

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G797	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2014
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NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 9029 S AMERICA RD LA FONTAINE, IN 46940
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W000000	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>This visit was in conjunction with a PCR (Post Certification Revisit) to the investigation of complaint #IN00143156 completed on 2/6/14.</p> <p>Dates of Survey: 3/10, 3/11, 3/12, 3/13, 3/14, 3/18, 3/19, and 3/20/2014.</p> <p>FACILITY NUMBER: 0012563 PROVIDER NUMBER: 15G797 AIM NUMBER: 201018540</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed April 3, 2014 by Dotty Walton, QIDP.</p>	W000000		
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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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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 observation and interview, for 4 of 4 clients (clients #1, #2, #3, and #4) who lived in the group home, the governing body failed to exercise operating direction over the facility to complete maintenance and repairs at the group home.</p> <p>Findings include:</p> <p>On 3/10/14 from 3:40pm until 5:55pm, and on 3/11/14 from 6:25am until 8:40am, observations were conducted at the group home. During both observation periods, clients #1, #2, #3, and #4 walked to access the dining room, bathrooms, kitchen, and the living room areas of the facility. On 3/10/14 at 4:10pm, the Residential Manager (RM) walked out of the group home's front door. When the front door closed, the alarm system verbally stated "front bedroom window open," and Group Home Staff (GHS) #1 went to look. GHS #1 indicated client #3 was not present in the group home at this time and client #3's bedroom window opened independently when the front door closed. GHS #1 stated "I was hoping you didn't notice" client #3's window open when the front door closed.</p>	W000104	<p>W104: Governing Body - Maintenance (1) Corrective action for resident(s) found to have been affected: Window replacement parts have been ordered, closet door has been replaced, carpets will be cleaned, holes and scratches in walls have been fixed. (2) How facility will identify other residents potentially affected & what measures taken: All residents potentially affected, and corrective measures address the needs of all clients. (3) Measures or systemic changes facility put in place to ensure no recurrence: Repairs and cleaning (4) How corrective actions will be monitored to ensure no recurrence: The Interdisciplinary Team (IDT) includes the Qualified Intellectual Disability Professional (QIDP), Group Home Manager, Behavior Clinician (BC), Nurse, Facility Administrator/Director, and others. The IDT holds regular documented meetings, and it monitors and updates Plans as needed. The Group Home manager is responsible for maintenance in the home and reports to the IDT at their regular meetings. Maintenance is a standing item on the meeting agenda. The manager completes home visit forms and will monitor the implementation of new corrections. The group home</p>	04/19/2014			

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	<p>GHS #1 indicated client #3's window needed repair.</p> <p>During both observation periods the following maintenance areas were identified:</p> <ul style="list-style-type: none"> -Client #2's bedroom closet was missing one of two closet doors. -Client #3's bedroom window was loose from the casing and opened outward when touched. -Client #4's tan colored bedroom carpet had dark stains and discolorations on the floor surrounding her bed. -Two of four wooden living room window casing controls were broken and exposed broken and splintered wood. -The group home had a hole in the dry wall behind the front door the shape of the front doorknob. -On 3/10/14 at 5:50pm, the Residential Manager (RM) stated two of two dining room walls had "over" eighteen areas in which the wall finish was damaged and/or discolored. <p>On 3/14/14 at 11:35am, an interview with the RM was conducted. The RM indicated the group home maintenance requests had been submitted for the repairs to be completed at the group home. The RM indicated clients #1, #2, #3, and #4 dining room walls, living room windows, and front door dry wall</p>		<p>manager will be required to monitor the facility in-person for a minimum of four (4) hours per week. The Director supervises the manager and reviews home visit forms at regular meetings, including ensuring that the manager has been in the home a minimum of four (4) hours per week.</p>		

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	needed repair. The RM indicated client #2 needed a closet door, client #3's window needed repair, and client #4's carpet needed to be cleaned. 9-3-1(a)						

