STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G383	A. BUILDING 00 B. WING	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REHABILITATION CENTER DEVELOPMENTAL SERVICES	2626 HELMUTH AVE EVANSVILLE, IN 47714

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W 0000 Bldg. 00	This visit was for a focused fundamental recertification and state licensure survey. Dates of Survey: 10/31/22, 11/1/22, 11/2/22, and 11/3/22. Facility Number: 000897 Provider Number: 15G383 AIM Number: 100235420 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/17/22.	W 0000		
W 0218 Bldg. 00	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility failed to ensure client #1's body position and the proper use of her wheelchair shoulder straps were assessed. Findings include: Observations was conducted on 10/31/22 from 3:17 PM to 5:20 PM and on 11/1/22 from 6:40 AM to 8:25 AM. The observations indicated the following: -At 3:27 PM, client #1 was seated in her wheelchair and was pulled up to the dining room table finishing up eating some pudding for a snack. As client #1 ate, she leaned out over the dining room table. Client #1 used her right hand to	W 0218	W218 Client #1, has a history of leaning forward in her wheelchair and her therapist have adjusted her seating and wheelchair straps to improve her positioning throughout the years that she has lived at Helmuth. Despite these efforts, it continues to be an issue and was observed during Helmuth's Annual survey. IDT met and agreed to have a wheelchair consult completed through the therapy department at Easterseals. The wheelchair evaluation was completed on 11/10/22. The OT adjusted her shoulder straps and specific placement of her shoulder	12/01/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Suzanne Ailstock	Residential Coordinator	12/01/2022

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	hold a spoon while she took bites of pudding by tilting her head sideways to her right. Client #1's head was approximately 6 inches above the surface of the dining room table while she ate. -At 3:35 PM, the Home Manager used a cloth to assist client #1 with cleaning some pudding off of her face. -At 3:38 PM, client #1 was seated in her wheelchair in the living room. Client #1's upper body leaned forward and her head was positioned above her knees. Client #1 had begun drooling. Due to the position of her head, the drool landed on client #1's right leg just above her knee. -At 4:28 PM, client #1 was in the hallway with a group of peers watching television. Client #1's left shoulder strap to her wheelchair hung off to the side of client #1's left arm. Client #1's upper body continued to lean forward and out over her lower legs. Client #1 continued to drool. -At 4:42 PM, client #1 continued to watch television with her peers. Client #1's left shoulder strap continued to hang off to the side of her left arm. Client #1 coughed and cleared her throat. The excessive drool came out of client #1's mouth and nose and due to her body position, fell onto her legs just above her knees. -At 4:47 PM, client #1 again coughed and drool from her mouth fell onto her legs. -At 5:08 PM, client #1 was seated in her wheelchair and pulled up to the dining room table for the start of the evening meal. Client #1 leaned forward out over her plate positioned on the dining room table.		straps was recommended. It was also recommended to have Amber in her wheelchair at a 25 degree angle at all times except when she is eating. All of Helmuth's group home staff have been trained on the specific placement of client #1's wheelchair positioning and shoulder strap placement. This includes having her in her wheelchair at a 25 degree angle at all times except when she is eating to improve the forward leaning. Preventatively, the QIDP's have been retrained on ensuring client's body position and wheelchair shoulder straps are assessed when needed to ensure her positioning and straps are appropriate. Systemically to prevent further occurrence, the Comprehensive Functional Assessment will be updated to assess further details of Sensorimotor skills. All of Easterseals QIDP's will be trained on the newly revised CAFA specific to the sensorimotor section of the assessment. This assessment will be completed at least annually.	

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	-At 5:10 PM, staff #1 brought client #1 a small plastic cup of pudding. Staff #1 stood to the left side of client #1. While attempting to take a bite of the pudding, client #1 tilted her head to her right and upward in an attempt to take a bite of the pudding from the spoon staff #1 was holding. The pudding fell from the spoon as client #1 tried to take a bite and landed on the surface of the table. Staff #1 used a plastic spoon to scoop up the pudding and successfully provided client #1 the bite of pudding on the second attempt. As staff #1 walked back toward the medication room, staff #1 was asked if she had provided client #1 medicine with the pudding she had served her. Staff #1 stated, "Yes. It was her calcium". Due to client #1's positioning, client #1 had to turn to her right and bend her neck upward when she attempted to take her pudding with calcium medication. The first attempt fell from client #1's mouth and the spoon onto the table. Morning observation: -At 6:40 AM, client #1 was in her bedroom with staff #2. Client #1 was completing her morning routine while staff #2 assisted her with dressing and getting ready for her day. -At 6:52 AM, staff #2 adjusted client #1's shoulder straps while client #1 was seated in her wheelchair. Staff #2 was asked if client #1's shoulder straps fit her. Staff #1 stated, "Yeah, they fit pretty good". Client #1's shoulder straps were crisscrossed in front of her and were not going vertically up and down over her shoulders like the evening observation on 10/31/22. -At 6:54 AM, client #1 used her motorized wheelchair to exit her bedroom. Client #1's shoulder straps were crisscrossed in front of her.			

