

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2012
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330
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W0000	<p>This visit was for a pre-determined full recertification and state licensure survey and for the investigation of complaint #IN00115785.</p> <p>Complaint #IN00115785: Substantiated-Federal/state deficiencies related to the allegation(s) are cited at W159 and W227.</p> <p>Dates of Survey: 10/2, 10/3, 10/4, 10/9 and 10/17/12</p> <p>Facility Number: 012632 Provider Number: 15G807 AIMS Number: 201065000</p> <p>Surveyors: Paula Chika, Medical Surveyor III-Team Leader Susan Eakright, Medical Surveyor III (10/2/12 to 10/4/12)</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 10/17/12 by Tim Shebel, Medical Surveyor III.</p>	W0000		

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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W0102	<p><b>483.410 GOVERNING BODY AND MANAGEMENT</b> The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 2 of 2 sampled clients (A and B) and for 2 additional clients (B and C). The governing body failed to ensure the facility's management provided oversight and management of running of the group home due to the group home's history of non-compliance with Conditions of Participation within the past year January 2012 to October 2012. The governing body failed to ensure clients' information was kept confidential, to ensure outside services met the identified needs of client B, and ensured the civil and constitutional rights of clients A, B, C and D. The governing body failed to ensure the facility implemented its financial policy to ensure a complete accounting of client A, B, C and D's funds. The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of client C, to ensure the facility had a reproducible system and/or conducted thorough investigations in regard to injuries of unknown origin and exploitation, completed investigations timely and put in place corrective</p>	W0102	<p><b>CORRECTION:</b> <i>The facility must ensure that specific governing body and management requirements are met.</i> Specifically, the governing body has provided direction and oversight to assure that:</p> <ol style="list-style-type: none"> <li>1. Confidential client information is no longer posted in plain view in the home.</li> <li>2. Rights restrictions have been approved after due process has occurred.</li> <li>3. Clients have the opportunity to register to vote.</li> <li>4. A system for accounting for Client A, B and D's finances has been implemented.</li> <li>5. Incidents of aggression and injuries of unknown origin are investigated thoroughly in a manner that can be reproduced as required.</li> <li>6. Corrective measures will be implemented when allegations are verified</li> <li>7. The QDDP receives the appropriate guidance, mentorship and training to adequately integrate, coordinate and monitor each client's active treatment program</li> <li>8. Nursing services meet the needs of all clients.</li> <li>9. Additional matching dining room chairs will be purchased</li> </ol> <p><b>PREVENTION:</b> The Operations,</p>	11/16/2012			

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	<p>measures/actions regarding client to client aggression when warranted for clients A, B, C and D. The governing body failed to ensure the facility's Qualified Mental Retardation Professional (QMRP) carried out their duties to monitor, coordinate and integrate client A, B, C and D's programs as needed. The governing body failed to ensure the facility's nursing services met the health care needs of clients A and B. The governing body failed to ensure the facility had enough dining room chairs for clients to sit in at meals.</p> <p>Findings include:</p> <p>1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 2 of 2 sampled clients (A and B) and for 2 additional clients (C and D). The governing body failed to implement its policy and procedures to prevent neglect of clients, to conduct thorough investigations/provide a reproducible system of its investigations, to conduct investigations timely and to put in place corrective actions. The facility failed to ensure the rights of the clients it served in regard to locking cleaning supplies, and in regard to not allowing the client to have free access to look out the windows of the group home and teach the clients their civil rights in regard to voting. The</p>		<p>Quality Assurance and Nursing Teams have committed to work together to assure that facility professional and direct support staff receive sufficient oversight and support to meet internal and regulatory expectations. This will be accomplished through an increased Governing Body presence at the facility that will include active treatment observations, support document reviews and on-site coaching. The Quality Assurance Manager will monitor incidents which require investigation and will follow-up with facility professional staff to assure thorough investigations occur within established timeframes, and corrective measures are implemented as needed. Additionally, The Program Manager will meet with the Behavioral Clinician weekly to review each client's behavioral status and discuss programmatic revisions to more effectively support clients' behavioral needs.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Behavior Clinician, Health Services Team, Quality Assurance Team, Operations Team</p>		

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	<p>facility failed to ensure a financial system was in place and/or being utilized to monitor clients' funds entrusted to the facility, and failed to ensure each client had the right to carry pocket money on them if they chose to. Please see W122.</p> <p>2. The governing body failed to provide oversight and management of the group home as indicated by the following: The governing body failed to allow clients to the right to have access to cleaning supplies as the supplies were locked in the group home, and to allow/encourage clients to register to vote to exercise their rights as citizens of the United States. The governing body failed to exercise general policy and operating direction over the facility to allow clients the right/freedom to look out the windows of their home as the windows were frosted over for clients A, B, C and D. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility allowed and/or encourage the clients to carry money on their person to the extent they were capable for client A, B, C and D.</p> <p>The governing body failed to ensure the facility had enough comfortable dining room chairs for the clients A, B, C and D to sit in when eating. The governing body failed to ensure the facility kept a</p>				

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	<p>complete accounting of client A, B, C and D's funds as the group home failed to utilize the facility's system for managing clients' finances.</p> <p>The governing body failed to ensure the facility implemented its policy and procedures to conduct thorough investigations in regard to client A, B, C and D's allegations of client to client abuse, injuries of unknown origin, and/or an allegation in regard to exploitation to ensure the clients were not neglected and/or abused. The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of client C in regard to the client's self-injurious/self harm behavior. The governing body failed to ensure the facility implemented its policy and procedures to conduct investigations within 5 working days for client C. The governing body failed to ensure the facility implemented its policy and procedures to put in place corrective actions for clients B, C and D.</p> <p>The governing body failed to ensure the facility maintained a reproducible system and/or failed to provide evidence of a thorough investigation regarding allegations of abuse, neglect and/or injuries of unknown origin for clients A, B, C and D. The governing body failed to</p>						