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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 observation, record review, and interview, for 6 of 19 BDDS (Bureau of Developmental Disabilities Services) reports (clients #1, #2, #3, and #4) reviewed, the facility neglected to implement the facility's policy and procedure to prohibit client to client abuse/mistreatment, neglected to protect clients #1, #2, #3, and #4 from the potential of further abuse, neglect, and/or mistreatment, and neglected to ensure sufficient staff supervision to implement client #3's behavioral requirements while in the community.</p> <p>Findings include:</p> <p>On 3/11/14 at 8:55am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 02/06/14 through 03/11/14.</p> <p>-A 3/7/14 BDDS report for an incident on 3/6/14 at 3:25pm indicated client #1 "was upset after [client #3] was disturbing (the) home environment with [client #3's] display of behavior (sic). [Client #1] went to her room, slammed the door, and began to head bang</p>	W000149	<p>W149: Staff Treatment of Clients – Supervision & Peer Aggression/Abuse. (1) Corrective action for resident(s) found to have been affected: Client who left supervision has transitioned to a more restrictive setting. All BSPs have interventions in place to prevent peer aggression. At staff meeting, BC, QIDP, and Manager discussed staffing level, keeping spacing between agitated clients rather than just getting between them, and changed how to address shift change,. Discussion included role play. (2) How facility will identify other residents potentially affected & what measures taken: All residents potentially affected, and corrective measures address the needs of all clients. (3) Measures or systemic changes facility put in place to ensure no recurrence: review with staff including role play. (4) How corrective actions will be monitored to ensure no recurrence: The Interdisciplinary Team (IDT) includes the Qualified Intellectual Disability Professional (QIDP), Group Home Manager, Behavior Clinician (BC), Nurse, Facility Administrator/Director, and others. The IDT holds regular documented meetings. The BC is the primary IDT member responsible for monitoring</p>	04/19/2014
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	<p>(banging her head on objects to cause injury)." The report indicated staff redirected client #1 and client #1 began to "head bang again. [Client #1] began physical aggression towards staff" and the staff placed client #1 in Mandt holds (facility approved behavior management restraint technique) on the floor for her safety (for) three minutes "on and off until calm."</p> <p>-A 3/5/14 BDDS report for an incident on 3/4/14 at 5:00pm indicated client #1 "began showing signs of escalation when a peer was displaying physical aggression towards staff and scratched them (the staff) on the face which caused the staff to bleed." The report indicated client #1 was redirected, (but) client #1 "continued to escalate and then charged at staff and peer." The report indicated client #1 was placed in a Mandt hold, and after the client calmed, client #1 went into her bedroom and began to head bang. Staff placed client #1 in an additional Mandt hold when client #1 refused to stop head banging. The report indicated the staff called a fourth staff person to the group home to supervise clients #1, #2, #3, and #4 because of client #1's escalating behaviors.</p> <p>-A 3/5/14 BDDS report for an incident on 3/4/14 at 3:40pm indicated client #3</p>		<p>and updating BSPs. The Group Home Manager supervises staff, including ensuring that their training needs are met. The Behavior Clinician BC trains staff on BSPs. Management staff work with and directly supervise DSPs, including implementation of all plans approved by the IDT. The Manager completes home visit forms and will monitor the implementation of new corrections. The group home manager will be required to monitor the facility in-person for a minimum of four (4) hours per week. The Director supervises management staff and reviews home visit forms at regular meetings, including ensuring that the manager has been in the home a minimum of four (4) hours per week. The IDT meets regularly, including special meetings where all Incident Reports (IRs) are reviewed. The agency's Incident Oversight Committee (IOC) – comprised of the Director, an agency Vice President, and a Compliance Officer – reviews all incidents and monitors IDT actions and follow-up. When insufficient corrective action is put in place, the IOC follows up with the agency's management staff. IRs are not considered "closed" by the IOC until all follow-up is complete.</p>		

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	<p>"began verbal aggression toward staff then she was not assigned the staff member [client #3] preferred. [Client #3] was redirected by staff...[client #3] escalated in her display of behavior to include throwing items in the home, slamming doors, spitting on staff, physically attacking staff by hitting, scratching, biting, and kicking (sic). This behavior began at 3:40pm and continued off and on until 5:13pm. During that time [client #3] was placed into 4 Mandt [holds/physical restraints] and three HRC holds (facility's Human Rights Committee approved emergency measures)." Client #3 made threats to staff "that she was going to tell the management that staff was hurting her to get [staff] fired." The report indicated client #3 made threats "to kill the staff."</p> <p>-A 2/18/14 BDDS report for an incident on 2/17/14 at 5:00pm indicated client #3 "began displaying attention seeking behavior by going into her room and opening the window. Staff were alerted by the window alarm. The report indicated client #3 was prompted by the staff to close the window when client #3 refused to allow staff inside her bedroom. Client #3 "went into the living room and began yelling at staff she hated them and would kill all staff. When staff ignored [client #3's] comments, [client #3] began</p>			
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	<p>taunting [client #1]...[Client #1] ignored [client #3's] comments at first. [Client #1] then asked [client #3] to stop. [Client #3] continued and went towards [client #1]. Staff blocked [client #3's] path and [client #3] began attacking staff." The report indicated client #3 was placed in a Mandt hold for "about 30 seconds," staff released client #3, and client #3 "tried to go towards [client #1] and continued to call names and make comments." The report indicated client #1 went towards client #3, staff stepped between the two clients, and staff redirected clients #1 and #3 to different parts of the group home.</p> <p>-A 2/16/14 BDDS report for an incident on 2/15/14 at 10:50am indicated client #3 "went to a Special Olympics event with a staff and peer. The peers (sic) game was about to begin and staff was assisting the peer. [Client #3] informed staff that she was going to go into the lobby to find her teammates. Staff informed [client #3] that all her team were there in the gym. [Client #3] insisted that she was going out into the lobby. Staff redirected and reminded [client #3] to make good choices. [Client #3] went out of the gym into the lobby and then returned in 2 mins. (minutes). Staff did not have visual contact for those 2 mins...."</p> <p>-A 2/14/14 BDDS report for an incident</p>						

