

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G666		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/27/2013	
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226			
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 6/24/13, 6/25/13, 6/26/13 and 6/27/13</p> <p>Facility Number: 000685 Provider Number: 15G666 AIMS Number: 100474600</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/3/13 by Ruth Shackelford, QIDP.</p>			W000000			

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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W000104	<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 record review and interview for 2 of 4 sampled clients (#1 and #2), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients #1 and #2 did not pay for prescription insurance coverage.</p> <p>Findings include:</p> <p>1. Client #1's financial record was reviewed on 6/25/13 at 9:00 AM. Client #1's RFMSSs (Resident Fund Management Service Statement) dated 4/1/13 through 6/24/13 indicated the following transaction:</p> <p>-6/3/13 description of debit activity indicated, "[Insurance], \$17.40."</p> <p>2. Client #2's financial record was reviewed on 6/25/13 at 9:10 AM. Client #2's RFMSSs dated 4/1/13 through 6/24/13 indicated the following transaction:</p> <p>-6/3/13 description of debit activity indicated, "[Insurance], \$17.40."</p> <p>AS (Administrative Staff) #1 was</p>	W000104	<p><b>CORRECTION:</b></p> <p><i>The governing body must exercise general policy, budget, and operating direction over the facility. Specifically, the governing body will begin paying Medicarex premiums for Client #1 and Client #2 and both clients will be reimbursed for past premiums for which they have payed for with personal funds.</i></p> <p><b>PREVENTION:</b></p> <p>The Business Manager has received additional training regarding the governing body's responsibility to utilize the daily Medicaid per diem to provide necessary services. The business manager will review all Resident Financial Management System disbursements to assure withdrawals are made for personal expenditures only. Additionally, at least two members of the administrative team will sign all RFMS checks before they are released to provide for additional budgetary oversight.</p> <p><b>RESPONSIBLE PARTIES:</b></p> <p>QIDP, Residential Manager, Business Manager, Office Coordinator, Quality Assurance Team, Operations Team</p>	07/27/2013			

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	<p>interviewed on 6/25/13 at 12:30 PM.</p> <p>When asked if clients #1 and #2's [insurance] debits were for prescription insurance coverage offered by [insurance agency], AS #1 stated, "Yes." When asked if clients should pay for prescription insurance coverage, AS #1 indicated the facility should be paying for [insurance agency] prescription insurance coverage.</p> <p>9-3-1(a)</p>			

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W000148	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &amp;</p> <p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#4), the facility failed to notify client #4's HCR (Health Care Representative) regarding an injury requiring emergency medical services and an elopement attempt.</p> <p>Findings include:</p> <p>The facility's BDDSR (Bureau of Developmental Disabilities Services Reports) and investigations were reviewed on 6/24/13 at 2:32 PM and 6/26/13 at 3:34 PM. The reviews indicated the following:</p> <p>-BDDSR dated 6/7/13 indicated on 6/7/13, "After leaving a doctor's appointment, [client #4]... asked to be taken to work. Staff took [client #4] to [day service #1] and she became very angry and stated she wanted to go to [day service #2]. Staff explained that she couldn't go to the [day service #2] until it was approved. [Client #4] asked to be taken home. On the way home [client #4] threatened to jump out of the van while it</p>	W000148	<p><b>CORRECTION:</b> <i>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. Specifically, The Clinical Supervisor has been retrained on the need to notify family members and/or legal representatives of all significant events including but not limited to injuries requiring medical treatment and elopement attempts.</i></p> <p><b>PREVENTION:</b> Staff completing initial incident reporting will include names and times of notification of all required individuals on the facility's incident reports/ These reports will be faxed electronically to the Quality Assurance Manager and Program Manager Lead for review and follow-up to assure family members and/or clients' legal representatives are notified of significant incidents as required.</p> <p><b>RESPONSIBLE PARTIES:</b></p>	07/27/2013			