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	Staff #4 verbally prompted client #1 to come to the medication room for her morning medicines. -At 6:59 AM, staff #4 assisted client #1 with her nasal spray. Staff #4 looked at client #1's shoulder straps and stated, "He crisscrossed them. I guess you're losing too much weight". -At 7:20 AM, staff #4 verbally prompted client #1 to sit up in her wheelchair as she attempted to provide client #1 her crushed medications in pudding. Staff #4 was asked what position client #1's wheelchair straps should be in. Staff #4 stated, "We used to crisscross them in the back. I wish they would have given her head straps". Staff #4 was asked when client #1 was last assessed for positioning in her wheelchair. Staff #4 stated, "She had that (wheelchair evaluation) about a year ago. She needs something to make her sit up. If we pull her straps tight, it cuts into her neck". Staff #4 was asked if client #1's body position affected her nasal drainage and drooling. Staff #4 stated, "Some days are worse than others". Staff #4 indicated client #1's primary care physician and an Ears, Nose and Throat (ENT) physician were monitoring client #1's nasal drainage and for gallstones. Staff #4 indicated client #1 was prescribed nasal spray by her team of physicians. On 11/1/22 at 8:10 AM, the Home Manager was interviewed. The Home Manager was asked about client #1's body position with the observation of nasal drainage and drool falling onto her lap. The Home Manager stated, "Yes. We've tried different types of seating systems. We've tried the plate in the front, she has no trunk control. She does that quite a bit (nasal drainage). We just took her to the doctor. They give her different types of nasal spray. That was last month. She's always had that.			

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	She went to the ENT, to look at her breathing. That's when they found her nasal cavity had not formed correctly. She was born that way". The Home Manager was asked about the straps to client #1's wheelchair fitting her and the correct positioning for them. The Home Manager stated, "They will fall down. PT (Physical Therapy) has treated it a couple different ways. We use the one going up and down. [Client #1] will lean forward if she falls asleep. When she is fully awake, the up and down (vertical shoulder straps) works well. If she is sleepy or not awake, the crisscross. Like a month ago, we used a breast plate, that was causing issues in her front with skin integrity". On 11/2/22 at 10:52 AM, a focused review of client #1's record was conducted. The review indicated the following: -Physical Therapy (PT) Consult dated 6/22/22 indicated, "Posture: Sitting forward head, leans forward ... knees slightly extended at times". The PT consult did not indicate the methodology for client #1's shoulder straps and/or how to secure her within her wheelchair by use of the straps to ensure appropriate body positioning, i.e. straps vertical, straps crisscross in the front, straps crisscross in the back or the use of a breast plate as strategies indicated through staff interviews to assist client #1 with body positioning while seated in her wheelchair. On 11/2/22 at 11:14 AM, the Nurse was interviewed. The Nurse was asked about client #1's body positioning in her wheelchair and the use of her shoulder straps. The Nurse stated, "That should be on her shoulders. It (PT consult) should say how she's to wear straps. I'll have to look further into that if you don't mind". At 11:30 AM, the Nurse provided additional follow-up and			

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	stated, "We need a wheelchair evaluation to make sure it (straps) fit her. We need to monitor her further on tone (muscle)". The Nurse indicated client #1's current consult was focused on exercise and client #1 required another assessment for proper fit and use of her shoulder straps while positioned in her wheelchair. On 11/3/22 at 3:47 PM, the Residential Director was interviewed. The Residential Director was asked about client #1's positioning in her wheelchair and the use of her shoulder straps. The Residential Director stated, "Yes. It sounds like she needs to be reevaluated to identify how to use the straps. Probably incorporate that into her safety protocol. We need to get that clarified and stated in paper (health risk protocol)". 9-3-4(a)			
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility failed to ensure client #1 had a plan to address supports, services, intervention and/or the monitoring of excessive nasal drainage and/or drooling. Findings include: Observations was conducted on 10/31/22 from 3:17 PM to 5:20 PM and on 11/1/22 from 6:40 AM to 8:25 AM. The observations indicated the following:	W 0227	W227 IDT met to discuss interventions related to Client #1's nasal drainage and drooling. IDT agreed to consult the medical team. Amber is having gall bladder issues and she is scheduled for surgery in late November. The medical team said her drooling has worsened likely due to nausea related to the gall bladder. This is expected to improve after surgery. Additionally, Amber sees an ENT	12/01/2022