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	<p>on 2/13/14 at 4:25pm indicated the Residential Manager (RM) was investigating a report that client #4 had told the RM that client #1 had taken client #4's DVD player. The report indicated the RM was talking to client #1 about the DVD player, client #1 indicated client #4 had given her the DVD player, and client #1 was told that even if client #4 had given client #1 the DVD player, that the DVD player must be returned. The report indicated client #1 became upset "threw it at the wall and broke (the DVD player)." The report indicated client #1 went to her room, the RM followed to stay outside client #1's doorway to listen for client #1 because she had a history of SIB (Self Injurious Behaviors). The report indicated client #1 "escalated and began throwing items, broke her door, and attacked [the RM]. [Client #1] continued to escalate and banged her head," and bit herself on her arms six times. The staff intervened, client #1's nose was bloodied, client #1 took "a brush and used it to hurt her skin on her forearm. [Client #1] made threats to kill herself. [Client #1] was placed on suicide watch and her room cleared."</p> <p>On 3/13/14 at 10:15am, the Residential Manager (RM) stated client #3 "targets" clients #2 and #4. The RM stated client #3 "will bully" client #1 and then client</p>						

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	<p>#1 reacts and "will then attack [client #3]." The RM indicated clients #1, #2, #3, and #4 needed to be supervised while at the group home if the clients were not alone in their bedrooms and/or in the bathroom. The RM indicated client #3 should not have been with a single staff and another client in the community. The RM indicated client #3 should have had a one on one while in the community.</p> <p>On 3/20/14 at 3:30pm, an interview with the Director was conducted. The Director indicated the facility continued to address peer to peer aggression in an effort to decrease the behaviors. The Director indicated decreasing the injuries suffered by the clients from peer to peer physical aggression continued to be a priority. The Director indicated the staff implemented each client's BSP, the IDT was reviewing incidents during weekly meetings, and action would be taken based on the discussion and team decisions made. The Director indicated the plan to resolve client to client physical aggression had decreased the incidents of client to client physical aggression. The Director indicated client to client physical aggression had continued at the group home. The Director indicated staff should know where client #3 was while in the community. The Director indicated client</p>						

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	<p>#3's supervision level changed from staff knowing where she was, to one on one staff supervision after 2/14/14. The Director indicated client #3's behaviors continued before and after one on one staff was added to supervise client #3. The Director indicated client #3 was aggressive with staff and clients #1, #2, and #4 on a daily basis "at times" and stated "these behaviors have decreased" since the added supervision was implemented. The Director indicated client #3 was discharged on 3/13/14 from the facility to a more secure active treatment environment because of client #3's behaviors of physical aggression and the potential of injury to clients #1, #2, and #4.</p> <p>Client #3's record review was conducted on 3/13/14 at 3:30pm. Client 3's 5/29/13 ISP (Individual Support Plan) and 8/1/13 BSP (Behavior Support Plan) indicated she had targeted behaviors of physical aggression and verbal aggression. Client #3's 8/1/13 BSP indicated "Required level of Supervision: [Client #3] requires a supervision level of 24 hours, seven days per week, with a minimum staff to client ratio of 3 staff to 4 clients during normally awake hours...During instances where 1:1 (one on one) staff is required, the staff member responsible to supervise [client #3] will not also be responsible for</p>						

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	<p>supervising anyone else. [Client #3] requires 1:1 supervision whenever smoking or whenever using any kitchen appliance, especially the stove or microwave. [Client #3] has a history of trying to set things on fire. [Client #3] requires 1:1 supervision whenever she is with her boyfriend and (staff) will maintain complete visual contact...."</p> <p>Client #3's BSP indicated client #3 required staff "in close enough proximity to provide safety. The staff member must be aware of [client #3's] location at all times." Client #3's 2/2014 Risk Plan and record indicated client #3 "has been in Jail for trespassing, criminal mischief, and battery (for) beating up her grandmother. When [client #3] is being verbally aggressive she will make racial slurs towards staff. [Client #3] has destroyed housemates (sic) items and items in the house when she has become physically aggressive."</p> <p>On 3/11/14 at 1:00pm, the 12/5/12 facility policy on "Abuse and Neglect" of clients was reviewed and indicated, "Purpose. To educate and inform staff of the definition, define reporting requirements and stress that AWS will not tolerate abuse, neglect or exploitation of any kind...Description, AWS does not tolerate abuse in any form by any person; this includes physical abuse, verbal</p>						