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	<p>was moving if she wasn't take to [day service #2]. [Client #4] opened the side door of the van and attempted to jump out. Staff stopped the van to prevent [client #4] from hurting herself. [Client #4] jumped out and started walking. Staff followed [client #4], she grabbed the antenna, bent it and continued to walk up [street]. [Client #4] picked up a brick, hurled it into the windshield, shattering it. Staff immediately called the [CS #1 (Clinical Supervisor)] and [RM #1 (Resident Manager)]. [CS #1] arrived and [client #4] was inside [store] looking through her purse for change."</p> <p>-BDDSR dated 6/11/13 indicated on 6/10/13, "While riding to day program, [client #4] became upset about a delay in transferring to new day service site. [Client #4] hit [client #8], who in turn hit [client #4] in the mouth several times before staff could separate them. [Client #8] was not injured as a result of the incident. [Client #4], however, sustained a laceration on the inside of her lip. Staff transported [client #4] to the [emergency room] where the injury was closed with 3 self dissolving sutures."</p> <p>Interview with client #4's HCR on 6/26/13 at 3:11 PM indicated she had not been informed of the 6/7/13 elopement attempt or the 6/11/13 injury/emergency</p>		QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team		

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	<p>room visit. When asked if she would like to have been notified of the 6/7/13 and 6/11/13 incidents regarding client #4, client #4's HCR stated, "Yes."</p> <p>Interview with AS #1 (Administrative Staff) on 6/24/13 at 4:17 PM indicated clients guardians should be notified of significant incidents.</p> <p>9-3-2(a)</p>			

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W000149	<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 record review and interview for 3 of 7 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to implement its policy and procedures to complete an investigation for an incident of client to client aggression for clients #4 and #6, an allegation of theft regarding clients #4 and #6 and an incident of client to client aggression for clients #4 and #8.</p> <p>Findings include:</p> <p>The facility's BDDSR (Bureau of Developmental Disabilities Services Reports) and investigations were reviewed on 6/24/13 at 2:32 PM and 6/26/13 at 3:34 PM. The reviews indicated the following:</p> <p>-BDDSR dated 3/24/13 indicated on 3/23/13, "At the dinner table [client #4] accused [client #6] of wearing [client #4's] clothes. Staff were able to redirect her by telling her that [client #6] will change clothes after dinner. [Client #4] was redirected to a quiet area away form [client #6]. [Client #6] was in the kitchen talking with staff and [client #4] rushed in</p>	W000149	<p><b>CORRECTION:</b> <i>The facility must have evidence that all alleged violations are thoroughly investigated.</i> Specifically, the facility will investigate an incident of aggression between Client #4 and Client #6 on 3/23/13, an allegation made by Client #4 that Client #6 had stolen personal belongings from Client #4, and an incident of aggression between Client #4 and Client #8 on 6/11/13.</p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding the criteria for conducting investigations at the facility and will receive an updated copy of the agency's incident-investigation tracking spreadsheet no less than weekly to assure thorough investigations are conducted within required timeframes. The QIDP will turn in copies of completed investigations to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up. Additionally, the facility's Clinical Supervisor will meet with the Quality Assurance Manager weekly to review incidents that require follow-up and investigation to assure timely</p>	07/27/2013
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	<p>and hit [client #6] with a belt acrossed (sic) her upper back that caused a 4-5 inch red raised area on the upper back." The 3/24/13 BDDSR indicated, "Team will investgate (sic) and meet to discuss preventative measures."</p> <p>The review did not indicate documentation of an investigation regarding the 3/24/13 incident of client to client aggression for clients #4 and #6.</p> <p>-BDDSR dated 5/11/13 indicated on 5/10/13, "[Client #4] was upset yelling and screaming that one of her housemates [client #6] had take (sic) some of (sic) personal belongings."</p> <p>The review did not indicate documentation of an investigation of client #4's allegation of theft regarding client #6.</p> <p>-BDDSR dated 6/11/13 indicated on 6/10/13, "While riding to day program, [client #4] became upset about a delay in transferring to new day service site. [Client #4] hit [client #8], who in turn hit [client #4] in the mouth several times before staff could separate them. [Client #8] was not injured as a result of the incident. [Client #4], however, sustained a laceration on the inside of her lip. Staff transported [client #4] to the [emergency</p>		<p>completion. The Executive Director will monitor the facility's incident – investigation tracking spreadsheet and follow-up as needed with the clinical Supervisor and Program Manager to provide for increased accountability.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>				

