

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G476	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/08/2015
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2944 DIETZ ST INDIANAPOLIS, IN 46203
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W 0000 Bldg. 00	<p>This visit was for the annual recertification and state licensure survey. This visit included the investigation of complaint #IN00173627.</p> <p>Complaint #IN00173627: Unsubstantiated, due to lack of sufficient evidence.</p> <p>Dates of survey: 6/30/15, 7/1/15 and 7/8/15</p> <p>Facility Number: 000990 Provider Number: 15G476 AIMS Number: 100244930</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 2 of 4 sampled clients (A and B) plus 1 additional client DC (Deceased Client) A, the facility failed to</p>	W 0149	Area Director will retrain the Program Director on thoroughly completing investigations; to include interviewing all clients and potential witnesses and	08/07/2015

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

TITLE

(X6) DATE

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

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	<p>implement its policy and procedures to complete thorough investigations regarding an allegation of staff to client mistreatment for client B, an elopement incident for client A, the death of DC A and failed to implement recommendations to address and prevent client A's elopement behaviors.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 6/30/15 at 1:10 PM. The review indicated the following:</p> <p>1. BDDS report dated 3/14/15 indicated, "[Client B] reported to her staff today that another staff person called her a [expletive] while she was working with [client B] 2 PM- 10 PM on 3/13/15."</p> <p>-Summary of Internal Investigation Report (SIIR) dated 3/17/15 included a written narrative statement from client B which indicated, "On Friday I was on the phone with my friend [name]. [Staff #1] came up to me and told me it was time for dinner. [Staff #1] didn't ask me in a nice way, she was being mean about it. I told her I would eat dinner when I was done talking to [friend]. After a couple of minutes [staff #1] told me again to get off</p>		<p>adequately following up on client related concerns brought up during the course of an investigation. Regional Director will retrain the Quality Assurance Specialist on completing thorough death investigations; to include analysis of the evidence gathered and providing a finding fact and determination of whether the facility appropriately followed and addressed clients plans/needs leading to a passing. Investigations will be reviewed by the administrator upon completion and examined for required components needed for a thorough investigation. Area Director will retrain Program Director on therequirements for the use of a restriction as an intervention; to include,required approvals, inclusion of the intervention in a monitored plan and identifyingthe target behavior that requires the intervention in the plan as well asintervention techniques to prevent or respond t to the target behavior. An IDT meeting was held on 4/7/15 in relation to the3/28/15, but the documentation was not made available in the file at time ofsurvey. Area Director will retrain Program Director on adequate documentationand filing necessary documents appropriately to adequately reflect protective measures,recommendations and IDT participation following critical incidents. In conjunction with the</p>	

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	<p>of the phone and eat dinner. I told her I would eat when I wanted to. [Staff #1] then said a few choice words and I said a few choice words. [Staff #1] called me a [expletive] and [friend] heard her say it too."</p> <p>The 3/17/15 SIIR did not indicate documentation of interview with client B's friend or other clients in the home, clients A, C, D, E, F or G, as witnesses or potential witnesses to the alleged incident.</p> <p>2. BDDS report dated 10/28/14 indicated client A eloped from the group home and was returned to the group home by a neighbor.</p> <p>-BDDS report dated 3/28/15 indicated, "On 3/27/15, [client A] vacated the group home (and) walked about 3 blocks down the street before staff picked [client A] (up) in the company vehicle."</p> <p>-SIIR dated 4/6/15 indicated, "When I picked [client A] up from day program it took me and two of the day program workers to get him into the van, using a wheelchair because he did not want to leave."</p> <p>The SIIR dated 4/6/15 did not indicate documentation of reconciliation of staff's statement regarding the use of a</p>		<p>IDT, the Program Director will add elopement and the restrictive intervention used for client A into the Behavior Support plan and Individual Support Plan. Program Director will obtain necessary Guardian and HRC approval for the restriction. Upon approval, Program Director will facilitate necessary trainings for residential and day program staff on the implementation of the restrictive intervention techniques identified in the plan. Program Director will review plans for all clients in the home to ensure all target behaviors and any restrictive interventions are appropriately addressed in the plan and all required approvals have been obtained. Program Director will submit all client ISPs and BSPs to the Area Director and Quality assurance Specialist at each annual update or as amendments are needed. Internal Program audits will be completed by the Quality Assurance Specialist at least annually to include thorough record review and adequate plan implementation. Findings will be reported to the Program Director and Area Director and findings will be addressed appropriately within 10 business days. Responsible Party: Regional Director, Area Director, Program Director, Quality assurance Specialist</p>	