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	<p>abuse, psychological abuse or sexual abuse." The policy indicated abuse, neglect, and/or mistreatment was "not tolerated" by the agency.</p> <p>9-3-2(a)</p>			

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>Based on observation, interview, and record review, for 2 of 2 sampled clients (clients #1 and #2) and for 2 additional clients (clients #3 and #4), the facility failed to ensure client #1, #2, #3 and #4's BSPs (Behavior Support Plans) were implemented to secure knives when opportunities existed and failed to provide staff supervision for client #3 while in the community.</p> <p>Findings include:</p> <p>1. On 3/10/14 from 3:40pm until 5:55pm, clients #1, #2, #3, and #4 were observed at the group home and sharp knives and sharps were kept locked with only staff having the keys. At 5:30pm, GHS (Group Home Staff) #1, GHS #4, and GHS #5 used a sharp five inch (5") bladed knife to cut clients #1, #2, #3, and #4's steak into bite size pieces. At 5:30pm, GHS #4 set the five inch bladed knife on top of the counter across from the dining room table and walked away from the knife. From 5:30pm until</p>	W000249	<p>W249: Program Implementation – Client out of Supervision & Knife left out. (1) Corrective action for resident(s) found to have been affected: Client who left supervision has transitioned to more-restrictive facility. Sharps restrictions were reviewed at staff meeting, including requirement to keep them locked when not in use. (2) How facility will identify other residents potentially affected & what measures taken: All residents potentially affected, and corrective measures address the needs of all clients. (3) Measures or systemic changes facility put in place to ensure no recurrence: Client transition and review at staff meeting. (4) How corrective actions will be monitored to ensure no recurrence: The Interdisciplinary Team (IDT) includes the Qualified Intellectual Disability Professional (QIDP), Group Home Manager, Behavior Clinician (BC), Nurse, Facility Administrator/Director, and others. The IDT holds regular documented meetings. The BC is the primary IDT member responsible for monitoring and updating BSPs,</p>	04/19/2014			

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	<p>5:50pm, client #3 stared at the knife from her seat a few feet way at the dining room table. At 5:50pm, the Residential Manager (RM) identified the five inch blade knife the surveyor and client #3 were looking at which lay loose on top of the counter a few feet away from client #3. At 5:50pm, the RM took the knife, and indicated it should have been cleaned and relocked. At 5:50pm, the RM cleaned the five inch bladed knife, returned the knife to the locked security box, and stated "it should not have been left out unsecured."</p> <p>On 3/13/14 at 12:45pm, client #1's record was reviewed. Client #1's 4/17/13 ISP (Individual Support Plan) and 4/17/13 BSP both indicated client #1's behaviors included physical aggression, Bullying behaviors, SIB, suicidal threats, and verbal aggression. Client #1's BSP indicated she needed knives and sharps secured at "all times" for her safety.</p> <p>On 3/13/14 at 10:45am, client #2's record was reviewed. Client #2's 4/17/13 ISP (Individual Support Plan) and 4/17/13 BSP both indicated "Due to [client #2's] history of SIB and physical aggression: sharps such as knives, forks, scissors etc. will be kept locked. [Client #2] will have supervised access when needed for food preparation or engaging in crafting</p>		<p>which include sharps restrictions. The Group Home Manager supervises staff, including ensuring that their training needs are met. The Behavior Clinician BC trains staff on BSPs, including sharps restrictions. Management staff work with and directly supervise DSPs, including implementation of all plans approved by the IDT. The Manager completes home visit forms and will monitor the implementation of new corrections. The group home manager will be required to monitor the facility in-person for a minimum of four (4) hours per week. The Director supervises management staff and reviews home visit forms at regular meetings, including ensuring that the manager has been in the home a minimum of four (4) hours per week.</p>				

