfamiliar environment. Client returned mid (middle) of May ... Spoke with staff and recommend to add ice cream to ensure for added carb/fats...." Client #3's ISP dated 5/14/15 indicated client #3's desired weight was 106-130 pounds." Client #3's 9/2015 MAR did not indicate current weight. Weight for July, 2015 was 80 pounds as indicated by the nutritional assessment.</p> <p>Client #4's record was reviewed on 9/28/15 at 2:15 P.M. Client #4's ISP</p>			

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	<p>dated 3/19/15 indicated he was to have a "regular soft diet, mechanical, Boost twice daily. Client #4's MAR for 9/2015 did not indicate current weight. His ISP indicated his weight was "138 pounds and he was 65.5 inches tall. His ideal body weight range was 126-167."</p> <p>Client #5's record was reviewed on 9/28/15 at 12:35 P.M. Client #5's PO dated for 9/2015 indicated client #5 was prescribed a regular low fat, low cholesterol, NCS (no concentrated sweets) diet with Boost once daily.</p> <p>Client #6's record was reviewed on 9/29/15 at 3:28 P.M. Client #6's PO dated for 9/2015 indicated he was prescribed a "regular, no extra portions" diet.</p> <p>Client #7's record was reviewed on 9/29/15 at 3:47 P.M. Client #7's PO dated for 9/2015 indicated he was prescribed a "regular, no extra portions" diet.</p> <p>Client #8's record was reviewed on 9/22/15 at 2:29 P.M. Client #8's PO dated for 9/2015 indicated he was to have a "pureed diet, may have extra portions."</p> <p>The Area Director (AD) and group home nurse were interviewed on 9/23/15 at 2:50 PM and indicated clients should be offered all food groups as listed on the</p>			

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	<p>menu, diets should be prepared to the prescribed consistency and indicated clients should have been offered seconds. The group home nurse indicated she thought the clients were receiving their nutritional supplement. The AD indicated she had checked with the group home manager and the manager indicated she had not been made aware of the need for client #1 to receive a nutritional supplement and the supplement was not on client #1's physician's orders or MAR. The nurse indicated there was not a definition of what a high calorie diet should consist of to be considered a high calorie diet, but that staff knew the clients were to receive seconds when on a high calorie diet. She stated staff "have a list" of what constituted a high calorie diet.</p> <p>There was no evidence of a list of high calorie diet for staff to use to provide for clients or of the nurse's training on signs and symptoms of cellulitis for staff working in the group home provided.</p> <p>The Area Director (AD) was interviewed on 10/9/15 at 9:39 AM and indicated there was no evidence the nurse had trained staff on high calorie diets. The AD indicated it was the RN's responsibility to develop and train staff on dining plans for each of the clients.</p>			

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W 0377 Bldg. 00	<p>9-3-6(a)</p> <p>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of sanitation. Based on observation, record review and interview, the facility failed to provide a storage system for medications which insured medications were maintained under proper conditions of sanitation for 2 of 4 sampled clients (clients #4 and #1).</p> <p>Findings include:</p> <p>An observation of client #4's medications was conducted on 9/22/15 at 7:02 A.M. Client #4's topical medications were inside a plastic bag. Client #4's tube of Econazole Nitrate ointment (for feet) was inside the bag with other medications, but the cap was off the container. The box with the bottle of client #4's ear drops was in the plastic bag. There was no date written on the container indicating when the medication had been opened. Client #4's bottle of oral rinse also was not dated when it was opened.</p> <p>An interview was conducted with (direct care staff) DCS #4 on 9/22/15 at 7:02 A.M. DCS #4 was asked if there was any</p>			W 0377	<p>All Direct Care staff, Program Coordinator and QIDP will receive training to include ensuring that all topical, liquid and other treatment medications are stored individually and are dated when opened to determine date that they need to be disposed.</p> <p>Ongoing, the Program Coordinator and/or Program Nurse will go through the medication cabinet a minimum of weekly to ensure the cabinet is clean and well organized, all medications are stored separately, all topical, liquid and other treatment medications are stored individually, all open treatment medications are dated when opened and all expired medications are disposed of.</p> <p>Responsible party: Direct Care Staff, Program Coordinator, Program Nurse</p>		11/18/2015

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	<p>way to determine if the medications were outdated when they were not dated. DCS #4 stated, "No, I guess not."</p> <p>An observation of the medication storage closet was conducted on 9/22/15 at 5:40 P.M. There were two containers of topical medications laying on the floor of the closet. Both of the topical medications were for client #1.</p> <p>An interview was conducted with Direct Care Staff (DCS) #6 on 9/22/15 at 5:41 P.M. DCS #6 was asked if the medication closet usually had medications on the floor; DCS #6 did not respond.</p> <p>An interview was conducted with the RN and the Area Director (AD) on 9/23/15 at 5:15 P.M. When asked about the medications being on the floor and not being dated when opened, the RN stated "They should date them. They (medications) should have been on the shelf, not on the floor. They probably fell off the shelf."</p> <p>9-3-6(a)</p>			

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W 0382 Bldg. 00	<p>483.460(I)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, the facility failed to assure all drugs and biologicals were locked except when being prepared for administration for 2 of 4 sampled clients (clients #1 and #4).</p> <p>Findings include:</p> <p>During observations at the group home on 9/21/15 between 4:55 P.M. and 6:58 P.M. an unlabeled tube of Santyl (prescription wound care ointment) and a bottle (2/3 full) of Sodium Chloride (saline) 0.9% were found inside one of the closets of client #1's and #4's bedroom. There was also an unwound piece of gauze wrap and a pair of blunt edge scissors in the closet. These items were located on the top of a chest of drawers which had been placed inside the closet, but had no drawers and some of the drawer ledges were missing.</p>	W 0382	<p>All staff will receive retraining on ensuring that the medication cabinet is locked during medication administration when exiting the medication area for any reason and all medication administration supplies are kept in the locked medication cabinet instead of consumers' rooms.</p> <p>Home Manager and/or QIDP will complete medication administration observations at least twice per week for four weeks to ensure that all staff are locking the medication cabinet during medication administration when staff are out of the area for any reason and all medication administration supplies are kept in the locked medication cabinet instead of consumers rooms.</p> <p>Ongoing, the Home Manager and/or QIDP will complete medication administration observations at least once per week to ensure that all staff are</p>	11/18/2015

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	<p>An interview was conducted with Direct Care Staff (DCS) #2 on 9/21/15 at 6:47 P.M. DCS #2 indicated clients #1 and #4 could not have items in their closets or room due to client #1's behaviors of ripping and tearing items and client #4's behaviors of throwing items out the window or dunking them in the toilet. DCS #2 indicated he did not know why the medication and other medical items were inside the closet.</p> <p>An interview was conducted with the Home Manager (HM) on 9/21/15 at 6:52 P.M. The HM stated, "Oh that is stuff that we use for [client #3's] cellulitis. The Home Health Aide must have left it in here. I am not sure why it would be in [client #1's and #4's] bedroom, unless she had to change [client #3's] leg wound dressing in this room instead of his own bedroom for some reason."</p> <p>An interview was conducted with the RN and the Area Director (AD) on 9/23/15 at 5:15 P.M. When asked about the medication and medical supplies being in the bedroom closet of client #1's and #4's room, the RN stated "They should not have been in there. We think Home Health left the items in the room."</p> <p>9-3-6(a)</p>		<p>locking the medication cabinet during medication administration when staff are out of the area for any reason and all medication administration supplies are kept in the locked medication cabinet instead of consumers rooms.</p> <p>Responsible Party: Home Manager, QIDP</p>				