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	<p>room] where the injury was closed with 3 self dissolving sutures."</p> <p>The review did not indicate documentation of an investigation regarding the 6/11/13 incident of client to client aggression for clients #4 and #8.</p> <p>Interview with AS #1 (Administrative Staff) on 6/24/13 at 4:17 PM indicated there were no additional investigations available for review. AS #1 indicated allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be investigated. AS #1 indicated the facility's policy and procedures to detect, prevent and report allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be implemented.</p> <p>The facility's policy and procedures were reviewed on 6/26/13 at 5:19 PM. The facility's 9/14/07 policy and procedure entitled, "Investigations" indicated, "Practices: 3. (b) Ensure alleged incident of abuse, neglect, mistreatment, exploitation or injuries of unknown origin are fully investigated within 5 calendar days from the date the allegations were made and investigation was initiated."</p> <p>9-3-2(a)</p>				

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 3 of 7 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to complete an investigation for an incident of client to client aggression for clients #4 and #6, an allegation of theft regarding clients #4 and #6 and an incident of client to client aggression for clients #4 and #8.</p> <p>Findings include:</p> <p>The facility's BDDSR (Bureau of Developmental Disabilities Services Reports) and investigations were reviewed on 6/24/13 at 2:32 PM and 6/26/13 at 3:34 PM. The reviews indicated the following:</p> <p>-BDDSR dated 3/24/13 indicated on 3/23/13, "At the dinner table [client #4] accused [client #6] of wearing [client #4's] clothes. Staff were able to redirect her by telling her that [client #6] will change clothes after dinner. [Client #4] was redirected to a quiet area away form [client #6]. [Client #6] was in the kitchen talking with staff and [client #4] rushed in and hit [client #6] with a belt accrossed</p>	W000154	<p><b>CORRECTION:</b> <i>The facility must have evidence that all alleged violations are thoroughly investigated.</i> Specifically, the facility will investigate an incident of aggression between Client #4 and Client #6 on 3/23/13, an allegation made by on 5/10/13 Client #4 that Client #6 had stolen personal belongings from Client #4, and an incident of aggression between Client #4 and Client #8 on 6/11/13.</p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding the criteria for conducting investigations at the facility and will receive an updated copy of the agency's incident-investigation tracking spreadsheet no less than weekly to assure thorough investigations are conducted within required timeframes. The QIDP will turn in copies of completed investigations to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up. Additionally, the facility's Clinical Supervisor will meet with the Quality Assurance Manager weekly to review incidents that require follow-up and investigation to assure timely</p>	07/27/2013			

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	<p>(sic) her upper back that caused a 4-5 inch red raised area on the upper back." The 3/24/13 BDDSR indicated, "Team will investgate (sic) and meet to discuss preventative measures."</p> <p>The review did not indicate documentation of an investigation regarding the 3/24/13 incident of client to client aggression for clients #4 and #6.</p> <p>-BDDSR dated 5/11/13 indicated on 5/10/13, "[Client #4] was upset yelling and screaming that one of her housemates [client #6] had take (sic) some of (sic) personal belongings."</p> <p>The review did not indicate documentation of an investigation of client #4's allegation of theft regarding client #6.</p> <p>-BDDSR dated 6/11/13 indicated on 6/10/13, "While riding to day program, [client #4] became upset about a delay in transferring to new day service site. [Client #4] hit [client #8], who in turn hit [client #4] in the mouth several times before staff could separate them. [Client #8] was not injured as a result of the incident. [Client #4], however, sustained a laceration on the inside of her lip. Staff transported [client #4] to the [emergency room] where the injury was closed with 3</p>		<p>completion. The Executive Director will monitor the facility's incident – investigation tracking spreadsheet and follow-up as needed with the clinical Supervisor and Program Manager to provide for increased accountability.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>		

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	<p>self dissolving sutures."</p> <p>The review did not indicate documentation of an investigation regarding the 6/11/13 incident of client to client aggression for clients #4 and #8.</p> <p>Interview with AS #1 (Administrative Staff) on 6/24/13 at 4:17 PM indicated there were no additional investigations available for review. AS #1 indicated allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be investigated.</p> <p>9-3-2(a)</p>				