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	<p>wheelchair as an intervention to facilitate client A's involuntary departure from day services.</p> <p>-Follow up BDDS report dated 4/3/15 indicated, "IDT (Interdisciplinary Team) will meet on 4/7/15 to add elopement into [client A's] plans and to put safety measures in place."</p> <p>Observations were conducted at the group home on 6/30/15 from 4:30 PM through 5:45 PM and on 7/1/15 from 6:20 AM through 7:45 AM. Client A was observed throughout both observation periods and did not utilize a wheelchair or other adaptive device to ambulate.</p> <p>Client A's record was reviewed on 7/1/15 at 12:58 PM. Client A's BSP (Behavior Support Plan) dated 11/15/14 and/or ISP (Individual Support Plan) dated 11/15/14 did not indicate staff should utilize a wheelchair as an intervention to address client A's refusals to leave an area. Client A's BSP dated 11/15/14 did not indicate documentation of elopement as a targeted behavior or describe intervention techniques to prevent or respond to client A's elopement behaviors.</p> <p>Client A's record did not indicate documentation of IDT review or recommendations to assess client A's</p>			

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	<p>elopement intervention needs.</p> <p>3. BDDS report dated 5/17/15 indicated, "[DC A] was checked on/woke up by staff at 5:45 AM but [DC A] did not want to get up so staff let him stay in bed. At approximately 7:00 AM, staff went to wake up [DC A] again and she found him cold and unresponsive. One staff immediately started CPR (Cardiopulmonary Resuscitation) (first aid) while the other staff called 911. EMS (Emergency Medical Services) arrived 3 minutes later and took over care. EMS announced [DC A] dead. Cause of death is unknown at this time but suspected prolonged seizure or complications of a seizure."</p> <p>-SIIR dated 5/22/15 indicated, "Conclusion: Cause of death is pending receipt of death certificate."</p> <p>The 5/22/15 SIIR did not indicate documentation of an analysis of the evidence gathered, and a finding of fact and determination as to whether client rights were violated.</p> <p>AD (Area Director) #1 was interviewed on 7/1/15 at 2:22 PM. AD #1 indicated a thorough investigation should include documentation of an analysis of the evidence gathered and a finding of fact</p>						

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	<p>and determination as to whether client rights were violated. AD #1 indicated all witnesses and potential witnesses to alleged incidents should be interviewed in the investigation of the allegation. AD #1 indicated the SIIR dated 4/6/15 regarding client A did not address staff's statements regarding the use of a wheelchair as a behavior intervention technique to address client A's refusals to leave the day services. AD #1 indicated client A's BSP/ISP did not indicate staff should utilize a wheelchair as a behavior intervention technique to address client A's refusal s to leave the day services or other areas. AD #1 indicated the follow up BDDS report dated 4/3/15 recommendation for the IDT to review client A's BSP/ISP regarding elopement behaviors. AD #1 indicated there was not documentation of IDT review or recommendations regarding client A's elopement behavior. AD #1 indicated the facility's abuse and neglect policy should be implemented, investigations of allegations of abuse, neglect and mistreatment should be thoroughly investigated and recommendations to prevent recurrence should be developed and implemented.</p> <p>The facility's policy and procedures were reviewed on 7/8/15 at 11:08 AM. The facility's Quality and Risk Management</p>			
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W 0154 Bldg. 00	<p>policy dated 4/2011 indicated the following:</p> <p>- "Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor services thorough 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."</p> <p>The 4/2011 Quality and Risk Management Policy indicated, "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 AD for review wand development of further recommendations as needed within 5 days of the incident."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on observation, record review and</p>	W 0154	Area Director will retrain the Program Director onthoroughly	08/07/2015			