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	<p>ensure the facility reported the results of a client to client allegation of abuse to the administrator within 5 days for client C. The governing body failed to ensure the facility developed/put in place corrective actions for client to client incidents of aggression/abuse for clients B, C and D.</p> <p>The governing body failed to ensure the facility's QMRP monitored clients' data in regard to completing monthly summaries for clients A and B to determine if the clients had met, lost skill, regressed and/or should be moved on toward new training. The governing body failed to ensure the QMRP developed an active treatment schedule which encompassed client B and D's total day to ensure active treatment/training. The governing body failed to ensure the QMRP monitored/coordinated clients' programs in ensuring all day service providers/workshops participated as members in team meetings and documented/coordinated information in regard to client B's attendance at a workshop and/or ensured a team process was involved when it was decided the client would no longer attend. The governing body failed to ensure the QMRP assessed client A, B, C and D's needs in regards to locking cleaning supplies and the need for frosted windows. The governing body failed to</p>			

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	<p>ensure the QMRP conducted accurate assessments of clients in regard to their vocational needs, informed consent assessments and to coordinate/obtain an a communication assessment for clients A and B. The governing body failed to ensure the QMRP completed comprehensive functional assessments, addressed refusals of needed adaptive equipment, and addressed clients identified behavior al needs for clients A and B. The governing body failed to ensure the QMRP coordinated with the facility's Human Rights Committee to ensure the specially constituted committee reviewed and/or approved all facility blanket practices to ensure the protection of client A, B, C and D's rights.</p> <p>The governing body failed to ensure the facility's nursing services developed risk plans/nursing protocols for client A's edema and when to call the nurse in regard to the client's low blood pressure, and for client B's diabetes. The governing body failed to ensure the facility's nursing services conducted quarterly nursing assessments of clients health status and medical needs for clients A and B. Please see W149.</p> <p>9-3-1(a)</p>						

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W0104	<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, interview and record review for 2 of 2 sampled clients (A and B) and for 2 additional clients (B and C), the facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's management provided oversight and management of running of the group home due to the group home's history of non-compliance with Conditions of Participation within the past year January 2012 to October 2012. The governing body failed to exercise general policy and operating direction over the facility to ensure clients' information was kept confidential, to ensure outside services met the identified needs of client B, and ensured the civil and constitutional rights of clients A, B, C and D. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its financial policy to ensure a complete accounting of client A, B, C and D's funds. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of client C, to ensure the facility had a</p>	W0104	<p><b>CORRECTION:</b> <i>The Governing body must exercise general policy, budget and operating direction over the facility. Specifically, the governing body has provided direction and oversight to assure that:</i></p> <ol style="list-style-type: none"> <li>1. Confidential client information is no longer posted in plain view in the home.</li> <li>2. Rights restrictions have been approved after due process has occurred.</li> <li>3. Clients have the opportunity to register to vote.</li> <li>4. A system for accounting for Client A, B and D's finances has been implemented.</li> <li>5. Incidents of aggression and injuries of unknown origin are investigated thoroughly in a manner that can be reproduced as required.</li> <li>6. Corrective measures will be implemented when allegations are verified</li> <li>7. The QDDP receives the appropriate guidance, mentorship and training to adequately integrate, coordinate and monitor each client's active treatment program</li> <li>8. Nursing services meet the needs of all clients.</li> <li>9. Additional matching dining room chairs will be purchased</li> </ol> <p><b>PREVENTION:</b> The Operations,</p>	11/16/2012			

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	<p>reproducible system and/or conducted thorough investigations in regard to injuries of unknown origin and exploitation, completed investigations timely and put in place corrective measures/actions regarding client to client aggression when warranted for clients A, B, C and D. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Qualified Mental Retardation Professional (QMRP) carried out their duties to monitor, coordinate and integrate client A, B, C and D's programs as needed. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services met the health care needs of clients A and B. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility had enough dining room chairs for clients to sit in at meals.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's management/administration monitored/provided oversight of the group home to ensure the group home followed and implemented the facility's</p>		<p>Quality Assurance and Nursing Teams have committed to work together to assure that facility professional and direct support staff receive sufficient oversight and support to meet internal and regulatory expectations. This will be accomplished through an increased Governing Body presence at the facility that will include active treatment observations, support document reviews and on-site coaching. The Quality Assurance Manager will monitor incidents which require investigation and will follow-up with facility professional staff to assure thorough investigations occur within established timeframes, and corrective measures are implemented as needed. Additionally, The Program Manager will meet with the Behavioral Clinician weekly to review each client's behavioral status and discuss programmatic revisions to more effectively support clients' behavioral needs.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Behavior Clinician, Health Services Team, Quality Assurance Team, Operations Team</p>		

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	<p>policy and procedures to meet the needs of the clients it served as indicated by the following:</p> <p>-The group home failed to meet the Conditions of Participation: Governing Body and Client Protections on 3/23/12 and 5/7/12 of this year at two previous surveys.</p> <p>-The facility failed to ensure its financial system was in place and monitored to ensure the group home had a complete accounting of clients funds in regards to client A, B, C and D's cash on hand and in regard to outside accounts as the group home did not have ledgers and or statements for the clients' bank accounts and did not keep up to date entries in the cash on hand ledgers. The group home was not following the facility's 12/12/07 financial policy and procedure for clients finances.</p> <p>-The facility failed to ensure its QMRP monitored clients finances, conducted investigations, completed timely investigations, ensured clients' rights, integrated and/or coordinated outside services to meet the needs of clients, and/or to ensure support staff (nursing staff and behavioral consultants) completed documentation of their specific programs to ensure the needs of the</p>						