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	<p>activities." Client #2's BSP identified targeted behaviors of physical aggression, SIB, Suicidal threats, verbal aggression, and depression.</p> <p>On 3/14/14 at 11:35am, an interview with the Residential Manager (RM) was conducted. The RM indicated facility staff should have ensured knives were kept secured and locked after each use. The RM indicated the unsecured knife should not have been left out on the counter top. The RM indicated clients #1, #2, #3, and #4 had the identified need for locked sharps which included knives for their safety.</p> <p>2. On 3/11/14 at 8:55am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 02/06/14 through 03/11/14 for client #3. A 2/16/14 BDDS report for an incident on 2/15/14 at 10:50am indicated client #3 "went to a Special Olympics event with a staff and peer. The peers game was about to begin and staff was assisting the peer. [Client #3] informed staff that she was going to go into the lobby to find her teammates. Staff informed [client #3] that all her team were there in the gym. [Client #3] insisted that she was going out into the lobby. Staff redirected and reminded [client #3] to make good</p>			
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	<p>choices. [Client #3] went out of the gym into the lobby and then returned in 2 mins. (minutes). Staff did not have visual contact for those 2 mins...."</p> <p>On 3/13/14 at 10:15am, the Residential Manager (RM) stated client #3 "will bully" other clients. The RM indicated client #3 needed to be supervised while at the group home if the clients were not alone in their bedrooms and/or in the bathroom. The RM indicated client #3 should not have been with a single staff and another client in the community. The RM indicated client #3 should have had a one on one staff while in the community.</p> <p>On 3/20/14 at 3:30pm, an interview with the Director was conducted. The Director indicated the facility continues to address peer to peer aggression in an effort to decrease the behaviors. The Director indicated decreasing the injuries suffered by the clients from peer to peer physical aggression continued to be a priority. The Director indicated staff should know where client #3 was while in the community. The Director indicated client #3's supervision level changed from staff knowing where she was, to one on one staff supervision after 2/14/14. The Director indicated client #3's behaviors continued before and after one on one staff was added to supervise client #3.</p>			
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	<p>The Director indicated client #3 was aggressive with staff, clients #1, #2, and #4 on a daily basis "at times" and stated "these behaviors have decreased" since the added supervision was implemented.</p> <p>Client #3's record review was conducted on 3/13/14 at 3:30pm. Client 3's 5/29/13 ISP (Individual Support Plan) and 8/1/13 BSP (Behavior Support Plan) indicated she had targeted behaviors of physical aggression and verbal aggression. Client #3's 8/1/13 BSP indicated "Required level of Supervision: [Client #3] requires a supervision level of 24 hours, seven days per week, with a minimum staff to client ratio of 3 staff to 4 clients during normally awake hours...During instances where 1:1 (one on one) staff is required, the staff member responsible to supervise [client #3] will not also be responsible for supervising anyone else. [Client #3] requires 1:1 supervision whenever smoking or whenever using any kitchen appliance, especially the stove or microwave. [Client #3] has a history of trying to set things on fire. [Client #3] requires 1:1 supervision whenever she is with her boyfriend and staff will maintain complete visual contact..." Client #3's BSP indicated client #3 required staff "in close enough proximity to provide safety. The staff member must be aware of [client #3's] location at all times." Client</p>				

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	<p>#3's 2/2014 Risk Plan and record indicated client #3 "has been in Jail for trespassing, criminal mischief, and battery (for) beating up her grandmother. When [client #3] is being verbally aggressive she will make racial slurs towards staff. [Client #3] has destroyed housemates (sic) items and items in the house when she has become physically aggressive."</p> <p>9-3-4(a)</p>			
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W000336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview, for 2 of 2 sampled clients (clients #1 and #2), the facility failed to complete nursing quarterlies.</p> <p>Findings include:</p> <p>On 3/13/14 at 12:45pm, client #1's record was reviewed and indicated no "Nursing Quarterly" assessments completed. Client #1's record indicated she was admitted to the facility in 2011. Client #1's record indicated a 2/2014 nursing assessment but no nursing quarterly physical assessments were available for review from 3/2013 through 1/2014. Client #1's record indicated she was seen by her personal physician and/or a nurse practitioner on 1/24/14, 12/2/13, 4/2/13, and 3/7/13.</p> <p>On 3/13/14 at 10:45am, client #2's record was reviewed. Client #2's record indicated she was admitted to the facility in 2011. Client #2's record indicated a nursing assessment completed 1/2014 but no nursing quarterly physical assessments were available for review from 3/2013</p>	W000336	<p>W336: Nursing Services – Nurse Quarterlies. (1) Corrective action for resident(s) found to have been affected: A new RN has been hired and will complete all nursing reports as required. (2) How facility will identify other residents potentially affected & what measures taken: All residents potentially affected, and corrective measures address the needs of all clients. (3) Measures or systemic changes facility put in place to ensure no recurrence: New nurse hired – she already has been working with other nurses in the agency and has reviewed reporting procedures. (4) How corrective actions will be monitored to ensure no recurrence: Nurse is part of IDT that meets at least quarterly for client meetings; each quarterly meeting includes an IDT note and nurse report; the Director is the supervisor of the RN and will ensure that the reports are included.</p>	04/19/2014			