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W 0390 Bldg. 00	<p>483.460(m)(2)(i) DRUG LABELING</p> <p>The facility must remove from use outdated drugs.</p> <p>Based on observation and interview, the facility failed to have a system to insure contaminated/outdated/expired medications were removed in a timely manner from the facility for 1 of 4 sampled clients (client #4).</p> <p>Findings include:</p> <p>An observation of client #4's medications was conducted on 9/22/15 at 7:02 A.M. Client #4's topical medications were inside a plastic bag. Client #4's tube of Econazole Nitrate ointment (for feet) was inside the bag with other medications, the cap was off the container. The box with the bottle of client #4's Duralzol 0.05% (eye drops for post cataract surgery) was in the plastic bag. There was no date</p>	W 0390	<p>All Direct Care staff, Program Coordinator and QIDP will receive training to include ensuring that all topical, liquid and other treatment medications are stored individually and are dated when opened to determine date that they need to be disposed.</p> <p>Ongoing, the Program Coordinator and/or Program Nurse will go through the medication cabinet a minimum of weekly to ensure the cabinet is clean and well organized, all medications are stored separately, all topical, liquid and other treatment medications are stored individually, all open treatment medications are dated when opened and all expired medications are disposed of.</p> <p>Responsible party: Direct Care</p>	11/18/2015	

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	<p>written on the container indicating when the medication had been opened. The prescription fill date was 3/11/15. Client #4's bottle of Chlorhexidine Gluconate 0.12% (oral rinse) was not dated when it was opened. The fill date was 7/25/14.</p> <p>An interview was conducted with DCS #4 on 9/22/15 at 7:02 A.M. DCS #4 was asked if there was any way to determine if the medications were outdated if they were not dated when they were opened. DCS #4 stated, "No, I guess not." DCS #4 was asked when client #4 had his eye surgery. DCS #4 stated "He hasn't had surgery since I'm here."</p> <p>An interview was conducted with the RN and the Area Director (AD) on 9/23/15 at 5:15 P.M. When asked about the medications not being dated when opened, the RN stated "They should date them." The RN indicated client #4's eyes may get dry since his surgery. The RN did not verify if client #4 was to still get the Durazol eye drops.</p> <p>9-3-6(a)</p>		Staff, Program Coordinator, Program Nurse		

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W 0391 Bldg. 00	<p>483.460(m)(2)(ii) DRUG LABELING</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation and interview, the facility failed to assure all medications were labeled for 1 of 4 sampled clients (client #3).</p> <p>Findings include:</p> <p>During observations at the group home on 9/21/15 between 4:55 P.M. and 6:58 P.M. an unlabeled tube of Santyl (prescription wound care ointment) and an unlabeled bottle (2/3 full) of Sodium Chloride (saline) 0.9% were found inside one of the closets of client #1's and #4's bedroom.</p> <p>An interview was conducted with the Home Manager (HM) on 9/21/15 at 6:52 P.M. The HM stated, "Oh that is stuff that we use for [client #3's] cellulitis." The HM indicated the items were not labeled.</p> <p>An interview was conducted with the RN and the Area Director (AD) on 9/23/15 at</p>	W 0391	<p>HM and Program Nurse will receive retraining to include ensuring that all medications have a pharmacy label and have instructions for how staff are to administer the medication. All direct care staff will receive retraining on medication administration including ensuring that they are administering all medications/medical treatments as directed.</p> <p>If a new medication/treatment is added the HM and/or Program Nurse will ensure that the medication has a pharmacy label and instructions for how staff are to administer the medication prior to it being placed in the medication cabinet.</p> <p>Home Manager and/or QIDP will complete medication administration observations at least twice per week for four weeks to ensure that all staff are administering medications/treatments as directed.</p>	11/18/2015

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	5:15 P.M. When asked about medications not being labeled, the RN stated, "I think those are items that came home with [client #3] when he returned from rehab recently." The RN indicated she was aware medications were to be labeled. 9-3-6(a)		Ongoing, the Home Manager and/or QIDP will complete medication administration observations at least once per week to ensure that all staff are administering medications/treatments as directed. The HM or Program Nurse will go through the medication cabinet a minimum of weekly to ensure that all medications have a pharmacy label and instructions for use. Responsible Party: HM, QIDP, Program Nurse		
W 0419 Bldg. 00	483.470(b)(4)(iii) CLIENT BEDROOMS The facility must provide each client with bedding appropriate to the weather and climate. Based on observation and interview, the facility failed to provide appropriate bedding for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8). Findings include: Observations of the group home where clients #1, #2, #3, #4, #5, #6, #7 and #8	W 0419	Direct care still will receive retraining to include ensuring that adequate bedding, including mattress pads, pillows, blankets, comforters and sheets are provided to consumers at all times. Program Coordinator and/or Program Director will complete walkthroughs of the home a minimum of twice weekly for 4 weeks to ensure that adequate bedding, including mattress pads,	11/18/2015	

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	<p>lived were conducted on 9/22/15 between 5:20 P.M. and 6:05 P.M. including each of the client's bedrooms. Each of the client's beds consisted of a plastic/vinyl mattress. Some of the mattresses were covered with an additional piece of plastic. There was then a flat sheet over the plastic mattress. There was no mattress pad or additional barrier to make the bed more comfortable and less prone to increase sweating. Some of the beds had only the bottom sheet and no top sheet. One bed (client #6's) had toss pillows (2) and no bed pillow. Client #4 had no pillow at all on his bed. Each bed had a comforter.</p> <p>The Home Manager (HM) was interviewed on 9/23/15 at 5:20 P.M. The HM stated "They didn't have mattress pads on the beds? They should have had a pad on each bed. There are plenty of fitted sheets and mattress pads in the linen closet."</p> <p>The RN was interviewed on 9/23/15 at 5:15 P.M. The RN stated, "Yes, the plastic mattresses needed a barrier, they can increase issues with skin integrity."</p> <p>9-3-7(a)</p>		<p>pillows, blankets, comforters and sheets are provided to consumers at all times.</p> <p>Ongoing the Program Coordinator and/or Program Director will complete walkthroughs of the home a minimum of weekly to ensure that adequate bedding, including mattress pads, pillows, blankets, comforters and sheets are provided to consumers at all times.</p> <p>Responsible Party: Program Coordinator, QIDP</p>		

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W 0455 Bldg. 00	<p>483.470(I)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, record review and interview, the facility failed to encourage 3 of 3 sampled clients to practice good hygiene and infection prevention at all formal and informal opportunities (clients #3, #4 and #1).</p> <p>Findings include:</p> <p>Observations of the 7:00 A.M. medication pass was conducted on 9/22/15.</p> <p>At 6:50 A.M. Client #3 was moved into the medication area of the kitchen and a room divider was placed around the area to offer privacy during the medication pass. Client #3 was not encouraged to cleanse his hands prior to the medication pass.</p> <p>At 6:55 A.M. Client #4 was assisted in walking to the medication area in the kitchen. Client #4 was not encouraged to cleanse his hands prior to the medication pass.</p> <p>At 7:11 A.M. Client #1 was moved into</p>	W 0455	<p>All direct care staff will receive retraining on infection control and universal precautions including encouraging clients to wash their hands and/or use hand sanitizer prior to mealtimes. Training will also include ensuring that staff are washing their own hands or using hand sanitizer prior to assisting clients with their meals.</p> <p>Program Coordinator and/or QIDP will complete mealtime observations at least twice per week for four weeks to ensure that all staff are encouraging clients to wash their hands and/or use hand sanitizer prior to mealtimes as well as ensuring staff are washing their own hands or using hand sanitizer prior to assisting clients with their meals.</p> <p>Ongoing, the Program Coordinator and/or QIDP will complete mealtime observations at least once per week to ensure that all staff are encouraging clients to wash their hands and/or use hand sanitizer prior to mealtimes as well as ensuring staff are washing their own hands or using hand sanitizer prior to assisting clients with their meals.</p>	11/18/2015