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	<p>clients. The facility failed to ensure the QMRP met and/or provided them assistance to meet the program needs of clients A, B, C and D in regard to monitoring the clients' data/Individual Support Plan (ISP) objectives, completing assessments, and to address identified needs of clients A, B, C and D. The facility failed to ensure the QMRP coordinated services with Human Rights Committee to ensure the facility's HRC reviewed all facility practices (frosted windows/locking of cleaning supplies) were reviewed to ensure clients' rights were protected.</p> <p>-The facility failed to ensure its nursing services visited the group home and/or documented their visits to the group home to ensure the nursing needs of the clients' were being met. The facility's Visitor Log (all support staff and visitors) sign in and out sheets were reviewed on 10/4/12 at 10:45 AM. The visitors logs from 6/12 to 10/12 indicated RN #1 was at the group home on 6/14/12. The logs did not indicate any additional documentation of the nurse being in the group home.</p> <p>Interview with RN (registered nurse) #1 on 10/4/12 at 10:35, by phone, indicated she had took over being the nurse for the group home since the first of June 2012. RN #1 indicated she visited the group</p>				

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	<p>home at least 2 times a week.</p> <p>Interview with the QMRP and Behavior Consultant (BC) #1 on 10/4/12 at 11:07 AM indicated there was no behavior data/behavioral monthlies in regard to client A, B, C and D's behavioral objectives to review. BC #1 indicated he had just started on 8/1/12. BC #1 indicated he would be doing monthly summaries in regard to the client's behavioral objectives. The QMRP indicated she had completed monthly reviews for the clients' ISP objectives. The QMRP did not provide any additional documentation of the clients' monthly summaries for the past year (12/11 to 10/12).</p> <p>Interview with administrative staff #2 on 10/9/12 at 11:52 AM, by phone, indicated management staff had been providing oversight of the group home. Administrative staff #2 indicated administrative staff #2 had been providing the management oversight of the group home as administrative staff #2 had to serve in the behavioral consultant roll when the group home was without a BC. Administrative staff #2 stated "We have had more face to face time with the managers/Program Coordinators of the ESN (Extensive Support Need) group homes than any other homes. Her focus</p>				

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	<p>has been behavioral and providing oversight." Administrative staff #2 indicated the administrative staff #1 and administrative staff #3 trained the QMRP on her job duties. Administrative staff #2 indicated the QMRP had been dealing with the clients' behaviors at the group home which took up most of the QMRP's time. When asked if the administrative staff had provided additional supports and/or assistance for the QMRP to complete her duties, administrative staff indicated administrative staff #1 was currently at the group home helping the QMRP locate information the surveyors had requested. Administrative staff #2 indicated the group home should be following the 12/12/07 financial policy in regard to monitoring/managing the clients' finances. Administrative staff #2 indicated he had been made aware there was no documentation of when the nurse was in the group home. Administrative staff #2 indicated he was sure the nurse had been at the group home and they were in the process of trying to get that resolved as all visitors and support staff were to sign in and out of the group home.</p> <p>2. On 10/2/12 from 4:55pm until 6:30pm, clients A, B, C, and D were at the group home. The dining room table had four (4) regular wooden dining room chairs and</p>						

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	<p>two (2) folding metal chairs at the table. At 5:42pm, clients A, C, and D with three (3) facility staff sat down at the dining room table. Clients A and D sat on folding metal chairs at the dining room table. At 6pm, client A told staff she did not want to sit on a metal chair and FS (Facility Staff) #1 exchanged chairs with client A.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on 10/4/12 at 11:07 AM indicated the group home did not have enough chairs. The QMRP indicated clients had broke the chairs when having behaviors. The QMRP indicated she thought the maintenance staff was ordering new chairs.</p> <p>Interview with administrative staff #2 on 10/9/12 at 11:53 AM, by phone, indicated he was not aware the group home was in need of chairs and was not sure if maintenance staff knew the group home chairs needed to be replaced. Administrative staff #2 stated "They will now."</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to allow clients to the right to have access to cleaning supplies as the supplies were locked in the group</p>						

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	<p>home, and to allow/encourage clients to register to vote to exercise their rights as citizens of the United States. The governing body failed to exercise general policy and operating direction over the facility to allow clients the right/freedom to look out the windows of their home as the windows were frosted over for clients A, B, C and D. Please see W125.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility allowed and/or encourage the clients to carry money on their person to the extent they were capable for client A, B, C and D. Please see W126.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility kept a complete accounting of client A, B, C and D's funds as the group home failed to utilize the facility's system for managing clients' finances. Please see W140.</p> <p>6. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to conduct thorough investigations in regard to client A, B, C and D's allegations of client to client abuse, injuries of unknown origin, and/or an allegation in regard to</p>						

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	<p>exploitation to ensure the clients were not neglected and/or abused. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client C in regard to the client's self-injurious/self harm behavior. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to conduct investigations with 5 working days for client C. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to put in place corrective actions for clients B, C and D. Please see W149.</p> <p>7. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility maintained a reproducible system and/or failed to provide evidence of a thorough investigation regarding allegations of abuse, neglect and/or injuries of unknown origin for clients A, B, C and D. Please see W154.</p> <p>8. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility</p>			

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	<p>reported the results of a client to client allegation of abuse to the administrator within 5 days for client C. Please see W156.</p> <p>9. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility developed/put in place corrective actions for client to client incidents of aggression/abuse for clients B, C and D. Please see W157.</p> <p>10. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's QMRP monitored clients' data in regard to completing monthly summaries for clients A and B to determine if the clients had met, lost skill, regressed and/or should be moved on toward new training. The governing body failed to exercise general policy and operating direction over the facility to ensure the QMRP developed an active treatment schedule which encompassed client B and D's total day to ensure active treatment/training. The governing body failed to exercise general policy and operating direction over the facility to ensure the QMRP monitored/coordinated clients' programs in ensuring all day service providers/workshops participated as members in team meetings and</p>						