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	<p>through 1/2014. Client #2's record indicated she was seen by her personal physician and/or a nurse practitioner on 1/8/14, 12/4/13, 4/22/13, and 3/21/13.</p> <p>On 3/14/14 at 11:35am, an interview with the facility's Registered Nurse (RN) was completed. The RN indicated client #1 and #2's nursing quarterly and monthly assessments had been completed and the RN indicated she had searched the records. The RN indicated she could not locate client #1 and #2's quarterly assessments. The RN indicated the facility had experienced a change in nursing personnel at the facility and it was possible the quarterly documents had not yet been filed.</p> <p>On 3/20/14 at 3:30pm, an interview with the Director of the facility was conducted. The Director indicated the facility had experienced a change in the nursing personnel who completed client #1 and #2's nursing quarterly physical assessments. The Director indicated no additional documentation was available.</p> <p>9-3-6(a)</p>			
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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on observation, record review, and interview, for 2 of 2 sampled clients (clients #1 and #2) who were observed during medication administration, the facility failed to administer medications without error and as prescribed by client #1 and #2's personal physician.</p> <p>Findings include:</p> <p>1. On 3/10/14 at 5:35pm, client #1's "Simethicone 125mg (milligrams for gas) chew, 1 tab (tablet) after meals and at bedtime" was administered by GHS (Group Home Staff) #2. At 5:42pm, client #1 took her first bite of the supper meal.</p> <p>On 3/11/14 at 7:12am, client #1's "Simethicone 125mg chew, 1 tab (tablet) after meals and at bedtime" was administered by GHS #3. From 6:25am until 8:40am, client #1 had not eaten breakfast. At 8:40am, GHS #3 indicated client #1 had not eaten breakfast yet that morning.</p> <p>On 3/10/14 at 5:42pm, client #1's 3/2014 MAR (Medication Administration</p>	W000368	<p>W368: Drug Administration. (1) Corrective action for resident(s) found to have been affected: The administration time for simethicone has been changed to 6pm, so it will occur with food. The nurse has changed the MAR for fluoxetine to reflect the physician order. (2) How facility will identify other residents potentially affected & what measures taken: summarize All residents potentially affected, and corrective measures address the needs of all clients. (3) Measures or systemic changes facility put in place to ensure no recurrence: The newly hired nurse will transcribe each MAR every month to ensure accuracy. The manager will review as needed. (4) How corrective actions will be monitored to ensure no recurrence: The Director supervises the nurse. Whenever medication errors take place, the causal factors are determined by the IDT and reviewed by the Incident Oversight Committee. Corrective actions are then put in place before the incident is "closed."</p>	04/19/2014
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	<p>Record) was reviewed and indicated "Simethicone 125mg, 1 tab (tablet) orally after meals and at bedtime" for gas.</p> <p>On 3/13/14 at 12:45pm, client #1's record was reviewed. Client #1's 4/2/13 and 12/2/13 "Physician's Order(s)" indicated "Simethicone 125mg chew, 1 tab orally after meals and at bedtime."</p> <p>2. On 3/11/14 at 7:45am, GHS #3 administered client #2's "Fluoxetine (Prozac) 20mg (for depression) 1 cap (capsule) 1 x (one time) a day with 40mg = (to equal) 60mg." Client #2 did not receive her 40mg dose of Fluoxetine medication. At 8:00am, client #2's 3/2014 MAR indicated "Fluoxetine HCL 20mg Capsule, give 1 capsule orally once a day w/ (with) 40mg capsule to= (to equal) 60mg total dose for depression." Client #2's MAR indicated the 8:00am documentation line for client #2's 40mg dose of Prozac had an uninitialed line marked through the pharmacy entry area. Client #2's MAR had an uninitialed handwritten entry; Prozac 40mg to be administered at 8:00pm.</p> <p>On 3/13/14 at 10:45am, client #2's record was reviewed. Client #2's 4/22/13 and 12/2013 "Physician's Order(s)" were reviewed and indicated "Fluoxetine 20mg</p>			
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	<p>tablet 1 tab once a day, and Prozac 40mg capsule 1 cap once a day for Intermittent Explosive Disorder."</p> <p>On 3/14/14 at 11:35am, an interview with the agency's Registered Nurse (RN) was conducted. The RN indicated the staff should administer medications according to physician's orders. The RN indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders. The RN indicated client #2's 20mg and 40mg capsules of Prozac medication should have been administered according to the physician's orders and according to the pharmacist's recommendation to be given together. The RN indicated she had not been contacted when client #2's medication labels did not match client #2's MAR. The RN indicated the nurse would need to initial any changes made in each client's MAR. The RN indicated the nurse should be contacted when the medication records and labels do not coincide.</p> <p>On 3/14/14 at 12:15pm, a review of the facility's undated Medication Administration Policy and Procedure was conducted. The policy and procedure indicated staff should administer client medications according to the physician's</p>			
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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, 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 2 of 2 sampled clients (clients #1 and #2) who wore prescribed eyeglasses, the facility failed to teach and encourage clients #1 and #2 to wear their prescribed eyeglasses.</p> <p>Findings include:</p> <p>During observations on 3/10/14 from 3:40pm until 5:55pm, and on 3/11/14 from 6:25am until 8:40am, at the group home clients #1 and #2 were not prompted and were not encouraged to wear their prescribed eyeglasses. During both observation periods, clients #1 and #2 watched television, colored on paper, completed medication administration, cooked with the facility staff, and counted their money.</p> <p>On 3/13/14 at 12:45pm, client #1's record was reviewed. Client #1's 4/17/13 ISP (Individual Support Plan) did not include a goal/objective to wear her prescribed eye glasses. Client #1's 7/2/13 vision</p>	W000436	<p>W436: Space and Equipment - Glasses. (1) Corrective action for resident(s) found to have been affected: Glasses reminders will be entered into the MAR for each waking shift. In the past it was once per day, but that allowed too much room for error since another staff might do it later. Having it each waking shift also allows for multiple prompts during the day if there is an early refusal. (2) How facility will identify other residents potentially affected & what measures taken: All residents with glasses affected, and corrective measures address the needs of all clients. (3) Measures or systemic changes facility put in place to ensure no recurrence: MAR reminders. (4) How corrective actions will be monitored to ensure no recurrence: The nurse transcribes the MAR each month and is responsible for ensuring that the prompts are in place. The Director supervises the nurse.</p>	04/19/2014			