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W 0459 Bldg. 00	<p>the medication area of the kitchen. Client #1 was not encouraged to cleanse his hands prior to the medication pass.</p> <p>Interviews were conducted with the Home Manager (HM), Qualified Intellectual Disabilities Professional (QIDP) and the Area Director (AD) on 9/28/15 at 3:18 P.M. When asked if the clients should be cleansing their hands prior to medication administration, the AD and QIDP both indicated the clients should be washing their hands or using hand sanitizer prior to their medication pass.</p> <p>9-3-7(a)</p> <p>483.480 DIETETIC SERVICES The facility must ensure that specific dietetic services requirements are met.</p> <p>Based upon observation, record review and interview, the facility failed to meet the Condition of Participation: Dietetic Services. The facility failed to provide well balanced diets and modified specially prescribed diets (clients #1, #2, #3, #4, #5, #6, #7, and #8), failed to serve</p>	W 0459	<p>Responsible Party: Program Coordinator, QIDP</p> <p>1. Please refer to W460 2. Please refer to W474 3. Please refer to W475 4. Please refer to W483 5. Please refer to W485 6. Please refer to W487 7. Please refer to W488</p>	11/18/2015			

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	<p>food in the form consistent with individual needs (clients #1 and #8), failed to utilize appropriate and/or adaptive dining equipment (clients #1, #2, #3, #4, #5, #6, #7, and #8), failed to encourage client #5 to eat at the table with peers instead of off of his lap tray, failed to supervise clients during meal times (clients #1, #2, #3, #4, #5, #6, #7, and #8), failed to provide a sufficient amount of food at meals to allow for second servings and to meet the nutritional needs (clients #1, #2, #3, #4, #5, #6, #7, and #8) and failed to encourage clients' participation in the dining process (clients #1, #2, #3, #4, #5, #6, #7, and #8).</p> <p>Findings include:</p> <p>1. Please see W460: The facility failed to provide 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) with well-balanced diets including modified and specially prescribed diets.</p> <p>2. Please see W474: The facility failed to serve food for 1 of 4 sampled clients (client #4) and 1 of 4 additional clients (client #8) in the form consistent with their individual needs.</p> <p>3. Please see W475: The facility failed to</p>			

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	<p>utilize appropriate tableware and/or adaptive dining equipment at all opportunities for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) to enable them to eat as independently as possible.</p> <p>4. Please see W483: The facility failed for 1 of 1 client who utilized a lap tray on his wheelchair to encourage him to eat at the table with peers (client #5).</p> <p>5. Please see W485: The facility failed to supervise 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) during meal times.</p> <p>6. Please see W487: The facility failed to provide a sufficient amount of food at meals to allow for second servings and to meet the nutritional needs for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8).</p> <p>7. Please see W488: The facility failed to encourage 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) to participate in the dining process as much as possible.</p>			

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W 0460 Bldg. 00	<p>9-3-8(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview, the facility failed to provide 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) with well-balanced diets including modified and specially prescribed diets.</p> <p>Findings include:</p> <p>Observations were conducted on 9/21/15 between 4:55 P.M. and 6:58 P.M. including the evening meal at 5:29 P.M. The evening meal provided was spaghetti with meat sauce, whole kernel corn, tossed salad, choice of two salad dressings and iced tea or milk. There were four staff working in the home, the Home Manager (HM), Direct Care Staff</p>	W 0460	All direct care staff will receive retraining on mealtime protocols including ensuring that all consumers are receiving a sufficient amount of food as designated by the menu and the consumers diet orders. Training will include ensuring that extra portions are offered as designated by individual consumers diet orders. In addition, training will include ensuring that if an item on the menu is not conducive to preparing for consumers that have modified diet orders that appropriate substitutions are provided. All direct care staff will receive retraining to include ensuring that consumers are offered nutritional supplements as directed by the consumers PCP and/or dietician.	11/18/2015

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	<p>(DCS) #1, #2 and #3. Client #1 was not offered salad or a substitution, not provided with more than one glass of beverage, or offered second helpings. Client #2 was not offered more than one beverage or second helpings. Client #3 was not offered corn, salad or a substitution for them, more than one beverage or second helpings. Client #4 was not offered salad or a substitution and not offered more than one beverage.</p> <p>The Menu dated, Fall 2015 Week #2, for the meal was reviewed on 9/21/15 at 5:47 p.m. and indicated "1 cup Italian spaghetti (1 cup pasta) with 3 ounces meat, 1/2 cup cooked squash, 1 cup tossed salad with 1 tablespoon dressing, 1 slice french bread with 1 teaspoon margarine, 1 cup milk and coffee or tea."</p> <p>During observations at the group home on 9/22/15 from 5:05 PM until 5:45 PM, clients #1, #2, #3, #4, #5, #6, #7, and #8 were in the dining room. Direct Support Staff (DSP) #1 and DSP #6 were the only staff in the home during the observation. DSP #6 prepared lasagna, creamed corn and green beans and poured into the same bowl causing the food to run together. The bowls of food were prepared in the adjacent kitchen by staff #6 and lined up on the counter before she placed the bowls in front of the clients seated at the</p>		<p>The Program Coordinator and/or QIDP will complete mealtime observations at least three times weekly for 4 weeks to ensure that consumers are being offered sufficient amounts of food, are offered appropriate substitutions, staff are following diet orders and consumers are being offered their nutritional supplements as directed.</p> <p>Ongoing after the 4 weeks the Program Coordinator and/or QIDP will complete mealtime observations at least twice weekly to ensure that consumers are being offered sufficient amounts of food, are offered appropriate substitutions, staff are following diet orders and consumers are being offered their nutritional supplements as directed.</p> <p>Dining plans have been created or updated for all consumers. All direct care still will receive retraining on every consumer's specific dining plan including each consumers specified diet orders. Retraining will include ensuring that staff are following all consumers diet orders including if consumers have modified diets such as mechanical soft and pureed.</p> <p>Staff will also receive retraining on how to prepare the specialized diets prescribed for each consumer. Previous Program</p>		

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	<p>dining room table. Client #8's food had chunks of pasta in the bowl. Client #1 ate his lasagna in bites 2 inches in diameter without redirection.</p> <p>During observations on 9/22/15 between 5:20 P.M. and 6:05 P.M. including the evening meal. The clients were eating their evening meal from a bowl. The meal consisted of creamed corn, green beans, lasagna, lemonade and milk. The gallon of milk sat on the table, but was never opened or served to any of the clients. There were two staff working DCS #1 and #6. Client #2 completed his meal and went outside. DCS #1 followed client #2. There were no staff in the dining room with the remaining clients. Client #1 grabbed client #2's bowl and started to eat from it. Client #7 grabbed the lemonade pitcher and began to drink from the spout of the pitcher. Client #7 then grabbed some food from another client's bowl across the table and ate it. Client #7 stood up and went to client #5 and attempted to take client #5's bowl. Client #5 hit client #7 in the abdomen. Client #5 stated "He tried to take my bowl." DCS #1 was informed of what had occurred when he returned to the dining room. DCS #1 removed the lemonade and the contaminated food bowls. Other food was not provided for those clients other than client #1 was</p>		<p>Nurse is no longer working for Indiana Mentor. The new Program Nurse will receive retraining on ensuring that specified dining plans are developed for each consumer based on PCP and dietician recommendations. Training will include ensuring that dining plans are updated a minimum of annually at the ISP and more often as needed if any changes occur. Training will also include ensuring that all staff working in the home are trained on all consumers specified dining plans.</p> <p>The Program Coordinator and/or QIDP will complete mealtime observations at least three times weekly for 4 weeks to ensure that staff are following all consumers prescribed diet orders and are preparing meals as directed by the specialized diets. Observations will also include ensuring that staff are following all aspects of consumers specified dining plans.</p> <p>Ongoing after the 4 weeks the Program Coordinator and/or QIDP will complete mealtime observations at least twice weekly to ensure that staff are following all consumers prescribed diet orders and are preparing meals as directed by the specialized diets. Observations will also include ensuring that staff are following all aspects of consumers specified dining plans</p>		