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	documented/coordinated information in regard to client B's attendance at a workshop and/or ensured a team process was involved when it was decided the client would no longer attend. The governing body failed to exercise general policy and operating direction over the facility to ensure the QMRP assessed client A, B, C and D's needs in regards to locking cleaning supplies and the need for frosted windows. The governing body failed to exercise general policy and operating direction over the facility to ensure the QMRP conducted accurate assessments of clients in regard to their vocational needs, informed consent assessments and to coordinate/obtain an a communication assessment for clients A and B. The governing body failed to exercise general policy and operating direction over the facility to ensure the QMRP completed comprehensive functional assessments, addressed refusals of needed adaptive equipment, and addressed clients identified behavior al needs for clients A and B. The governing body failed to exercise general policy and operating direction over the facility to ensure the QMRP coordinated with the facility's Human Rights Committee to ensure the specially constituted committee reviewed and/or approved all facility blanket practices to ensure the protection of client A, B, C and D's rights.			

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	<p>Please see W159.</p> <p>11. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services developed risk plans/nursing protocols for client A's edema and when to call the nurse in regard to the client's low blood pressure, and for client B's diabetes. Please see W331.</p> <p>12. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services conducted quarterly nursing assessments of clients health status and medical needs for clients A and B. Please see W336.</p> <p>9-3-1(a)</p>				

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W0112	<p><b>483.410(c)(2)</b> <b>CLIENT RECORDS</b> The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.</p> <p>Based on observation, record review, and interview, for 4 of 4 clients (clients A, B, C, and D) living in the group home, the facility failed to keep clients medical and personal information confidential by posting information on the kitchen refrigerator.</p> <p>Findings include:</p> <p>On 10/2/12 from 4:55pm until 6:30pm, observation and interview were completed at the group home and on the kitchen refrigerator were four sheets of paper each individual paper had client A, B, C, or D's name in bold printed colors on each "October, 2012" page. The four pages indicated:</p> <p>- "[Client A's full name] October, 2012. Monday 10/1 - Therapy @ (at) 1pm... Wednesday 10/3 - [Dr. Name] @ 1:30pm, Thursday 10/4 - Therapy @ 1pm... Monday 10/8 - Therapy @ 1pm and [Dr. Name] @10:25am... Thursday 10/11 - Therapy @ 1pm and Flu Vac (vaccination) @10am... Monday 10/15 - Therapy @ 1pm and [Dr. Name] @</p>	W0112	<p><b>CORRECTION:</b> <i>The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.</i> Specifically, private medical information for Clients A – D is no longer posted in plain view in the home</p> <p><b>PREVENTION:</b> Professional staff have been trained regarding the need to protect the confidentiality of individuals residing at the facility. Members of the Operations and Quality Assurance Teams will perform visual observations of the home no less than monthly to assure that confidentiality is maintained.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Quality Assurance Team, Operations Team</p>	11/16/2012

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	<p>10:15am, Tuesday 10/16 - [Dr. Name] @ 9:45am...Thursday 10/18 - Therapy @ 1pm...Monday 10/22 - Therapy @ 1pm...Thursday 10/25 - Therapy @ 1pm...Monday 10/29 - Therapy @ 1pm...."</p> <p>-"[Client B's full name] October, 2012. Monday 10/1 - Therapy @ (at) 9am and Dr. [name] @ 10am, Tuesday 10/2 - Case mgt (Management) w/ (with) [Behavior Specialist #2] @ 8am...Thursday 10/4 - Therapy @ 9am [and] Case mgt w/ [Behavior Specialist #2] @ 8am...Monday 10/8 - Therapy @ 9am, Tuesday 10/9 - Case. w/ [Behavior Specialist #2] @ 8am...Thursday 10/11 - Therapy @ 9am and Case mgt. w/ [Behavior Specialist #2] @ 8am...Monday 10/15 - Therapy @ 9am, Tuesday 10/16 - Case mgt. w/ [Behavior Specialist #2]...Thursday 10/18 - Therapy @ 9am [and] Case mgt. w/ [Behavior Specialist #2], Friday 10/19 - Oral Surgeon consult @ 9:45am...Monday 10/22 - Therapy @ 9am, Tuesday 10/23 - Case mgt. w/ [Behavior Specialist #2] @ 8am...Thursday 10/25 - Therapy @ 9am, Case mgt. w/ [Behavior Specialist #2] @ 8am, [and] Flu Vac (vaccination) @9:30am...Monday 10/29 - Therapy @ 9am [and] Dr. [name] @ 8am, Tuesday 10/30 - Case mgt. w/ [Behavior Specialist #2] @ 8am...."</p>			

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	<p>-"[Client C's full name] October, 2012. Monday 10/1 - Therapy @ (at) 8am, Tuesday 10/2 - Dr [name] 10am, Wednesday 10/3 - Dr.[name] @ 8:45am, Thursday 10/4 - Therapy @ 8am [and] mouth guard re fit @ 10am...Monday 10/8 - Therapy @ 8am...Thursday 10/11 - Therapy @ 8am...Wednesday 10/17 - flu vac (vaccine) @10am, Thursday 10/18 - Therapy @ 8am...Monday 10/22 - Therapy @ 8am...Thursday 10/25 - Therapy @ 8am...Monday 10/29 - Therapy @ 8am...."</p> <p>-"[Client D's full name] October, 2012. Monday 10/1 - Therapy @ (at) 2pm...Thursday 10/4 - Therapy @ 2pm...Monday 10/8 - Therapy @ 2pm...Thursday 10/11 - Therapy @ 2pm [and] Flu Vac. @ 9:40am...Monday 10/15 - Therapy @ 2pm...Thursday 10/18 - Therapy @ 2pm...Monday 10/22 - Therapy @ 2pm [and] [Dr. Name] @ 10am...Thursday 10/25 - Therapy @ 2pm...Monday 10/29 - Therapy @ 2pm...."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/2/12 at 5:30pm. At 5:30pm, the QMRP indicated client A, B, C, and D's personal information of their full names, doctor's names, appointment</p>						