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	<p>assessment indicated she wore prescribed eyeglasses. Client #1's 4/2/13 "Physician's Order" indicated client #1 wore prescribed eyeglasses. Client #1's 3/2014 MAR (Medication Administration Record) indicated "Glasses to be checked & (and) cleaned every AM, Notify Nurse if glasses need repaired" and indicated facility staff had initialed the tasks as completed daily from 3/1/14 through 3/13/2014.</p> <p>On 3/13/14 at 10:45am, client #2's record was reviewed. Client #2's 4/17/13 ISP (Individual Support Plan) did not include a goal/objective to wear her prescribed eyeglasses. Client #2's 5/24/11 vision assessment indicated she wore prescribed eyeglasses. Client #2's 3/21/13 "Physician's Order" indicated client #2 wore prescribed eyeglasses. Client #2's 3/2014 MAR (Medication Administration Record) indicated "Glasses to be checked & (and) cleaned every AM, Notify Nurse if glasses need repaired" and indicated facility staff had initialed the tasks as completed daily from 3/1/14 through 3/13/2014.</p> <p>On 3/14/14 at 11:35am, an interview with the facility's Registered Nurse (RN) and the Residential Manager (RM) was conducted. The RN indicated clients #1 and #2 wore prescribed eye glasses. The</p>			
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	<p>RN indicated staff should have taught and encouraged clients to wear their prescribed eyeglasses when opportunities existed.</p> <p>On 3/20/14 at 3:30pm, an interview with the Director of the facility was conducted. The Director indicated the facility staff should have taught and encouraged clients #1 and #2 to wear their prescribed eyeglasses during formal and informal opportunities.</p> <p>9-3-7(a)</p>			
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W000440	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on interview and record review, for 4 of 4 clients (clients #1, #2, #3, and #4) living in the group home, the facility failed to ensure evacuation drills were conducted every ninety (90) days for each shift of personnel for day and evening personnel shifts.</p> <p>Findings include:</p> <p>The facility evacuation drills for clients #1, #2, #3, and #4 were reviewed on 3/13/14 at 10:30am and indicated the following:</p> <ul style="list-style-type: none"> -Evacuation drills for first shift personnel (from 7:00am until 3:00pm)- on 9/21/13 at 10:30am and no evacuation drills were available from 9/21/13 through 3/13/14 -Evacuation drills for second shift personnel (3:00pm until 11:00pm)- on 3/4/13 at 6:30pm, on 8/25/13 at 7:28pm, and no evacuation drills were available from 8/25/13 through 3/13/14. <p>On 3/13/14 at 10:45am, an interview with the Director and the Residential Manager (RM) was conducted. Both the Director and the RM indicated they would look for additional evacuation drills.</p> <p>On 3/14/14 at 11:35am, the RM indicated</p>	W000440	<p>W440: Evacuation Drills. (1) Corrective action for resident(s) found to have been affected: a year-long schedule has been placed in the home. (2) How facility will identify other residents potentially affected & what measures taken: All residents potentially affected, and corrective measures address the needs of all clients. (3) Measures or systemic changes facility put in place to ensure no recurrence: a new schedule is in place. (4) How corrective actions will be monitored to ensure no recurrence: a regular home audit includes a summary of evacuation drills. These are scanned and sent to the Director and to the agency's compliance department. If evacuation drills are not conducted, an action plan is required to correct the problem.</p>	04/19/2014			