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	-At 3:38 PM, client #1 was seated in her wheelchair in the living room. Client #1's upper body leaned forward with her head positioned above her knees. Client #1 had begun drooling. Due to the position of her head, the drool landed on client #1's right leg just above her knee. -At 4:28 PM, client #1 was in the hallway with a group of peers watching television. Client #1's left shoulder strap to her wheelchair hung off to the side of client #1's left arm. Client #1's upper body continued to lean forward and out over her lower legs. Client #1 continued to drool. -At 4:42 PM, client #1 continued to watch television with her peers. Client #1's left shoulder strap continued to hang off to the side of her left arm. Client #1 coughed and cleared her throat. The excessive drool came out of client #1's mouth and nose and due to her body position, fell onto her legs just above her knees. -At 4:47 PM, client #1 again coughed and drool from her mouth fell onto her legs. Morning observation: -At 6:59 AM, staff #4 assisted client #1 with her morning medicines. Staff #4 assisted client #1 with her nasal spray. -At 7:20 AM, staff #4 verbally prompted client #1 to sit up in her wheelchair as she attempted to provide client #1 her crushed medications in pudding. Staff #4 was asked if client #1's body position affected her nasal drainage and drooling. Staff #4 stated, "Some days are worse than others". Staff #4 indicated client #1's primary care physician and an Ears, Nose and Throat (ENT)		related to her nasal drainage. She is prescribed Azelastine nasal spray, as she has thickened mucous likely related to allergies. IDT agreed that Amber will be closely monitored and if the nasal drainage does not improve, additional consult with the ENT related to allergy medications will be sought. Preventatively, the medical team implemented a respiratory distress protocol to ensure staff awareness and monitoring of Client #1's drainage. The protocol includes instruction to reposition her and ensure she is elevating her head to prevent drainage. Also, she will sit at a 25 degree angle unless eating, and be tilted back in her wheelchair two to three times per day. The QIDP's, GH managers, and GH coordinators have been retrained to ensure they are monitoring for proper positioning and/or excessive drainage (saliva or nasal) with clients. If any concerns are noted, they are to report to the medical team and/or therapy as applicable. Systemically to prevent future occurrence, the Group Home Monthly Observation Checklist has been updated to include observation for client positioning and excessive drainage. The checklists are completed one to two times per month by the Group Home Managers and/or Group Home Coordinators. Adding the	

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	physician were monitoring client #1's nasal drainage and for gallstones. Staff #4 indicated client #1 was prescribed nasal spray by her team of physicians to aid with the excessive drainage. On 11/1/22 at 8:10 AM, the Home Manager was interviewed. The Home Manager was asked about client #1's body position with the observation of nasal drainage and drool falling onto her lap. The Home Manager stated, "Yes. We've tried different types of seating systems. We've tried the plate in the front, she has no trunk control. She does that quite a bit (nasal drainage). We just took her to the doctor. They give her different types of nasal spray. That was last month. She's always had that (nasal drainage). She went to the ENT, to look at her breathing. That's when they found her nasal cavity had not formed correctly. She was born that way". On 11/2/22 at 10:52 AM, a focused review of client #1's record was conducted. The review indicated the following: -CT Scan (imaging) dated 9/7/22 indicated, "CT Scan of sinus without contrast. Scan went well". -ENT consult dated 9/22/22 indicated, "Consultants Notes and Recommendations: Sinus CT reviewed ... Sinus surgery unlikely to be very beneficial ...". -No Health Risk Plan for the supports, interventions and/or monitoring of client #1's nasal drainage and/or drooling was available for review. On 11/2/22 at 11:14 AM, the Nurse was interviewed. The Nurse was asked about client #1's body positioning and the observation of		observation for positioning and excessive drainage on the Monthly Observation Checklist will ensure future monitoring and prevention with all clients served in Easterseals Group Homes.	