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	<p>times, and group therapy and personal information should not have been posted on the group home refrigerator where visitors to the home had access.</p> <p>9-3-1(a)</p>			

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W0120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client.</p> <p>Based on observation, record review, and interview, for 1 of 1 sample client (client B) who did not attend the outside contracted workshop, the facility failed to ensure outside services provided services based on client B's identified need.</p> <p>Findings include:</p> <p>On 10/3/12 from 10:30am until 11:45am, the facility's outside contracted workshop was visited and client B was not present. At 10:45am, Workshop Staff (WKS) #1 was interviewed and WKS #1 stated client B "no longer attended the (outside contracted) workshop because of [client B's] behaviors." WKS #1 provided an email dated 4/4/12 which indicated from WKS #2 at 8:40am: "[Group Home Staff #5] asked [WKS #1] today if [client B] could start spending full days in GE (General Education class). Is this something you would like for her to do?... [WKS #1] said that she doesn't work down in the workshop so it would be beneficial for her to stay in GE." WKS #1's response on 4/4/12 at 9:07am: "In the future, we need to discuss program changes with you prior to being</p>	W0120	<p><b>CORRECTION:</b> <i>The facility must assure that outside services meet the needs of each client. Specifically, the interdisciplinary team met with Anthony Wayne Services on 10/29/12 to discuss Client B's current vocational and pre-vocational needs. Client B has been targeted for a move into a new residential setting. The interdisciplinary team will communicate Client B's assessed vocational and pre-vocational needs to the new residential provider.</i></p> <p><b>PREVENTION:</b> Professional staff will be trained regarding the need to bring the interdisciplinary team together to reach consensus prior to making changes in a client's level of day service participation. The QDDP will report results of IDT discussions with the Clinical Supervisor and Program Manager prior to implementation of changes.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Behavior Clinician, Quality Assurance Team, Operations Team</p>	11/16/2012			

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	<p>implemented. I would rather us discuss program placement, time changes, etc. prior to the clients being informed that a change will occur...." QMRP (Qualified Mental Retardation Professional) responded on 4/4/12 at 11:09am: "Most definitely! Sometimes the staff gets ahead of me on things I am trying to accomplish with the girls. I had no idea they had told the girls yesterday...that they were staying all day...staff were not suppose to make that decision without me...I did not know [client B] went today until just a few minutes ago...."</p> <p>During an interview on 10/3/12 at 10:45am, WKS #1 stated client B had not attended workshop services at the contracted workshop "since 3/6/12." WKS #1 indicated client B had Absent With Out Leave (AWOL) behaviors. WKS #1 stated the contracted workshop staff "was not involved with the decision" of client B no longer attending the workshop. WKS #1 stated "one day she didn't come and I found out later" the group home made the decision "we weren't asked."</p> <p>On 10/3/12 from 12noon until 2:55pm observation at the group home was completed. Client B went into the community with her one on one assigned staff person from the group home, played</p>				

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	<p>table games, and talked to her staff person.</p> <p>On 10/3/12 at 12:45pm, client B's record was reviewed. Client B's 11/29/11 CFA (Comprehensive Functional Assessment) and 11/27/11 Vocational Skills assessment both indicated client B had the skills to attend the sheltered workshop. Client B's 11/29/11 CFA indicated "Can perform simple work." Client B's 1/5/12 ISP (Individual Support Plan) indicated client B attended the contracted workshop daily and completed "half days." Client B's Active Treatment Schedule did not indicate her activity scheduled from 8am until 2pm Monday through Friday. No reassessment of client B's vocational needs was available for review. No documentation for client B's workshop/day services attendance was available for review.</p> <p>On 10/3/12 at 12:45pm, client B's 5/17/12 "Interdisciplinary Team Meeting" progress note indicated client B had "behaviors during [name of contracted service] day program/workshop...[Name of Workshop] to provide community Mon-Fri (Monday - Friday) for 1 hour. Team feels 9am-10am would be a good time to avoid anxiety of waiting through the afternoon...group home to be prepared when sending staff tentatively to start the</p>			

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	<p>first week of June (2012)." No reassessment of client B's vocational needs was available for review. No workshop attendance records, no QMRP entries, and no further information was available for review.</p> <p>On 10/4/12 at 8:40am, an interview was conducted with the QMRP. The QMRP indicated no further information regarding client B's vocational placement was available for review. The QMRP stated "I can't remember when [client B] stopped attending workshop." The QMRP stated "March of 2012, sounds right." The QMRP stated client B stopped attending workshop when "I pulled her out." The QMRP indicated a meeting with workshop was held on 5/17/12 and it was decided that she would attend day services in the classroom. The QMRP stated she could not recall the dates or if client B "ever attended." The QMRP stated client B "currently stayed home all day."</p> <p>9-3-1(a)</p>				