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	<p>interview for 3 of 5 allegations of abuse, neglect or mistreatment reviewed, the facility failed to complete thorough investigations regarding an allegation of staff to client mistreatment for client B, an elopement incident for client A and the death of DC (Deceased Client) A.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 6/30/15 at 1:10 PM. The review indicated the following:</p> <p>1. BDDS report dated 3/14/15 indicated, "[Client B] reported to her staff today that another staff person called her an [expletive] while she was working with [client B] 2 PM- 10 PM on 3/13/15."</p> <p>-Summary of Internal Investigation Report (SIIR) dated 3/17/15 included a written narrative statement from client B which indicated, "On Friday I was on the phone with my friend [name]. [Staff #1] came up to me and told me it was time for dinner. [Staff #1] didn't ask me in a nice way, she was being mean about it. I told her I would eat dinner when I was done talking to [friend]. After a couple of minutes [staff #1] told me again to get off of the phone and eat dinner. I told her I</p>		<p>completing investigations; to include interviewing all clients and potential witnesses and adequately following up on client related concerns brought up during the course of an investigation.</p> <p>Regional Director will retrain the Quality Assurance Specialist on completing thorough death investigations; to include analysis of the evidence gathered and providing a finding fact and determination of whether the facility appropriately followed and addressed clients plans/needs leading to a passing.</p> <p>Investigations will be reviewed by the administrator upon completion and examined for required components needed for a thorough investigation.</p> <p>Responsible Party: Area Director, Regional Director</p>	

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	<p>would eat when I wanted to. [Staff #1] then said a few choice words and I said a few choice words. [Staff #1] called me an [expletive] and [friend] heard her say it too."</p> <p>The 3/17/15 SIIR did not indicate documentation of interview with client B's friend or other clients in the home, clients A, C, D, E, F or G, as witnesses or potential witnesses to the alleged incident.</p> <p>2. BDDS report dated 3/28/15 indicated, "On 3/27/15, [client A] vacated the group home (and) walked about 3 blocks down the street before staff picked [client A] (up) in the company vehicle."</p> <p>-SIIR dated 4/6/15 indicated, "When I picked [client A] up from day program it took me and two of the day program workers to get him into the van, using a wheelchair because he did not want to leave."</p> <p>The SIIR dated 4/6/15 did not indicate documentation of reconciliation of staff's statement regarding the use of a wheelchair as an intervention to facilitate client A's involuntary departure from day services.</p> <p>Observations were conducted at the group home on 6/30/15 from 4:30 PM</p>			

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	<p>through 5:45 PM and on 7/1/15 from 6:20 AM through 7:45 AM. Client A was observed throughout both observation periods and did not utilize a wheelchair or other adaptive device to ambulate.</p> <p>Client A's record was reviewed on 7/1/15 at 12:58 PM. Client A's BSP (Behavior Support Plan) dated 11/15/14 and/or ISP (Individual Support Plan) dated 11/15/14 did not indicate staff should utilize a wheelchair as an intervention to address client A's refusals to leave an area.</p> <p>3. BDDS report dated 5/17/15 indicated, "[DC A] was checked on/woke up by staff at 5:45 AM but [DC A] did not want to get up so staff let him stay in bed. At approximately 7:00 AM, staff went to wake up [DC A] again and she found him cold and unresponsive. One staff immediately started CPR (Cardiopulmonary Resuscitation) (first aid) while the other staff called 911. EMS (Emergency Medical Services) arrived 3 minutes later and took over care. EMS announced [DC A] dead. Cause of death is unknown at this time but suspected prolonged seizure or complications of a seizure."</p> <p>-SIIR dated 5/22/15 indicated, "Conclusion: Cause of death is pending receipt of death certificate."</p>			

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	<p>The 5/22/15 SIIR did not indicate documentation of an analysis of the evidence gathered, and a finding of fact and determination as to whether client rights were violated.</p> <p>AD (Area Director) #1 was interviewed on 7/1/15 at 2:22 PM. AD #1 indicated a thorough investigation should include documentation of an analysis of the evidence gathered and a finding of fact and determination as to whether client rights were violated. AD #1 indicated all witnesses and potential witnesses to alleged incidents should be interviewed in the investigation of the allegation. AD #1 indicated the SIIR dated 4/6/15 regarding client A did not address staff's statements regarding the use of a wheelchair as a behavior intervention technique to address client A's refusals to leave the day services. AD #1 indicated client A's BSP/ISP did not indicate staff should utilize a wheelchair as a behavior intervention technique to address client A's refusal s to leave the day services or other areas. AD #1 indicated all allegations of abuse, neglect and mistreatment should be thoroughly investigated.</p> <p>9-3-2(a)</p>			