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W000262	<p>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview for 3 of 4 sampled clients (#1, #3 and #4), the facility's HRC (Human Rights Committee) failed to review, monitor and approve the use of psychotropic medications for management of clients #1, #3 and #4's behavior.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 6/25/13 at 10:50 AM. Client #1's POF (Physicians Order Form) dated 6/1/13 indicated the use of Lithium Carbonate 450 milligrams (bipolar disorder), Olanzapine 10 milligrams (bipolar disorder) and Risperidone 3 milligrams (bipolar disorder). Client #1's record did not indicate review/approval by the facility's HRC for the use of psychotropic medications.</p> <p>2. Client #3's record was reviewed on 6/25/13 at 11:27 AM. Client #2's POF dated 6/1/13 indicated the use of Lithium Carbonate 600 milligrams (intermittent explosive disorder), Risperidone 1</p>	W000262	<p><b>CORRECTION:</b> <i>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Specifically, the use of behavior controlling medications for Clients #1, #2, #3 and #4 will be reviewed and approved consensually by the Human Rights Committee.</i></p> <p><b>PREVENTION:</b> The QIDP will be retrained regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Administrative staff will conduct visits to the facility as needed but no less than monthly. The Program Manager –Lead will incorporate monitoring of annual HRC approvals of restrictive programs into the current tracking process.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations</p>	07/27/2013			

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	<p>milligram (intermittent explosive disorder) and Sertraline 100 milligrams (intermittent explosive disorder). Client #3's record did not indicate review/approval by the facility's HRC for the use of psychotropic medications.</p> <p>3. Client #4's record was reviewed on 6/25/13 at 10:07 AM. Client #4's POF dated 6/1/13 indicated the use of Divalproex 250 milligrams (schizophrenia) and Quetiapine 200 milligrams (schizophrenia). Client #4's record did not indicate review/approval by the facility's HRC for the use of psychotropic medications.</p> <p>Interview with AS #1 (Administrative Staff) on 6/24/13 at 4:17 PM indicated the use of psychotropic medications should be reviewed and approved by the facility's HRC. AS #1 indicated there was not additional documentation of HRC review or approval for clients #1, #3 and #4.</p> <p>9-3-4(a)</p>		Team		

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W000263	<p><b>483.440(f)(3)(ii)</b> <b>PROGRAM MONITORING &amp; CHANGE</b> 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.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#1 and #4), the facility failed to obtain the client's and/or guardian's written approval before the use of behavior controlling medications for clients #1 and #4.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 6/25/13 at 10:50 AM. Client #1's ISP (individual support plan) dated 6/5/13 indicated client #1 served as her own legal guardian with a HCR (health care representative). Client #1's POF (Physicians Order Form) dated 6/1/13 indicated the use of Lithium Carbonate 450 milligrams (bipolar disorder), Olanzapine 10 milligrams (bipolar disorder) and Risperidone 3 milligrams (bipolar disorder). Client #1's BSP (behavior support plan) dated 6/5/13 included the use of Lithium Carbonate, Olanzapine and Risperidone. Client #1's BSP was not signed by client #1's HCR. Client #1's MCF (medication consent form) dated 6/5/13 did not indicate client #1 or client #1's HCR's signature/written informed consent for the use of behavior control medications.</p> <p>2. Client #4's record was reviewed on 6/25/13 at 10:07 AM. Client #4's POF dated 6/1/13 indicated the use of Divalproex 250 milligrams (schizophrenia) and Quetiapine 200 milligrams (schizophrenia). Client #4's ISP dated 9/26/12 indicated client #4 served as her own legal</p>	W000263	<p><b>CORRECTION:</b> <i>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. Specifically, the team will obtain written consent from Client #1 and Client #4's healthcare representatives for the use of their prescribed behavior controlling medications.</i></p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding the need to obtain prior written informed consent from guardians, advocates and healthcare representatives for all restrictive programs prior to implementation. Retraining will focus on assuring that the QIDP has a clear understanding of what specifically constitutes a restrictive program and proper preparation for presenting program modifications guardians and other legal representatives. Prior to granting approval to restrictive programs, the Human Rights Committee will obtain confirmation that the facility has received prior written informed consent from Guardian or other legal representatives. The agency</p>	07/27/2013

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	<p>guardian with a HCR. Client #4's BSP dated 9/27/12 included the use of Divalproex and Quetiapine. Client #4's BSP dated 9/27/12 was not signed by client #4 or client #4's HCR. Client #4's MCF dated 9/26/12 did not include a list of specific psychotropic medications to be used. Client #4's MCF dated 9/26/12 did not indicate client #4 and/or client #4's HCR had signed the form or given written informed consent for the use of behavior control medications.</p> <p>Interview with AS #1 (Administrative Staff) on 6/24/13 at 4:17 PM indicated written informed consent was needed before the use of psychotropic medications used for behavior control.</p> <p>9-3-4(a)</p>		<p>has established a quarterly system of internal audits that review all facility systems including, but not limited to due process and prior written informed consent. Administrative staff will conduct visits to the facility as needed but no less than monthly.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>				