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients (A and B) and for 2 additional clients (C and D). The facility failed to implement its policy and procedures to prevent neglect of clients, to conduct thorough investigations/provide a reproducible system of its investigations, to conduct investigations timely and to put in place corrective actions. The facility failed to ensure the rights of the clients it served in regard to locking cleaning supplies, and in regard to not allowing the client to have free access to look out the windows of the group home and teach the clients their civil rights in regard to voting. The facility failed to ensure a financial system was in place and/or being utilized to monitor clients' funds entrusted to the facility, and failed to ensure each client had the right to carry pocket money on them if they chose to.</p> <p>Findings include:</p> <p>1. The facility failed to allow clients to have the right to access cleaning supplies as the supplies were locked in the group home, and to allow/encourage clients to</p>	W0122	<p><b>CORRECTION:</b> <i>The facility must ensure that specific client protections requirements are met. Specifically, the facility will assure that:</i></p> <ol style="list-style-type: none"> <li>1. Confidential client information is no longer posted in plain view in the home.</li> <li>2. Rights restrictions have been approved after due process has occurred.</li> <li>3. Clients have the opportunity to register to vote.</li> <li>4. A system for accounting for Client A, B and D's finances has been implemented.</li> <li>5. Incidents of aggression and injuries of unknown origin are investigated thoroughly in a manner that can be reproduced as required.</li> <li>6. The clients have the right to carry pocket money based on their assessed abilities</li> </ol> <p><b>PREVENTION:</b> The Operations, Quality Assurance and Nursing Teams have committed to work together to assure that facility professional and direct support staff receive sufficient oversight and support to meet internal and regulatory expectations. This will be accomplished through an increased Governing Body presence at the facility that will include active treatment observations, support document reviews and on-site coaching.</p>	11/16/2012			

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	<p>register to vote to exercise their rights as citizens of the United States. The facility also failed to allow clients the right/freedom to look out the windows of their home as the windows were frosted over for clients A, B, C and D. Please see W125.</p> <p>2. The facility failed to allow and/or encourage the clients to carry money on their person to the extent they were capable for clients A, B, C and D. Please see W126.</p> <p>3. The facility to keep a complete accounting of client A, B, C and D's funds as the group home failed to utilize the facility's system for managing clients' finances. Please see W140.</p> <p>4. The facility failed to implement its policy and procedures to conduct thorough investigations in regard to client A, B, C and D's allegations of client to client abuse, injuries of unknown origin, and/or an allegation in regard to exploitation to ensure the clients were not neglected and/or abused. The facility failed to implement its policy and procedures to prevent neglect of client C in regard to the client's self-injurious/self harm behavior. The facility failed to implement its policy and procedures to ensure its investigations included</p>		<p>Additionally, the Quality Assurance Manager will monitor incidents which require investigation and will follow-up with facility professional staff to assure thorough investigations occur within established timeframes, and corrective measures are implemented as needed. <b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Behavior Clinician, Health Services Team, Quality Assurance Team, Operations Team</p>				

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	<p>corrective actions to prevent recurrence in regard to client to client allegations of abuse/incidents for client D. The facility failed to implement its policy and procedures to conduct investigations with 5 working days for client C. The facility failed to implement its policy and procedures to put in place corrective actions for clients B, C and D. Please see W149.</p> <p>5. The facility failed to maintain a reproducible system and/or failed to provide evidence of a thorough investigation regarding allegations of abuse, neglect and/or injuries of unknown origin for clients A, B, C and D. Please see W154.</p> <p>6. The facility failed to report the results of a client to client allegation of abuse to the administrator within 5 days for client C. Please see W156.</p> <p>7. The facility failed to develop/put in place corrective actions for client to client incidents of aggression/abuse for clients B, C and D. Please see W157.</p> <p>9-3-2(a)</p>				

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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 2 of 2 sampled clients (A and B) and for 2 additional clients (C and D), the facility failed to allow clients to have the right to access cleaning supplies as the supplies were locked in the group home, and to allow/encourage clients to register to vote to exercise their rights as citizens of the United States.</p> <p>The facility also failed to allow clients the right/freedom to look out the windows of their home as the windows were frosted over.</p> <p>Findings include:</p> <p>1. During the 10/3/12 observation period between 5:23 AM and 8:05 AM, at the group home, cleaning supplies were locked in the office area of the group home and in a cabinet under the kitchen sink. Interview with staff #3 on 10/3/12 at 5:40 AM indicated the cleaning supplies were kept locked in the office at the back of the home. Staff #3 indicated clients A, B, C and D did not have a key to access the chemicals. When asked why</p>	W0125	<p><b>CORRECTION:</b> <i>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Specifically, the facility has reassessed Clients A – D and consensually agrees that there is no current need to keep cleaning supplies in a locked cabinet and the household chemicals are no longer secured. Additionally, based on civil awareness assessment data, Clients A – D have received the opportunity to register to vote.</i></p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding the need to implement rights restrictions, only after appropriate due process, based on assessed needs. Members of the Operations and Quality Assurance Teams will review assessment data and monitor the facility for rights restrictions no less than monthly to assure rights are restricted only to protect the health and safety of clients and only after appropriate due process has occurred.</p>	11/16/2012			

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	<p>the cleaning supplies were locked, staff #3 stated "They have always been locked." Staff #3 then indicated she thought the cleaning supplies were locked as client A may drink the chemicals.</p> <p>Client A's record was reviewed on 10/3/12 at 12:55 PM. Client A's 5/3/12 Behavior Support Plan (BSP) indicated client A demonstrated "Suicide Attempts" which was defined as using sharps or other items to cause bodily harm (i.e. rubbing off skin, cutting open her skin, picking at healing wounds, using items to strangle herself), this also includes if she is attempting to ingest chemicals." Client A's 5/3/12 BSP and/or 2/1/12 Individual Support Plan (ISP) did not indicate the cleaning supplies in the home should be locked. Client A's 2/1/12 ISP indicated client A was her own guardian. Client A's 2/1/12 ISP and/or 4/17/12 BSP did not indicate the client gave written informed consent to lock the cleaning supplies, and/or indicate the facility's Human Rights Committee (HRC) reviewed and approved the systemic restriction.</p> <p>Client C's record was reviewed on 10/4/12 at 10:05 AM. Client C's 11/29/11 ISP and/or 4/18/12 BSP did not indicate client C had been assessed in regard to the need to lock cleaning supplies. Client C's 4/18/12 BSP indicated client C had a</p>		<p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Quality Assurance Team, Operations Team</p>		