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W 0157 Bldg. 00	<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 for 1 of 5 allegations of abuse, neglect or mistreatment reviewed, the facility failed to implement recommendations to address and prevent client A's elopement behaviors.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 6/30/15 at 1:10 PM. The review indicated the following:</p> <p>-BDDS report dated 10/28/14 indicated client A eloped from the group home and was returned to the group home by a neighbor.</p> <p>-BDDS report dated 3/28/15 indicated, "On 3/27/15, [client A] vacated the group home (and) walked about 3 blocks down the street before staff picked [client A] (up) in the company vehicle."</p> <p>-Follow up BDDS report dated 4/3/15 indicated, "IDT (Interdisciplinary Team) will meet on 4/7/15 to add elopement into</p>	W 0157	<p>An IDT meeting was held on 4/7/15 in relation to the 3/28/15, but the documentation was not made available in the file at time of survey. Area Director will retrain Program Director on adequate documentation and filing necessary documents appropriately to adequately reflect protective measures, recommendations and IDT participation following critical incidents. In conjunction with the IDT, the Program Director will add elopement and the restrictive intervention used for client A into the Behavior Support plan and Individual Support Plan. Program Director will obtain necessary Guardian and HRC approval for the restriction. Upon approval, Program Director will facilitate necessary trainings for residential and day program staff on the implementation of the restrictive intervention techniques identified in the plan. Program Director will review plans for all clients in the home to ensure all target behaviors and any restrictive interventions are appropriately addressed in the plan and all required approvals have been obtained. Responsible party: Area Director, Program Director</p>	08/07/2015

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	<p>[client A's] plans and to put safety measures in place."</p> <p>Client A's record was reviewed on 7/1/15 at 12:58 PM. Client A's BSP (Behavior Support Plan) dated 11/15/14 did not indicate documentation of elopement as a targeted behavior or describe intervention techniques to prevent or respond to client A's elopement behaviors.</p> <p>Client A's record did not indicate documentation of IDT review or recommendations to assess client A's elopement intervention needs.</p> <p>AD (Area Director) #1 was interviewed on 7/1/15 at 2:22 PM. AD #1 indicated the follow up BDDS report dated 4/3/15 recommendation for the IDT to review client A's BSP regarding elopement behaviors. AD #1 indicated there was not documentation of IDT review or recommendations regarding client A's elopement behavior. AD #1 indicated the facility's abuse and neglect policy should be implemented, investigations of allegations of abuse, neglect and mistreatment should be thoroughly investigated and recommendations to prevent recurrence should be developed and implemented.</p> <p>9-3-2(a)</p>			

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W 0287 Bldg. 00	<p>483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>Techniques to manage inappropriate client behavior must never be used for the convenience of staff.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (A), the facility failed to ensure staff did not utilize unapproved intervention techniques to address client A's refusal to leave his day service provider.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 6/30/15 at 1:10 PM. The review indicated the following:</p> <p>-BDDS report dated 10/28/14 indicated client A eloped from the group home and was returned to the group home by a neighbor.</p> <p>-BDDS report dated 3/28/15 indicated, "On 3/27/15, [client A] vacated the group home (and) walked about 3 blocks down the street before staff picked [client A] (up) in the company vehicle."</p> <p>-SIIR dated 4/6/15 indicated, "When I</p>	W 0287	<p>Area Director will retrain Program Director on the requirements for the use of a restriction as an intervention; to include, required approvals, inclusion of the intervention in a monitored plan and identifying the target behavior that requires the intervention in the plan as well as intervention techniques to prevent or respond t to the target behavior. An IDT meeting was held on 4/7/15 in relation to the 3/28/15, but the documentation was not made available in the file at time of survey. Area Director will retrain Program Director on adequate documentationand filing necessary documents appropriately to adequately reflect protective measures, recommendations and IDT participation following critical incidents. In conjunction with the IDT, the Program Director will add elopementand the restrictive intervention used for client A into the Behavior Support planand Individual Support Plan. Program Director will obtain necessary Guardianand HRC approval for the restriction. Upon approval, Program Director will facilitate necessary trainings forresidential</p>	08/07/2015