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	<p>given a pot pie upon the surveyor's question if he (client #1) was "allowed second servings?"</p> <p>DSP #6 was interviewed on 9/22/15 at 5:15 PM and indicated client #1 received a pureed diet. When the surveyor pointed out the chunks of food in client #1's bowl, DSP #6 took his bowl and client #1 did not receive a liquid nutritional supplement during the meal. DSP #1 and #6 did not offer a second portion and DSP #6 began washing dishes after the meal.</p> <p>DSP #6 was interviewed on 9/22/15 at 5:37 P.M. When asked what menu was followed for the evening meal DSP #6 stated "We didn't go by the menu."</p> <p>DSP #6 was interviewed again on 9/22/15 at 5:40 PM. When asked about additional food for client #1, DSP #6 indicated she had more food for him.</p> <p>Observations were conducted on 9/24/15 between 4:38 P.M. and 6:12 P.M. There were four staff working, the HM, DCS #1, #2 and #4. The evening meal served at 5:29 P.M. The clients were served tater tot casserole, spinach salad, 2 choices of salad dressing, cooked carrots, cantaloupe, tea, milk. The clients were offered at least three servings of casserole</p>		Responsible Party: Program Coordinator, QIDP	
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	<p>and carrots. The clients did not grab at each other's plates or the serving bowls. Clients #2, #3, #4 and #8 each were given a can of chocolate ensure (nutritional supplement). Client #8's meal was pureed and client #1's, #3's and #4's foods were mashed to a soft consistency with a fork.</p> <p>During observations on 9/25/15 from 7:10 AM until 8:20 AM, there were two staff in the home, DSPs #4 and #8. Clients #1, #2, #3, #4, #5, #6, #7 and #8 sat in the dining room unattended while DSPs #4 and #8 made breakfast in an adjacent kitchen upon arrival at the group home. DSP #8 prepared instant oatmeal by tearing open 2 packages and added milk without measuring the amount. DSP #8 poured sugar coated cereal with marshmallow bits and milk into a bowl for client #4 without measuring the amount. DSP #8 then administered medications and DSP #4 finished preparing breakfast for clients #1, #2, #3, #4, #5, #6, #7 and #8 consisting of instant oatmeal, pancakes, milk and tea. DSP #4 brought individual portions of oatmeal and pancakes to the table after they were heated up one at a time. Client #2 yelled out and stood up prior to being served breakfast, and DSP #4 stated, "I'm hurrying buddy." Client #1's oatmeal in a bowl fell to the floor, but staff did not see the bowl fall and client #7 ate client #3's</p>			

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	<p>oatmeal. DSP #4 asked what happened to client #1's oatmeal and was told by the surveyor his bowl had fallen to the floor. DSP #4 left the clients in the dining room to prepare more oatmeal for clients #1 and #3. Client #8 ate a pancake ground into a grainy texture that was prepared and placed in front of him. Client #1 did not receive a liquid nutritional supplement during the breakfast meal.</p> <p>The menu dated, Fall 2015 Week #2, was reviewed on 9/25/15 at 8:15 AM and indicated 1/2 cup of orange juice, 1/2 cup asst (assorted) hot cereal, 1-2 pancakes, 1 tsp (teaspoon) of margarine/syrup and 1 cup of skim milk/coffee/tea.</p> <p>DSP #4 was interviewed on 9/25/15 at 8:15 AM and when asked about juice as indicated on the menu, indicated the orange juice was frozen and therefore not served at the meal. She indicated client #1 did not receive a nutritional supplement.</p> <p>Client #1's records were reviewed on 9/22/15 at 2:25 PM. Client #1's nutritional assessments indicated the following: An assessment dated 10/15/14 indicated client #1 was "underweight" for his height and had a body mass index of 18.5. The assessment indicated goals to "increase weight...Noted [liquid</p>						

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	<p>nutritional supplement] was recommended in the past. No order noted at this time. Add [liquid nutritional supplement] TID (three times daily) to promote weight gain." An assessment dated 1/6/15 indicated "...Noted RN aware of [liquid nutritional supplement] recommend (sic) at last visit. Per staff, supplement is not on MAR (medication administration record). Recommend [liquid nutritional supplement] TID added to MAR to help with wt (weight) gain...." An assessment dated 6/10/15 indicated "...Still recommend supplement of [liquid nutritional supplement] BID (twice daily)-0 orders noted yet...Reg (regular) high cal (calorie) soft diet and 2 c (cups) of fortified cereal every morning. Rec (recommend) add oral nutrition supplement morning and evening HS (bedtime)." Client #1's physician's orders dated 9/1/15 failed to indicate a liquid nutritional supplement.</p> <p>Client #2's record was reviewed on 9/23/15 at 2:58 P.M. Client #2's Physician's Orders (PO) dated for 9/2015 indicated client #2 was to have Boost (nutritional supplement) 1 can 4 times a day. Regular high fiber diet, 2 cups of [name] cereal daily at breakfast. Client #2's Nutritional Assessment dated 6/10/2015 indicated "CBW (current body weight) 124 pounds</p>			
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	<p>BMI (body mass index) 17.8 below by 3.8%... though considered underweight for height (70 inches)...recommend to offer extra portions at meal times. Goal to increase weight by 2 pounds next quarter." Client #2's Individual Support Plan (ISP) dated 7/22/15 indicated client #2's "desired body weight was 160-178 pounds."</p> <p>Client #3's record was reviewed on 9/22/15 at 2:28 P.M. Client #3's Physician's Orders dated for 9/2015 indicated client #3 was to have a "soft high calorie diet, with 8 ounces of Ensure (nutritional supplement) four times a day to increase albumin, may have at meals." Client #3's nutritional assessment dated 6/10/15 indicated "73 pounds, BMI 14.7 (underweight) 12% loss between Feb. (February) 2015 - May 2015, spoke with staff, reports, client went to nursing home during this period and did not eat well in the unfamiliar environment. Client returned mid (middle) of May ... Spoke with staff and recommend to add ice cream to ensure for added carb/fats...." Client #3's ISP dated 5/14/15 indicated client #3's desired weight was 106-130 pounds." Client #3's 9/2015 MAR did not indicate current weight. Weight for July, 2015 was 80 pounds as indicated on the nutritional assessment.</p>			

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	<p>Client #4's record was reviewed on 9/28/15 at 2:15 P.M. Client #4's ISP dated 3/19/15 indicated he was to have a "regular soft diet, mechanical, Boost twice daily. Client #4's MAR for 9/2015 did not indicate current weight. His ISP indicated his weight was "138 pounds and he was 65.5 inches tall. His ideal body weight range was 126-167."</p> <p>Client #5's record was reviewed on 9/28/15 at 12:35 P.M. Client #5's PO dated for 9/2015 indicated client #5 was prescribed a regular low fat, low cholesterol, NCS (no concentrated sweets) diet with Boost once daily.</p> <p>Client #6's record was reviewed on 9/29/15 at 3:28 P.M. Client #6's PO dated for 9/2015 indicated he was prescribed a "regular, no extra portions" diet.</p> <p>Client #7's record was reviewed on 9/29/15 at 3:47 P.M. Client #7's PO dated for 9/2015 indicated he was prescribed a "regular, no extra portions" diet.</p> <p>Client #8's record was reviewed on 9/22/15 at 2:29 P.M. Client #8's PO dated for 9/2015 indicated he was to have a "pureed diet, may have extra portions."</p> <p>The Area Director (AD) and group home nurse were interviewed on 9/23/15 at</p>			