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	<p>guardian. The 4/18/12 BSP and/or 11/29/11 ISP did not indicate the client's guardian gave written informed consent for locking the cleaning supplies. Client C's 4/18/12 BSP also did not indicate the facility's HRC reviewed and/or approved the systemic restriction of locking the cleaning supplies.</p> <p>Client B's record was reviewed on 10/3/12 at 12:45pm. Client B's 1/5/12 ISP did not indicate the need for locked cleaning supplies. Client B's 4/17/12 BSP (Behavior Management Plan) did not identify the need for locked cleaning supplies. Client B's 12/2/11 "Chemical Safety Assessment" indicated "...Has rubbed cleaning wipes on face before...Recommendations: Supervision with all cleaning supplies." The client's BSP and/or ISP did not indicate the cleaning supplies should be locked and/or indicate the facility's HRC reviewed the blanket restriction.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and Behavior Consultant (BC) #1 on 10/4/12 at 11:07 AM indicated the cleaning supplies were locked at the group home. The QMRP indicated client A would ingest items to hurt herself. The QMRP indicated they had not assessed the clients in regard to locking the cleaning supplies.</p>						

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	<p>The QMRP indicated the facility's HRC had not reviewed and/or approved the locking of the cleaning supplies at the group home. The QMRP and the BC indicated the clients' ISPs did not indicate the cleaning supplies should be locked.</p> <p>2. On 10/2/12 from 4:55pm until 6:30pm, clients A, B, C, and D were at the group home and the living room windows, dining room windows, kitchen windows, and each of the four client bedroom windows were frosted and not clear glass. At 5:30pm, the QMRP (Qualified Mental Retardation Professional) stated each window was frosted "from the bottom to approximately six inches (6")" from the top of each window.</p> <p>On 10/4/12 at 8:10am, client B stated "I can't look out my windows, I feel like I'm in jail."</p> <p>On 10/3/12 at 12:45pm, client B's record was reviewed. Client B's record indicated she was admitted on 11/2011. Client B's 11/29/11 CFA (Comprehensive Functional Assessment) did not identify the need for frosted windows. No assessment for the restriction of frosted windows was available for review.</p> <p>On 10/4/12 at 8:50am, client D's record was reviewed. Client D's record</p>						

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	<p>indicated she was admitted on 11/17/2011. Client B's 11/29/11 CFA (Comprehensive Functional Assessment) did not identify the need for frosted windows. No assessment for the restriction of frosted windows was available for review.</p> <p>Client A's record was reviewed on 10/3/12 at 12:55 PM. Client A's 2/1/12 ISP (Individual Support Plan) did not indicate the client had an identified need for frosted windows, and/or indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice.</p> <p>Client C's record was reviewed on 10/4/12 at 10:05 AM. Client C's 11/29/11 ISP did not indicate the client had an identified need for frosted windows, and/or indicate the facility's Human Rights Committee (HRC) reviewed and/or approved the restrictive practice.</p> <p>On 10/4/12 at 11am, a review of the facility's HRC minutes were reviewed with the QMRP (Qualified Mental Retardation Professional). The QMRP and the HRC documents both indicated HRC had not reviewed the restriction for the frosted windows inside the group home.</p>			

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	<p>Interview with the QMRP on 10/3/12 at 11:07 AM and Behavior Consultant (BC) #1 indicated the group home had half frosted windows. The BC and the QMRP indicated the clients could not see out of the windows as they were not tall enough to see over the frosted part of the windows. The QMRP indicated the frosted windows were put place to protect the clients' privacy. BC #1 indicated he questioned why the windows were frosted when he came to the group home in 8/12. The BC indicated the frosted windows were a restriction of the clients' rights and should be removed.</p> <p>3. On 10/3/12 at 12:45pm, client B's record was reviewed. Client B's 1/5/12 ISP (Individual Support Plan) indicated client B was an emancipated adult and did not indicate if she was a registered voter. Client B's record indicated she was admitted 11/2011. Client B's record contained a "Civil Awareness and Responsibility...Communicates specific information about voting. Communicates specific information about issues in the upcoming election. Expresses a desire to vote. Is individual registered to vote." The assessment was blank.</p> <p>On 10/4/12 at 8:10am, client B stated "no one asked me if I wanted to vote."</p>			

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	<p>An interview with the QMRP was conducted on 10/4/12 at 9am. The QMRP stated she "was unaware" if client B was a registered voter.</p> <p>Client A's record was reviewed on 10/3/12 at 12:55 AM. Client A's 2/1/12 ISP did not indicate the client was not a registered voter. Client A's ISP and/or record did not indicate the facility had encouraged and/or taught the client her civil rights in regard to voting.</p> <p>Interview with client A on 10/3/12 at 11:32 AM indicated she did not know if she was registered to vote.</p> <p>Interview with the QMRP and BC #1 on 10/4/12 at 11:07 AM indicated client A was not registered to vote. BC #1 stated "I asked that." BC #1 indicated the clients should be taught their civil rights in regard to voting and should be allowed to vote if they chose to.</p> <p>9-3-2(a)</p>			