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	<p>he was continuing to look for additional evacuation drills and none were located. On 3/20/14 at 3:30pm, an interview with the Director was conducted. The Director indicated no additional drills had been located. The Director indicated the first shift of personnel was 7am until 3pm, the second shift of personnel was 3pm until 11pm, and the third shift of personnel was 11pm until 7am. The Director indicated clients #1, #2, #3, and #4 lived in the group home.</p> <p>9-3-7(a)</p>			

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W000455	<p>483.470(l)(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, for 2 of 2 sampled clients (clients #1 and #2) and 2 additional clients (clients #3 and #4), the facility failed to ensure client #1 used sanitary methods to set the dining room table for clients #1, #2, #3, and #4, when cooking, and during medication administration when opportunities existed.</p> <p>Findings include:</p> <p>1. On 3/10/14 at 5:35pm, client #1 had her evening medication administered by GHS (Group Home Staff) #2 and client #1 was not prompted or encouraged to wash her hands.</p> <p>On 3/11/14 at 7:12am, client #1 had her morning medication administered by GHS #3 and client #1 was not prompted or encouraged to wash her hands.</p> <p>On 3/11/14 at 7:45am, GHS #3 administered client #2's morning medications and client #2 was not prompted or encouraged to wash her hands.</p>	W000455	W455: Infection Control – Hand Washing. (1) Corrective action for resident(s) found to have been affected: Hand washing was a topic at a staff meeting. Washing before meals, meal preparation, and medication administration, and after restroom use were included. Also included was the need to maintain supplies (e.g., paper towels) as well as having clients use gloves when appropriate. (2) How facility will identify other residents potentially affected & what measures taken: All residents potentially affected, and corrective measures address the needs of all clients. (3) Measures or systemic changes facility put in place to ensure no recurrence: review at staff meeting. (4) How corrective actions will be monitored to ensure no recurrence: The manager is responsible to supervise staff. The Manager completes home visit forms and will monitor the implementation of new corrections. The group home manager will be required to monitor the facility in-person for a minimum of four (4) hours per week. The Director supervises management staff and reviews home visit forms at regular meetings, including ensuring that the manager has been in the	04/19/2014			

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	<p>On 3/14/14 at 11:35am, an interview with the agency Registered Nurse (RN) was conducted. The RN indicated the staff should had taught and encouraged clients #1 and #2 to wash their hands before medications were administered.</p> <p>2. On 3/10/14 from 3:40pm until 5:55pm, observation was completed at the group home. During the observation period clients #1 and #3 did not wash their hands before assisting the staff to handle pork steak and make Koolaid. During the observation period client #1 set the dining room table without washing the table before setting table service and before meals on the dining room tables for clients #1, #2, #3, and #4. During the observation periods client #1 handled each of the forks, spoons, and knives by the food contact ends for each of the table settings for clients #1, #2, #3, and #4 without redirection from the facility staff. During the observation period client #1 handled client #1, #2, #3, and #4's plates touching the food contact areas of the plates with her hands after client #1 touched her face and hair without redirection from the facility staff. During the observation period client #1 held the plates against her shirt while setting the table without redirection from the facility staff.</p>		home a minimum of four (4) hours per week.				

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	<p>On 3/14/14 at 11:35am, an interview with the Residential Manager (RM) was conducted. The RM indicated clients #1, #2, #3, and #4 should be taught and encouraged to wash their hands, the dining room table before dining, and to use sanitary methods to set the dining room table before dining. The RM indicated clients #1 and #3 should have been redirected by the facility staff to wash their hands before setting the table for meals, after touching their face, and before touching the food contact areas for each of the table service items before meals.</p> <p>On 3/18/14 at 6:00pm, a review of the facility's 10/1/2006 "Handwashing" policy and procedure indicated "Handwashing is the most important procedure for preventing healthcare associated infections." The policy and procedure indicated handwashing should be completed.</p> <p>9-3-7(a)</p>				