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W 0474 Bldg. 00	<p>2:50 PM and indicated clients should be offered all food groups as listed on the menu, diets should be prepared to the prescribed consistency and indicated clients should have been offered seconds. The group home nurse indicated she thought client #1 was receiving the nutritional supplement. The AD indicated she had checked with the group home manager and the manager indicated she had not been made aware of the need for client #1 to receive a nutritional supplement and the supplement was not on client #1's physician's orders or MAR.</p> <p>9-3-8(a)</p> <p>483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. Based on observation, record review and interview, the facility failed to serve food for 1 of 4 sampled clients (client #4) and 1 of 4 additional clients (client #8) in the form consistent with their individual needs.</p> <p>Findings include</p> <p>Observations were conducted on 9/21/15 between 4:55 P.M. and 6:58 P.M. including the evening meal at 5:29 P.M.</p>	W 0474	<p>Dining plans have been created or updated for all consumers. All direct care still will receive retraining on every consumer's specific dining plan including each consumers specified diet orders. Retraining will include ensuring that staff are following all consumers diet orders including if consumers have modified diets such as mechanical soft and pureed.</p> <p>Staff will also receive retraining on how to prepare the specialized</p>	11/18/2015	

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	<p>Client #4 was served spaghetti with meat sauce and whole kernel corn. Client #8 was served pureed spaghetti.</p> <p>During observations at the group home on 9/22/15 from 5:05 PM until 5:45 PM, DSP #6 prepared lasagna, creamed corn and green beans and poured into the same bowl causing the food to run together. Client #8's food had chunks of pasta and green beans in the bowl.</p> <p>Observations were conducted on 9/22/15 between 5:20 P.M. and 6:05 P.M. including the evening meal. Clients #4 and #8 were eating their food from a bowl, creamed corn, green beans and lasagna. There were visible pieces of lasagna noodles and green beans in their bowls.</p> <p>During observations on 9/25/15 from 7:10 AM until 8:20 AM, there were two staff in the home, DSPs #4 and #8. Clients #1, #2, #3, #4, #5, #6, #7 and #8 sat in the dining room unattended while DSPs #4 and #8 made breakfast in an adjacent kitchen upon arrival at the group home. DSP #8 prepared instant oatmeal by tearing open 2 packages and added milk without measuring the amount. Client #8 ate a pancake ground into a grainy texture.</p>		<p>diets prescribed for each consumer. Previous Program Nurse is no longer working for Indiana Mentor. The new Program Nurse will receive retraining on ensuring that specified dining plans are developed for each consumer based on PCP and dietician recommendations. Training will include ensuring that dining plans are updated a minimum of annually at the ISP and more often as needed if any changes occur. Training will also include ensuring that all staff working in the home are trained on all consumers specified dining plans.</p> <p>The Program Coordinator and/or QIDP will complete mealtime observations at least three times weekly for 4 weeks to ensure that staff are following all consumers prescribed diet orders and are preparing meals as directed by the specialized diets. Observations will also include ensuring that staff are following all aspects of consumers specified dining plans.</p> <p>Ongoing after the 4 weeks the Program Coordinator and/or QIDP will complete mealtime observations at least twice weekly to ensure that staff are following all consumers prescribed diet orders and are preparing meals as directed by the specialized diets. Observations will also include ensuring that staff are</p>				

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	<p>Client #4's record was reviewed on 9/28/15 at 2:15 P.M. Client #4's physician's orders for 9/2015 indicated he was prescribed a mechanical soft diet.</p> <p>Client #8's record was reviewed on 9/22/15 at 2:29 P.M. Client #8's physician's orders for 9/2015 indicated he was prescribed a pureed diet.</p> <p>An interview was conducted with the Area Director (AD) on 9/23/15 at 4:21 P.M. The AD indicated the clients were to be provided their food in the consistency prescribed by their physician.</p> <p>9-3-8(a)</p>		<p>following all aspects of consumers specified dining plans Responsible Party: Program Coordinator, QIDP</p>		
W 0475 Bldg. 00	<p>483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils. Based on observation, record review and interview, the facility failed to utilize appropriate tableware and/or adaptive dining equipment at all opportunities for</p>	W 0475	<p>All direct care staff will receive retraining to include ensuring that all consumers are offered regular table service including a fork,</p>	11/18/2015	

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	<p>4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) to enable them to eat as independently as possibly.</p> <p>Findings include</p> <p>Observations were conducted on 9/21/15 between 4:55 P.M. and 6:58 P.M. including the evening meal at 5:29 P.M. DCS #1 and #2 set the table. Client #1 ate his meal from a regular plate using a spoon and fork, no knife was provided. Client #2 ate his meal from a regular plate using a spoon and fork, no knife was provided. Client #3 ate his meal from a divided plate with a plate guard and used a built-up spoon, there were no built-up fork and knife provided. Client #4 ate his meal from a divided plate using a spoon and fork, no knife was provided. Client #5 ate his meal from a regular plate placed on top of the tray table of his wheelchair. He was provided with a regular fork and knife and a straw in his glass. Client #6 ate his meal from a regular plate using a spoon and fork, no knife was provided. Client #7 ate his meal from a regular plate using a spoon and fork, no knife was provided. Client #8 ate his meal from a divided plate using a spoon and fork, no knife was provided.</p> <p>During observations at the group home</p>		<p>spoon and knife unless they are prescribed the use of adaptive equipment during all meals. A weighted fork and knife have been ordered for Client #3 for use during mealtimes.</p> <p>Program Coordinator and QIDP will receive retraining to include ensuring that all adaptive equipment that is ordered for consumers is present in the home and available for consumers to use as directed.</p> <p>The Program Coordinator and/or QIDP will complete mealtime observations at least three times weekly for 4 weeks to ensure that consumers are offered regular table service including a fork, spoon and knife unless they are prescribed the use of adaptive equipment during all meals. Observations will also include that if adaptive equipment is prescribed for a specific consumer that it is present in the home and offered to the consumers as needed. Ongoing after the 4 weeks the Program Coordinator and/or QIDP will complete mealtime observations at least twice weekly to ensure that consumers are being offered regular table service including a fork, spoon and knife unless they are prescribed the use of adaptive equipment during all meals. Observations will also include that if adaptive equipment is</p>				

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	<p>on 9/22/15 from 5:05 PM until 5:45 PM, clients #1, #2, #3, #4, #5, #6, #7, and #8 were in the dining room. Direct Support Staff (DSP) #1 and DSP #6 were the only staff in the home during the observation. DSP #6 prepared lasagna, creamed corn and green beans and poured into the same bowl causing the food to run together.</p> <p>Observations were conducted on 9/22/15 between 5:20 P.M. and 6:05 P.M. including the evening meal. Clients #1, #2, #3, #4, #5, #6, #7 and #8 were each eating their creamed corn, green beans and lasagna all mixed together from red plastic bowls. They each had a regular spoon and glass.</p> <p>Observations were conducted on 9/24/15 between 4:38 P.M. and 6:12 P.M. Including the meal at 5:29 P.M. Client #1 ate his meal from a flat divided plate, no knife was provided. Client #2 ate his meal from a flat divided plate, no knife was provided. Client #3 ate his meal from a flat divided plate, no built-up utensils were provided. Client #4 ate his meal from a flat divided plate using a spoon and fork, no knife was provided. Client #5 ate his meal from a high sided divided plate placed on top of the tray table of his wheelchair. He was provided with a regular fork and knife and a straw in his glass. Client #6 ate his meal from a</p>				<p>prescribed for a specific consumer that it is present in the home and offered to the consumers as needed.</p> <p>Responsible Party: Program Coordinator, QIDP</p>		