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	excessive nasal drainage and/or drooling. The Nurse indicated client #1 had been evaluated by ENT concerning her nasal drainage and was also being monitored for gallstones which might contribute toward her leaning forward if in pain. The Nurse indicated her risk plan for the gallstones indicated monitoring for signs and symptoms of nausea and vomiting, but further review was needed concerning supports for monitoring excessive nasal drainage and/or drooling. At 11:30 AM, the Nurse indicated no health risk plan to address supports, services, intervention and/or the monitoring of client #1's excessive nasal drainage and/or drooling could be provided for review. The Nurse stated, "We'll add a Respiratory Distress Protocol. We can add that today. I've realized after talking with you I need to add that". On 11/3/22 at 3:47 PM, the Residential Director was interviewed. The Residential Director was asked about client #1's excessive nasal drainage and/or drooling and need for a protocol to identify health risk, supports, intervention and/or monitoring. The Residential Director stated, "Yes. It would provide staff more guidance and when the medical team needed to be contacted or what to look for". 9-3-4(a)			
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility failed to ensure client #1 did not receive contaminated medication after client #1's crushed	W 0455	W455 The Helmuth staff person responsible for administering Client #1's medication after it was	12/01/2022

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	calcium missed her mouth and landed on the dining room table. Findings include: An observation was conducted on 10/31/22 from 3:17 PM to 5:20 PM. The observation indicated the following: -At 5:08 PM, client #1 was seated in her wheelchair and pulled up to the dining room table for the start of the evening meal. Client #1 leaned forward out over her plate positioned on the dining room table. -At 5:10 PM, staff #1 brought client #1 a small plastic cup of pudding. Staff #1 stood to left side of client #1. While attempting to take a bite of the pudding, client #1 tilted her head to her right and upward in an attempt to take a bite of the pudding from the spoon staff #1 was holding. The pudding fell from the spoon as client #1 tried to take a bite and landed on the surface of the table. Staff #1 used a plastic spoon to scoop up the pudding and successfully provided client #1 the bite of pudding on the second attempt. As staff #1 walked back toward the medication room, staff #1 was asked if she had provided client #1 medicine with the pudding she had served her. Staff #1 stated, "Yes. It was her calcium". Due to client #1's positioning, client #1 had to turn to her right and bend her neck upward when she attempted to take her pudding with calcium medication. The first attempt fell from client #1's mouth and the spoon onto the table. On 11/1/22 at 11:50 AM, the Worksheet for Med (Medication) Training Checklist dated 9/14/22 was reviewed. The Medication Training Checklist indicated, "18 ... Mealtime meds must be given at		dropped on the dining room table was retrained on proper medication administration and infection control. Preventatively, all staff at Helmuth Group Home were retrained on proper medication administration and infection control related to ensuring a pill that is dropped on an unsanitized area is disposed of and a new medication administered. Systemically, all group home managers will in-service their Direct Support Professionals at their next staff meeting on proper medication administration and infection control, namely to ensure staff dispose of a contaminated pill if dropped on an unsanitized surface, and a new medication is administered. The RCDS medication administration training, which is completed with all new staff, thoroughly covers proper infection control related to disposal of a contaminated pill if it is dropped. All staff are trained by group home management at least three times related to this policy during their medication administration training in the group home. Additionally, the nurses ensure staff are competent to pass medications as well. During the staff's final medication pass-off, the nurse also covers disposal of a contaminated pill and administering a new pill out of the bubble packet. The RCDS	

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	the table ... 34 ... Sanitize med counter before initial med pass and PRN (as needed) if area becomes contaminated. You may only give the dropped pill if area has been sanitized and you pick the pill up with a gloved hand. 35. Know location of Disposal of Medication Form ...". On 11/2/22 at 11:14 AM, the Nurse was interviewed. The Nurse was asked about staff #1 providing client #1 her crushed calcium medication in pudding at the dining room table after it fell from the spoon and onto the surface of the dining room table. The Nurse stated, "No, that should not have been administered. If she had some of the medicine it would be a call to nursing. We would not know how much she received. I would then get with the doctor. Yeah, she (staff #1) would call nursing to see what to do". The Nurse indicated staff were trained if the surface was sanitized and the medicine picked up with a gloved hand, it would not be considered a contaminated medicine that could be administered and stated, "But to drop it on the table, that is contaminated. She should not have administered that. She should have called nursing". On 11/3/22 at 3:47 PM, the Residential Director was interviewed. The Residential Director was asked about client #1 receiving contaminated medicine that fell onto the dining room table surface. The Residential Director stated, "Correct (contaminated medicine)". The Residential Director indicated staff should not have administered client #1 the medication that fell onto the dining room table. The Residential Director indicated staff should have contacted nursing services to clarify the appropriate next step with client #1's medication administration. 9-3-7(a)		medication training, along with retraining all current staff, will ensure awareness and prevent future occurrence.	

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