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	<p>picked [client A] up from day program it took me and two of the day program workers to get him into the van, using a wheelchair because he did not want to leave."</p> <p>The SIIR dated 4/6/15 did not indicate documentation of reconciliation of staff's statement regarding the use of a wheelchair as an intervention to facilitate client A's involuntary departure from day services.</p> <p>Observations were conducted at the group home on 6/30/15 from 4:30 PM through 5:45 PM and on 7/1/15 from 6:20 AM through 7:45 AM. Client A was observed throughout both observation periods and did not utilize a wheelchair or other adaptive device to ambulate.</p> <p>Client A's record was reviewed on 7/1/15 at 12:58 PM. Client A's BSP (Behavior Support Plan) dated 11/15/14 and/or ISP (Individual Support Plan) dated 11/15/14 did not indicate staff should utilize a wheelchair as an intervention to address client A's refusals to leave an area. Client A's BSP dated 11/15/14 did not indicate documentation of elopement as a targeted behavior or describe intervention techniques to prevent or respond to client A's elopement behaviors.</p> <p>AD (Area Director) #1 was interviewed</p>		<p>and day program staff on the implementation of the restrictiveintervention techniques identified in the plan. Program Director will review plans for all clients in thehome to ensure all target behaviors and any restrictive interventions areappropriately addressed in the plan and all required approvals have been obtained. Program Director will submit all client ISPs and BSPs to theArea Director and Quality assurance Specialist at each annual update or as amendmentsare needed. In person, Quarterly HRC Reviews are held to review allclient target behaviors and restrictions. Responsible party: Area Director, Program Director</p>				

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W 0331 Bldg. 00	<p>on 7/1/15 at 2:22 PM. AD #1 indicated client A's BSP/ISP did not indicate staff should utilize a wheelchair as a behavior intervention technique to address client A's refusals to leave the day services or other areas.</p> <p>9-3-5(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 additional client (DC (Deceased Client) A), the facility nursing services failed to ensure DC A's seizure protocol included specific monitoring following the use of a PRN (As Needed) seizure medication.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 6/30/15 at 1:10 PM. The review indicated the following:</p> <p>-BDDS report dated 5/17/15 indicated, "[DC A] was checked on/woke up by staff at 5:45 AM but [DC A] did not want to get up so staff let him stay in bed. At approximately 7:00 AM, staff went to wake up [DC A] again and she found him</p>	W 0331	<p>Facility Nurse will be retrained by Nursing Director on establishing protocols to include instructions on specific monitoring following the use of a prescribed PRN medication. Facility Nurse will review all client protocols to ensure all monitoring instructions are identified; as well as identifying client status changes that require the nurse to be notified. Facility Nurse will train the staff on any protocol updates made during review and train staff on examining client status changes and when to notify the nurse. Facility Nurse will also train staff on when and where to document client status changes when monitoring based on client medical protocols. Home Manager will complete weekly documentation review to include review of MAR and necessary documentation of client status changes to ensure adequate</p>	08/07/2015