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W000356	<p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#4), the facility failed to ensure client #4 received recommended dental services.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 6/25/13 at 10:07 AM. Client #4's Dental Summary Form dated 9/11/12 indicated the recommendation for client #4 to return in 6 months for follow up examination and cleaning. Client #4's record did not indicate documentation of additional follow up dental services.</p> <p>AS #1 (administrative staff) was interviewed on 6/25/13 at 12:45 PM. AS #1 indicated dental recommendations should be followed. AS #1 indicated there was not additional documentation of dental services for review.</p> <p>9-3-6(a)</p>	W000356	<p><b>CORRECTION:</b> <i>The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Specifically, the facility will assist Client #4 with receiving recommended dental follow-up.</i></p> <p><b>PREVENTION:</b> The facility nurse will review dental records and follow up with other team members to assure recommendations are implemented as appropriate. The QIDP and members of the Operations and Quality Assurance Teams will review medical records on an ongoing basis to assure dental treatment services occur as required.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	07/27/2013			

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W000454	<p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation and interview for 2 of 3 sampled clients (#2 and #3) plus one additional client (#6), the facility failed to ensure a sanitary environment during the home's family style breakfast.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 6/25/13 from 6:00 AM through 7:45 AM. At 7:03 AM client #6 was seated at the dining room table participating in family style breakfast. While client #6 was eating her scrambled eggs a portion, 2 ounces, fell from her spoon to the dining room floor. Client #6 then reached down to the floor, picked up the scrambled eggs from the floor and returned the eggs to her plate. CS #2 (Clinical Supervisor) walked past client #6 as she picked up the scrambled eggs from the floor and returned them to her plate. CS #2 did not redirect client #6 from placing the scrambled eggs on her plate or encourage client #6 to wash her hands after touching the floor. Client #6 consumed the scrambled eggs that had been on the floor. At 7:09 AM clients #2, #3, #6 and #7 continued to participate in the group home's family style breakfast.</p>	W000454	<p><b>CORRECTION:</b> <i>The facility must provide a sanitary environment to avoid sources and transmission of infections.</i> Specifically, all facility professional and supervisory staff will be retrained regarding expectations for maintaining a sanitary environment during meal time as well as the need to provide clients with ongoing skills training toward observing social amenities and sanitary eating practices.</p> <p><b>PREVENTION:</b> The Clinical Supervisor and Residential Manager will each perform meal active treatment observations during no less than two breakfasts and two lunches/dinners per week and members of the Operations and Quality Assurance Teams will conduct meal time active treatment observations no less than monthly to assure a sanitary environment is maintained. Supervisory and administrative staff will provide hands on coaching and training to assure staff develop appropriate meal time active treatment skills.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Residential Manager, Direct Support Staff, Quality</p>	07/27/2013			

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	<p>CS #1 and #2 and DSP (Direct Support Professional) #1 were also seated at the dining room table. The dining room table had a container of sugar with a teaspoon which the clients used during the meal. At 7:10 AM client #7 used the sugar bowl and teaspoon to sweeten his cup of coffee. Client #7 placed the sugar's teaspoon in his personal cup of coffee, then removed the spoon after stirring his coffee and placed the spoon in his mouth before returning the teaspoon to the sugar container. CS #1, CS #2 and/or DSP #1 did not redirect client #7 from returning the spoon to the sugar container or remove the sugar container/spoon from the dining room table. At 7:11 AM client #3 used the same teaspoon and sugar container for his meal. At 7:15 AM DSP #1 assisted client #2 use the same teaspoon and sugar container for his meal with HOHA (Hand Over Hand Assistance). At 7:16 AM client #6 used the teaspoon and sugar container for her meal.</p> <p>AS #1 (administrative staff) was interviewed on 6/25/13 at 12:45 PM. AS #1 indicated clients should not consume food that has been on the floor. AS #1 indicated staff should not allow clients to consume food that has been contaminated. AS #1 stated, "[CS #2] said he saw [client #7] place the spoon in his</p>		Assurance Team, Operations Team				

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	<p>mouth and put it back in the container."</p> <p>AS #3 was interviewed on 6/25/13 at 11:00 AM. AS #3 stated, "If they, [CS #1], [CS #2] and [DSP #1], were at the table during the meal. They should have seen that. If they didn't see it, they should have. That should not happen."</p> <p>9-3-7(a)</p>			