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	<p>flat divided plate, no knife was provided. Client #7 ate his meal from a flat divided plate, no knife was provided. Client #8 ate his meal from a high sided divided plate using a spoon and fork, no knife was provided.</p> <p>Client #1's record was reviewed on 9/22/15 at 2:25 PM. An annual physical examination dated 11/4/14 did not indicate he was not able to utilize regular table service.</p> <p>Client #2's record was reviewed on 9/23/15 at 2:58 P.M. Client #2's Individual Support Plan (ISP) dated 7/22/15 did not indicate he was not able to utilize regular table service.</p> <p>Client #3's record was reviewed on 9/22/15 at 2:28 P.M. Client #3's ISP dated 5/14/15 indicated client #3 was to utilize a divided plate with plate guard and built-up spoon.</p> <p>Client #4's record was reviewed on 9/28/15 at 2:15 P.M. Client #4's ISP dated 3/19/15 did not indicate he was not able to utilize regular table service.</p> <p>Client #5's record was reviewed on 9/28/15 at 12:35 P.M. Client #5's ISP dated 10/15/14 did not indicate he was not able to utilize regular table service.</p>			

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	<p>Client #6's record was reviewed on 9/29/15 at 3:28 P.M. Client #6's Physician's Orders (PO) dated for 9/2015 did not indicate he was not able to utilize regular table service.</p> <p>Client #7's record was reviewed on 9/29/15 at 3:47 P.M. Client #7's PO dated for 9/2015 did not indicate he was not able to utilize regular table service.</p> <p>Client #8's record was reviewed on 9/22/15 at 2:29 P.M. Client #8's record indicated he was to utilize a high divided plate.</p> <p>An interview was conducted with the Area Director (AD) on 9/23/15 at 4:21 P.M. The AD indicated the clients were to use regular table service, including a knife, fork and spoon, unless they were prescribed the use of adaptive dining equipment. Then they should use the dining equipment prescribed for them to use.</p> <p>9-3-8(a)</p>			

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W 0483 Bldg. 00	<p>483.480(d)(2) DINING AREAS AND SERVICE The facility must provide table service for all clients who can and will eat at a table, including clients in wheelchairs. Based on observation, record review and interview, the facility failed for 1 of 1 client who utilized a lap tray on his wheelchair to encourage him to eat at the table with peers (client #5).</p> <p>Findings include:</p> <p>Observations were conducted on 9/21/15 between 4:55 P.M. and 6:58 P.M. including the evening meal at 5:29 P.M. Client #5 ate his meal from a regular plate placed on top of the tray table of his wheelchair.</p> <p>During observations at the group home on 9/22/15 from 5:05 PM until 5:45 PM, Client #5 sat slumped with his head to one side in his wheelchair with a lap tray.</p> <p>Observations were conducted on 9/24/15 between 4:38 P.M. and 6:12 P.M. including the meal at 5:29 P.M. Client #5</p>	W 0483	<p>Client #5 has a specially fitted wheelchair that assists him with sitting in an upright position. Due to his medical needs, it would be difficult for Client #5 to sit in a regular dining room table chair at mealtimes and be comfortable. Client #5 would be at an increased risk of falling or sliding off the regular chair due to his medical needs. At this time it is not recommended by the Program Nurse that Client #5 sit in a regular chair at mealtimes and utilize his specially fitted wheelchair to allow for proper upright positioning at mealtimes.</p> <p>Program Nurse will receive retraining on ensuring that documentation of this recommendation is noted in Client #5 dining plan.</p>	11/18/2015

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W 0485 Bldg. 00	<p>ate his meal from a high sided divided plate placed on top of the tray table of his wheelchair.</p> <p>Client #5's record was reviewed on 9/28/15 at 12:35 P.M. Client #5's ISP dated 10/15/14 did not indicate he was not able to sit at the table to eat his meals and must eat from his tray table.</p> <p>An interview was conducted with the Area Director (AD) on 9/23/15 at 4:21 P.M. The AD indicated Client #5 should be assessed for his current dining positioning needs.</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must supervise and staff dining rooms adequately. Based on observation and interview, the facility failed to supervise 4 of 4 sampled</p>	W 0485	The staff schedule has been revised to allow for 3 staff to be	11/18/2015
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	<p>clients (clients #1, #2, #3, and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) during meal times.</p> <p>Findings include:</p> <p>During observations at the group home on 9/22/15 from 5:05 PM until 5:45 PM, client #1 sat slumped in his wheelchair without a seat cushion or foot pedals/rests. Client #5 sat slumped with his head to one side in his wheelchair with a lap tray. Clients #1, #2, #3, #4, #5, #6, #7 and #8 were in the dining room. Direct Support Staff (DSP) #1 and DSP #6 were the only staff in the home during the observation. DSP #6 prepared lasagna, creamed corn and green beans and poured them into the same bowl causing the food to run together. Client #8's food had chunks of pasta in the bowl. Client #1 ate his lasagna in bites 2 inches in diameter without redirection or staff supervision.</p> <p>During observations on 9/22/15 between 5:20 P.M. and 6:05 P.M. The clients were eating their evening meal from a bowl. The meal consisted of creamed corn, green beans, lasagna, lemonade and milk. The gallon of milk sat on the table, but was never opened or served to any of the clients. There were two staff working DCS #1 and #6. Client #2 completed his</p>		<p>present at mealtimes to assist consumers. Direct care staff will receive retraining to include ensuring that medications are passed prior to mealtime so all staff present are available to assist during the meal. Direct care staff will receive retraining on ensuring that at least one staff is present in the dining room at all times to ensure consumers are following mealtime etiquette and are redirected as needed when behaviors occur.</p> <p>The Program Coordinator and/or QIDP will complete mealtime observations at least three times weekly for 4 weeks to ensure that consumers are being supervised during the meal, staff are redirecting consumers as needed when behaviors occur and ensuring that staff are passing medications prior to the meal to allow for all staff to assist with mealtimes.</p> <p>Ongoing after the 4 weeks the Program Coordinator and/or QIDP will complete mealtime observations at least twice weekly to ensure that consumers are being supervised during the meal, staff are redirecting consumers as needed when behaviors occur and ensuring that staff are passing medications prior to the meal to allow for all staff to assist with mealtimes</p> <p>Responsible Party: Program</p>		

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	<p>meal and went outside. DCS #1 followed client #2. There were no staff in the dining room with the remaining clients. Client #1 grabbed client #2's bowl and started to eat from it. Client #7 grabbed the lemonade pitcher and began to drink from the spout of the pitcher. Client #7 then grabbed some food from another clients bowl across the table and ate it. Client #7 stood up and went to client #5 and attempted to take client #5's bowl. Client #5 hit client #7 in the abdomen. Client #5 stated "He tried to take my bowl." DCS #1 was informed of what had occurred when he returned to the dining room. DCS #1 removed the lemonade and the contaminated food bowls. Other food was not provided for those clients other than client #1 was given a pot pie upon the surveyor's question of if he (client #1) was "allowed second servings?"</p> <p>During observations on 9/25/15 from 7:10 AM until 8:20 AM, there were two staff in the home, DSPs #4 and #8. Clients #1, #2, #3, #4, #5, #6, #7 and #8 sat in the dining room unattended while DSPs #4 and #8 made breakfast in an adjacent kitchen upon arrival at the group home. Client #6 came to the table, sat down, then hit the table and was redirected by staff. Client #6 then raised his spoon as if he was about to throw it</p>		Coordinator, QIDP				