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	<p>cold and unresponsive. One staff immediately started CPR (Cardiopulmonary Resuscitation) (first aid) while the other staff called 911. EMS (Emergency Medical Services) arrived 3 minutes later and took over care. EMS announced [DC A] dead. Cause of death is unknown at this time but suspected prolonged seizure or complications of a seizure."</p> <p>-Summary of Internal Investigation Report (SIIR) dated 5/22/15 indicated the following:</p> <p>-DC A experienced seizures on 5/16/15 at 8:00 AM and at 12:20 PM.</p> <p>-Facility staff notified the facility nurse at 12:30 PM on 5/16/15 to request approval to administer DC A's PRN seizure medication.</p> <p>-At 12:30 PM, DC A received Diastat 10 milligrams rectally.</p> <p>-DC A went to bed where he remained until prompted to eat dinner (unknown time). DC A refused to eat dinner, was given an Ensure (dietary supplement) and returned to bed.</p> <p>-DC A remained in bed from dinner time on 5/16/15 through the night until his death the morning of 5/17/15 at 7:00 AM.</p> <p>The 5/22/15 SIIR indicated staff #2</p>		<p>implementation. Facility nurse will complete documentation review at least monthly to include client protocols and staff documentation to ensure adequate implementation and staff has reported concerns to her per plan requirement. Program Director will complete home audit to include documentation review to ensure adequate implementation. Responsible Party: Facility Nurse, Home Manager, Program Director, Nursing Director</p>				

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	<p>administered DC A's seizure PRN, Diastat, at 12:30 PM. Staff #2's written narrative statement indicated, "Said after administering the Diastat she checked on [DC A] every 15 minutes thereafter. Said [DC A] stayed in bed after the second seizure and remained there until she left her shift." Staff #2's written narrative statement indicated, "Said [DC A] was 'a little loopy' from the Diastat." The 5/22/15 SIIR did not indicate documentation of staff #2 notifying the facility nurse regarding DC A's prolonged drowsiness.</p> <p>The 5/22/15 SIIR indicated, "[Staff #3] reported to work at 2:00 PM and worked until 10:00 PM on 5/16/15. [DC A] was in bed when she arrived and he stayed there until dinner time. [DC A's] brother visited [DC A] in his room. [DC A] came out of his room for dinner but refused to eat. [DC A] did consume a can of Ensure and returned to bed. [Staff #3] specifically checked on [DC A] at least once every hour.... When [staff #4] relieved her at 10:00 PM, she informed him that [DC A] had experienced two seizures that day, Diastat had been administered and he had been 'out of it' for the day." The 5/22/15 SIIR did not indicate documentation of staff #3 notifying the facility nurse regarding DC A's prolonged drowsiness or refusal to eat</p>			

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	<p>his evening meal.</p> <p>The 5/22/15 SIIR indicated, "The previous night (5/16/15), [DC A's] brother came to visit [DC A] and stated that [DC A] did not seem like himself. When asked to explain, he stated [DC A] is normally very talkative and he was not talking very much."</p> <p>Staff #2 was interviewed on 7/1/15 at 12:55 PM. Staff #2 indicated DC A remained in bed from 12:30 PM through the end of her shift following his Diastat PRN seizure medication. Staff #2 indicated she monitored DC A every 15 minutes but did not document her observations or concerns. When asked specifically what she was monitoring DC A for, staff #2 stated, "To see if he was comfortable, needed anything or if his pillow needed adjusted." When asked if the facility nurse had indicated any specific side effects such as drowsiness, headache, nervousness or abdominal pain occurred following the administration of DC A's Diastat, staff #2 stated, "No." Staff #2 indicated she did not contact nursing services to report DC A's drowsiness.</p> <p>Staff #3 was interviewed on 7/1/15 at 1:00 PM. Staff #3 indicated DC A was in his bed when she arrived for her shift at</p>						

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	<p>2:00 PM, remained there until dinner, refused to eat dinner and returned to bed where he remained through the end of her shift at 10:00 PM. Staff #3 indicated she did not notify the facility nurse regarding DC A's prolonged drowsiness or refusal to eat the evening meal. Staff #3 indicated she had not been given specific instructions regarding how to monitor and document DC A's behavior following the administration of Diastat.</p> <p>Nurse #1 was interviewed on 7/1/15 at 1:07 PM. Nurse #1 indicated staff #2 contacted her on 6/15/15 at 12:20 PM to notify her that DC A had two seizures and requested to administer DC A's PRN Diastat. Nurse #1 indicated she was not notified of concerns of DC A's prolonged drowsiness or refusal to eat. When asked when staff should notify the nurse regarding DC A's behavior following receiving his PRN Diastat, Nurse #1 stated, "Anytime there is any unusual behavior. I would hope they would notify me of anything out of the usual." Nurse #1 indicated DC A's 1/3/13 Diastat protocol should include specific monitoring instructions regarding DC A's behavior following him receiving his PRN Diastat.</p> <p>DC A's record was reviewed on 7/1/15 at 9:40 AM. DC A's Physician's Orders</p>			

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W 0436 Bldg. 00	<p>form dated 4/30/15 indicated, "Diazepam (seizures) 10 milligrams. Diazepam/Diastat 10 milligrams universal system. Insert 10 milligrams rectally as needed for prolonged seizures greater than 3 minutes...." DC A's Diastat Protocol dated 1/3/13 indicated, "Common side effects of this medication include: decreased coordination, diarrhea, dizziness, drowsiness, headache, nervousness, abdominal pain and nasal congestion. If rash, hives, itching, difficulty breathing, swelling of face, lips, mouth and/or tongue occurs, please notify the program nurse before using the medication again." The 1/3/13 Diastat Protocol did not indicate documentation of how staff should monitor DC A following the use of the Diastat, at what point staff should notify nursing staff regarding DC A's extended period of drowsiness and refusal to eat and/or how staff should document monitoring of DC A's behavior following the use of Diastat.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures,</p>				

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	<p>eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 1 of 3 clients with adaptive equipment (D), the facility failed to ensure client D utilized his prescription eyeglasses.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 6/30/15 from 4:30 PM through 5:45 PM and on 7/1/15 from 6:20 AM through 7:45 AM. Client D was observed throughout the observation period. Client D did not wear eyeglasses.</p> <p>Client D's record was reviewed on 7/1/15 at 2:07 PM. Client D's Visual Care form dated 6/25/14 indicated client D should wear bifocal prescription eyeglasses.</p> <p>AD (Area Director) #1 was interviewed on 7/1/15 at 2:22 PM. AD #1 indicated client D's visual care recommendations should be implemented.</p> <p>9-3-7(a)</p>	W 0436	<p>Program Director will establish a goal for client D to address to use of his prescription eye glasses per recommendations Program Director will train staff on the established goal and consistent encouragement for client D to wear his glasses as well as all clients adaptive equipment needs. Home Manager and/or Program Director will complete activetreatment observations 3 times weekly for 30 days to ensure implementation ofgoal. Ongoing, Home Manager will complete observations perestablished frequency. Responsible Party: Program Director, Home Manager</p>	08/07/2015

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W 0488 Bldg. 00	<p>483.480(d)(4) 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, record review and interview for 1 of 4 sampled clients (A), the facility failed to ensure client A participated in the home's meal preparation to the extent of his capabilities.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 6/30/15 from 4:30 PM through 5:45 PM. At 5:15 PM, staff #5 placed client A's portion of the evening meal which consisted of spaghetti, tossed salad and garlic bread into a food processor. Staff #5 pureed client A's food, placed the pureed food onto a serving plate and then served client A the plate of food at the dining room table. Client A was not encouraged to participate in the preparation of his meal.</p> <p>Observations were conducted at the group home on 7/1/15 from 6:20 AM through 7:45 AM. At 6:30 AM, staff #3 placed portions of client A's meal which consisted of cereal and toast into a food processor. Staff #3 pureed client A's food, placed the pureed food onto a</p>	W 0488	<p>Program Director will establish a formal goal to encourage participation of Client A during mealtime preparation. Program Director will train staff on the established mealtime goal as well as the participation of all clients in meal preparation to the extent of their abilities. Home Manager and/or Program Director will complete mealtime observations 3 times weekly for 30 days to ensure implementation of goal. Ongoing, Home Manager will complete observations per established frequency. Responsible Party: Program Director, Home Manager</p>	08/07/2015

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	<p>serving plate and then served client A the plate of food at the dining room table. Client A was not encouraged to participate in the preparation of his meal.</p> <p>Client A's record was reviewed on 7/1/15 at 12:58 PM. Client A's ISP (Individual Support Plan) dated 11/15/14 indicated, "[Client A] should be encouraged to assist with setting the table, meal preparation and after meal clean up."</p> <p>AD (Area Director) #1 was interviewed on 7/1/15 at 2:22 PM. AD #1 indicated client A should be encouraged to participate in the meal preparation.</p> <p>9-3-8(a)</p>			