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	<p>before being redirected by staff. DSP #8 then administered medications and DSP #4 finished preparing breakfast consisting of instant oatmeal, pancakes, milk and tea while the clients sat unattended in the dining room. DSP #4 brought individual portions of oatmeal and pancakes to the table after they were heated up one at a time. While DSP #4 prepared individual portions of microwave instant oatmeal and pancakes, client #2 made loud verbalizations and dug into his brief then wiped his hands on the table. Staff were not present in the room and did not observe his behavior. Client #1 slipped down in his wheelchair until his buttocks was on the edge of the seat unobserved by staff until he nearly slipped out of his seat. As the surveyor stepped toward client #1 to prevent his fall and notify staff of his position, DSP #4 came into the room to bring food to the table, saw client #1's position and repositioned him just as he began to slide out of his seat to the floor. Client #2 periodically yelled as DSP #4 prepared the food and slapped his head without redirection from staff who were not present to observe his behavior. Client #2 yelled out and stood up prior to being served breakfast, and DSP #4 stated, "I'm hurrying buddy." Client #2 ate his pancake in two bites then took client #6's pancake without staff present to observe. Client #7 ate his</p>			

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	<p>pancake with his hands, then took client #3's oatmeal and poured it into a his bowl and ate it. Client #1's oatmeal in a bowl fell to the floor, but staff did not see the bowl fall. DSP #4 asked what happened to client #1's oatmeal and was told by the surveyor his bowl had fallen to the floor. DSP #4 was present to observe client #7 taking client #3's oatmeal and then left the clients in the dining room to prepare more oatmeal for clients #1 and #3.</p> <p>Client #8 ate a pancake ground into a grainy texture and client #6 pounded the table 5 times during the meal when staff were not present. Client #7 took client #2's remaining pancake and client #2 took client #1's pancake and ate it unobserved by staff who were not present. Client #6 hit the table again and client #7 took client #3's nutritional substitute and poured it into his glass. Client #1 did not receive a nutritional substitute and tried to eat from client #3's oatmeal bowl, then took a bite of food laying on the table top. Client #6 gave client #3 his tea and client #1 drank the tea after client #3 drank some of it.</p> <p>During confidential interview, the interview indicated two staff in the home during the morning during the breakfast meal were not adequate to address the clients' needs.</p>			

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	<p>The Area Director (AD) was interviewed on 10/9/15 at 9:39 AM and indicated there were normally three staff working in the group home during morning and evening meals, and the facility was reviewing client schedules and staff deployment to ensure clients were not eating meals and receiving medication at the same time to provide more staff supervision at mealtimes.</p> <p>The Home Manager (HM), the Qualified Intellectual Disabilities Professional (QIDP) and the Area Director (AD) were interviewed on 9/28/15 at 3:18 P.M. When asked how many staff normally work at the group home during awake hours. The AD stated "It's 2-3 usually, it depends. Part of our plan is to have management in there more." The HM and the QIDP both shook their heads "no" when asked if even 4 staff were enough to meet the clients' needs at meal times. The AD was asked when she had last observed a meal at the group home and indicated it had been awhile.</p> <p>9-3-8(a)</p>			

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W 0487 Bldg. 00	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client receives enough food. Based on observation, record review and interview, the facility failed to provide a sufficient amount of food at meals to allow for second servings, and to provide nutritional supplements as prescribed by their physician and to meet the nutritional needs for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8).</p> <p>Findings include</p> <p>Observations were conducted on 9/21/15 between 4:55 P.M. and 6:58 P.M. including the evening meal at 5:29 P.M. The evening meal provided was spaghetti with meat sauce, whole kernel corn, tossed salad, choice of two salad dressings and iced tea or milk. The clients were not offered or encouraged to eat second servings, not provided substitutions for salad or corn and not provided their nutritional supplements.</p> <p>During observations at the group home on 9/22/15 from 5:05 PM until 5:45 PM, clients #1, #2, #3, #4, #5, #6, #7 and #8 were in the dining room. Direct Support Staff (DSP) #1 and DSP #6 were the only staff in the home during the observation. DSP #6 prepared lasagna, creamed corn</p>	W 0487	<p>All direct care staff will receive retraining on mealtime protocols including ensuring that all consumers are receiving a sufficient amount of food as designated by the menu and the consumers diet orders. Training will include ensuring that extra portions are offered as designated by individual consumers diet orders. In addition, training will include ensuring that if an item on the menu is not conducive to preparing for consumers that have modified diet orders that appropriate substitutions are provided. All direct care staff will receive retraining to include ensuring that consumers are offered nutritional supplements as directed by the consumers PCP and/or dietician. The Program Coordinator and/or QIDP will complete mealtime observations at least three times weekly for 4 weeks to ensure that consumers are being offered sufficient amounts of food, are offered appropriate substitutions, staff are following diet orders and consumers are being offered their nutritional supplements as directed.</p> <p>Ongoing after the 4 weeks the Program Coordinator and/or QIDP will complete mealtime</p>	11/18/2015			

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	<p>and green beans and poured into the same bowl causing the food to run together. The bowls of food were prepared in the adjacent kitchen by staff #6 and lined up on the counter before she placed the bowls in front of the clients seated at the dining room table. There were no second servings offered or encouraged until the surveyor asked if client #1 was permitted seconds and DSP #6 then heated up a pot pie for client #1.</p> <p>DSP #6 was interviewed on 9/22/15 at 5:15 PM and indicated client #1 received a pureed diet. When the surveyor pointed out the chunks of food in client #1's bowl, DSP #6 took his bowl and clients #1 did not receive a liquid nutritional supplement during the meal. DSP #1 and #6 did not offer a second portion and DSP #6 began washing dishes after the meal.</p> <p>DSP #6 was interviewed again on 9/22/15 at 5:40 PM. When asked about additional food for client #1, DSP #6 indicated she had more food for him.</p> <p>During observations on 9/25/15 from 7:10 AM until 8:20 AM, there were two staff in the home, DSPs #4 and #8. Clients #1, #2, #3, #4, #5, #6, #7 and #8 sat in the dining room unattended while DSPs #4 and #8 made breakfast in an</p>		<p>observations at least twice weekly to ensure that consumers are being offered sufficient amounts of food, are offered appropriate substitutions, staff are following diet orders and consumers are being offered their nutritional supplements as directed.</p> <p>Responsible Party: Program Coordinator, QIDP</p>		

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	<p>adjacent kitchen upon arrival at the group home. DSP #8 prepared instant oatmeal by tearing open 2 packages and added milk without measuring the amount. DSP #8 poured sugar coated cereal with marshmallow bits and milk into a bowl for client #4 without measuring the amount. DSP #8 then administered medications and DSP #4 finished preparing breakfast for clients #1, #2, #3, #4, #5, #6, #7 and #8 consisting of instant oatmeal, pancakes, milk and tea. DSP #4 brought individual portions of oatmeal and pancakes to the table after they were heated up one at a time. Client #2 yelled out and stood up prior to being served breakfast, and DSP #4 stated, "I'm hurrying buddy." Client #1's oatmeal in a bowl fell to the floor, but staff did not see the bowl fall and client #7 ate client #3's oatmeal. DSP #4 asked what happened to client #1's oatmeal and was told by the surveyor his bowl had fallen to the floor. DSP #4 left the clients in the dining room to prepare more oatmeal for clients #1 and #3. Client #8 ate a pancake ground into a grainy texture that was prepared and placed in front of him. Client #1 did not receive a liquid nutritional supplement during the breakfast meal.</p> <p>DSP #4 was interviewed on 9/25/15 at 8:15 AM and when asked about juice as indicated on the menu, indicated the</p>			

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	<p>orange juice was frozen and therefore not served at the meal. She indicated client #1 did not receive a nutritional supplement.</p> <p>Client #1's records were reviewed on 9/22/15 at 2:25 PM. Client #1's nutritional assessments indicated the following: An assessment dated 10/15/14 indicated client #1 was "underweight" for his height and had a body mass index of 18.5. The assessment indicated goals to "increase weight...Noted [liquid nutritional supplement] was recommended in the past. No order noted at this time. Add [liquid nutritional supplement] TID (three times daily) to promote weight gain." An assessment dated 1/6/15 indicated "...Noted RN aware of [liquid nutritional supplement] recommend (sic) at last visit. Per staff, supplement is not on MAR (medication administration record). Recommend [liquid nutritional supplement] TID added to MAR to help with wt (weight) gain..." An assessment dated 6/10/15 indicated "...Still recommend supplement of [liquid nutritional supplement] BID (twice daily)-0 orders noted yet...Reg (regular) high cal (calorie) soft diet and 2 c (cups) of fortified cereal every morning. Rec (recommend) add oral nutrition supplement morning and evening HS (bedtime). Client #1's physician's orders</p>			

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	<p>dated 9/1/15 failed to indicate a liquid nutritional supplement.</p> <p>Client #2's record was reviewed on 9/23/15 at 2:58 P.M. Client #2's Physician's Orders (PO) dated for 9/2015 indicated client #2 was to have Boost (nutritional supplement) 1 can 4 times a day. Regular high fiber diet, 2 cups of [name] cereal daily at breakfast. Client #2's Nutritional Assessment dated 6/10/2015 indicated "CBW (current body weight) 124 pounds BMI (body mass index) 17.8 below by 3.8%... though considered underweight for height (70 inches)...recommend to offer extra portions at meal times. Goal to increase weight by 2 pounds next quarter." Client #2's Individual Support Plan (ISP) dated 7/22/15 indicated client #2's "desired body weight was 160-178 pounds."</p> <p>Client #3's record was reviewed on 9/22/15 at 2:28 P.M. Client #3's Physician's Orders dated for 9/2015 indicated client #3 was to have a "soft high calorie diet, with 8 ounces of Ensure (nutritional supplement) four times a day to increase albumin, may have at meals." Client #3's nutritional assessment dated 6/10/15 indicated "73 pounds, BMI 14.7 (underweight) 12% loss between Feb. (February) 2015 - May 2015, spoke with staff, reports, client went to nursing home</p>			

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	<p>during this period and did not eat well in the unfamiliar environment. Client returned mid (middle) of May ... Spoke with staff and recommend to add ice cream to ensure for added carb/fats...."</p> <p>Client #3's ISP dated 5/14/15 indicated client #3's desired weight was 106-130 pounds." Client #3's 9/2015 MAR did not indicate current weight. Weight for July, 2015 was 80 pounds as indicated on the nutritional assessment.</p> <p>Client #4's record was reviewed on 9/28/15 at 2:15 P.M. Client #4's ISP dated 3/19/15 indicated he was to have a "regular soft diet, mechanical, Boost twice daily. Client #4's MAR for 9/2015 did not indicate current weight. His ISP indicated his weight was "138 pounds and he was 65.5 inches tall. His ideal body weight range was 126-167."</p> <p>Client #5's record was reviewed on 9/28/15 at 12:35 P.M. Client #5's PO dated for 9/2015 indicated client #5 was prescribed a regular low fat, low cholesterol, NCS (no concentrated sweets) diet with Boost once daily.</p> <p>Client #6's record was reviewed on 9/29/15 at 3:28 P.M. Client #6's PO dated for 9/2015 indicated he was prescribed a "regular, no extra portions" diet.</p>			

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W 0488	<p>Client #7's record was reviewed on 9/29/15 at 3:47 P.M. Client #7's PO dated for 9/2015 indicated he was prescribed a "regular, no extra portions" diet.</p> <p>Client #8's record was reviewed on 9/22/15 at 2:29 P.M. Client #8's PO dated for 9/2015 indicated he was to have a "pureed diet, may have extra portions."</p> <p>The Area Director and the nurse were interviewed on 9/23/15 at 2:50 PM and indicated clients should have been offered seconds and the clients should have received their liquid nutritional supplements during meals.</p> <p>9-3-8(a)</p>			
	483.480(d)(4)			

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Bldg. 00	<p>DINING AREAS AND SERVICE</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview, the facility failed to encourage 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) to participate in the dining process as much as possible.</p> <p>Findings include:</p> <p>Observations were conducted on 9/21/15 between 4:55 P.M. and 6:58 P.M. including the evening meal at 5:29 P.M. There were four staff working, the Home Manager (HM), Direct Care Staff (DCS) #1, #2 and #3. DCS #1 and #2 set the table for dinner. The staff prepared the meal (spaghetti with meat sauce, corn, salad, two salad dressings, tea and milk) and put the items on the table. The clients were offered choice of tea or milk. The clients were assisted in serving themselves hand-over-hand. Towards the end of the meal Direct Care Staff (DCS) #3 scraped all of client #3's food together on his plate mixing it all together for him to eat the remaining foods. After the meal clients #2 and #7 took their plate to the kitchen sink.</p> <p>During observations at the group home on 9/22/15 from 5:05 PM until 5:45 PM,</p>	W 0488	<p>All Direct Support staff will receive retraining on ensuring that active treatment opportunities are being provided to clients, especially at mealtime, based on their developmental levels. Training will include ensuring that consumers are offered opportunities to assist with meal preparation and serve themselves their meals based on their developmental disability.</p> <p>The Program Coordinator, Program Nurse and/or QIDP will complete mealtime observations at least three times weekly for 4 weeks to ensure that consumers are being offered opportunities to assist with meal preparation and serving themselves meals based on their developmental abilities.</p> <p>Ongoing after the 4 weeks the Program Coordinator, Program Nurse and/or QIDP will complete mealtime observations at least twice weekly to ensure that consumers are being offered opportunities to assist with meal preparation and serving themselves meals based on their developmental abilities.</p> <p>Responsible Party: Program Coordinator, QIDP, Program Nurse</p>	11/18/2015			

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	<p>clients #1, #2, #3, #4, #5, #6, #7 and #8 were in the dining room. DSP #6 prepared lasagna, creamed corn and green beans and poured into the same bowl causing the food to run together. The bowls of food were prepared in the adjacent kitchen by staff #6 and lined up on the counter before she placed the bowls in front of the clients seated at the dining room table without involving the clients in meal preparation.</p> <p>DSP #6 was interviewed again on 9/22/15 at 5:40 PM. When asked if the clients liked to have their food mixed together into a bowl, she stated, "They're eating it."</p> <p>During observations on 9/25/15 from 7:10 AM until 8:20 AM, there were two staff in the home, DSPs #4 and #8. Clients #1, #2, #3, #4, #5, #6, #7 and #8 sat in the dining room unattended while DSPs #4 and #8 made breakfast in an adjacent kitchen upon arrival at the group home. DSP #8 prepared instant oatmeal by tearing open 2 packages and added milk. DSP #8 poured sugar coated cereal with marshmallow bits and milk into a bowl for client #4 without measuring the amount or involving client #4. DSP #8 then administered medications and DSP #4 finished preparing breakfast for clients #1, #2, #3, #4, #5, #6, #7 and #8</p>			

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	<p>consisting of instant oatmeal, pancakes, milk and tea while the clients sat unattended and unengaged in preparing breakfast in the dining room. DSP #4 brought individual portions of oatmeal and pancakes to the table after they were heated up one at a time. Client #2 yelled out and stood up prior to being served breakfast, and DSP #4 stated, "I'm hurrying buddy." Client #2 was not prompted to assist in preparing the meal and prompted to sit back down at the table. Client #1's oatmeal in a bowl fell to the floor, but staff did not see the bowl fall and client #7 ate client #3's oatmeal. DSP #4 asked what happened to client #1's oatmeal and was told by the surveyor his bowl had fallen to the floor. DSP #4 left the clients in the dining room to prepare more oatmeal for clients #1 and #3 without prompting clients #1 or #3 to assist in preparing their food. Client #8 ate a pancake ground into a grainy texture that was prepared and placed in front of him.</p> <p>The Area Director and the nurse were interviewed on 9/23/15 at 2:50 PM and indicated clients should have participated in preparing meals.</p> <p>9-3-8(a)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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