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W0126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on observation, interview and record review for 2 of 2 sampled clients (A and B) and for 2 additional clients (C and D), the facility failed to allow and/or encourage the clients to carry money on their person to the extent they were capable.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>During the 10/3/12 workshop observation between 10:45 AM and 11:45 AM, clients A, B and C brought their lunches and drinks from the group home. When the clients went on break for lunch at 11:30 AM, the clients did not utilize the vending machine in the break room. Clients A and C had Kool-Aid in plastic containers to drink. Client A independently walked over to the microwave and placed her container with meatloaf in the microwave. Client A independently set the dials of the microwave without assistance.</li> </ol> <p>Interview with client A on 10/3/12 at at 11:32 AM indicated the client did not get to carry money on her. Client A indicated</p>	W0126	<p><b>CORRECTION:</b> <i>The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Specifically, based on current financial assessments, Clients A – D will receive weekly spending money from their personal accounts consistent with their assessed developmental status.</i></p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding each client's right to carry personal spending money. The Quality Assurance Manager will perform monthly reviews of Resident Financial Management System records to assure weekly spending money is being dispersed appropriately.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Quality Assurance Team, Operations Team</p>	11/16/2012			

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	<p>she would like to have money to carry to work.</p> <p>Interview with client C on 11/3/12 at 11:33 AM indicated she did not get to carry money on her person. Client C indicated she worked Monday through Friday at the workshop and she would like to be able to carry some pocket change on her. When asked what she did if she wanted to get something out of the vending machine, client C stated "My friend gets it."</p> <p>Client A's record was reviewed on 10/3/12 at 12:55 PM. Client A's 2/1/12 Individual Support Plan (ISP) did not indicate client A should not be allowed to carry money/pocket change. Client A's 9/11/12 review of Modification of Individual's Rights indicated "...[Client A] is currently receiving weekly spending money based on her financial assessment and is given training on economic priorities and wise use of money...."</p> <p>Client A's 1/20/12 Financial Assessment indicated client A could complete a financial transaction independently up to \$10. The assessment indicated the client "...Will have access to weekly spending money in the amount of \$20.00...."</p> <p>Client C's record was reviewed on</p>				

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	<p>10/4/12 at 10:05 PM. Client C's 11/29/11 ISP did not indicate the client C should not be allowed to carry money/pocket change. Client C's undated Financial Assessment indicated client C was able to identify bills up to \$100 and could make a purchase up to \$100. The assessment did not indicate the amount of weekly spending money client C could have access to as it was blank.</p> <p>Interview with the Behavior Consultant (BC) and the Qualified Menatl Retardation Professional (QMRP) on 10/4/12 at 11:07 AM indicated clients A and C should be allowed to carry money/pocket change on their person.</p> <p>2. On 10/3/12 at 12:45pm, client B's record was reviewed. Client B's 1/5/12 ISP (Individual Support Plan) indicated a goal/objective for her to identify her weekly account balance for her personal funds. Client B's record indicated she was an emancipated adult.</p> <p>On 10/4/12 at 8:10am, client B stated "I'd like to carry my money" and indicated staff carried her money on outings.</p> <p>An interview with the QMRP was conducted on 10/4/12 at 9am. The QMRP stated "no clients" carried their own money. The QMRP indicated client</p>				

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	<p>B had the skill to carry her own money.</p> <p>3. On 10/3/12 from 11am until 11:45am, at the contracted workshop client D was observed to not have money for the vending machines in the break area. At 11:25am, client D stated "I have no money, I can't" have money to carry "staff carries my money." At 11:25am, client D indicated she would like to carry her own money to spend when she wants something out of the vending machines.</p> <p>On 10/4/12 at 8:50am, client D's record was reviewed. Client D's 1/9/12 ISP indicated goals/objectives to use a calculator to balance her personal funds account and obtain a receipt after she made a purchase. Client D's 11/2011 CFA (Comprehensive Functional Assessment) indicated client B could identify coins, bills, and handle money.</p> <p>An interview with the QMRP was conducted on 10/4/12 at 9am. The QMRP stated "no clients" carried their own money. The QMRP indicated client D had the skill to carry her own money.</p> <p>9-3-2(a)</p>						

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W0140	<p><b>483.420(b)(1)(i)</b> <b>CLIENT FINANCES</b> The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on interview and record review for 2 of 2 sampled clients (A and B) and for 2 additional clients (C and D), the facility to keep a complete accounting of the clients' funds as the group home failed to utilize the facility's system for managing clients' finances.</p> <p>Findings include:</p> <p>1. Client B's financial records were reviewed on 10/2/12 at 4:51 PM and on 10/4/12 at 8:36 AM. Client B's Resident Funds Management Services (RFMS) (facility held account of clients' funds) ledger sheet from 10/1/11 to 10/1/12 indicated the client withdrew the following on 5/31/12 from the facility's RFMS account: \$500 summer clothes \$500 bedroom furniture \$500 dining room furniture \$500 living room furniture</p> <p>Interview with administrative staff #1 on 10/2/12 at 5:00 PM indicated administrative staff #1 did not know why client B purchased living room and dining room furniture. Administrative staff #1</p>	W0140	<p><b>CORRECTION:</b> <i>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Specifically, for Clients A – D, the Team Lead will maintain an up to date ledger to track purchases for all clients including a sign-out log for money to be spent at day service and workshops. All staff will assure that clients provide receipts for purchases as appropriate and the QDDP will maintain copies of receipts for purchases recorded on the ledgers.</i></p> <p><b>PREVENTION:</b> The Team Lead will maintain responsibility for maintaining client financial records and the QDDP will audit these records no less than weekly. All staff will be retrained regarding the need to assist clients with budgeting and collecting receipts. The QDDP will turn in client financial records to the Business Manager no less than monthly for review and filing. Additionally, members of the Operations and Quality Assurance Teams will include audits of client finances as part of an ongoing facility audit process</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Quality Assurance</p>	11/16/2012			

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	<p>indicated the furniture at the group home was purchased by the facility. When asked to see the receipts, administrative staff #1 indicated the receipts would be at the group home.</p> <p>Client B's 8/8/checking account statement indicated the client had a balance of \$1.60. Client B had no checking account ledger sheet and/or documentation which indicated client B's current balance and/or expenditures/deposits since 8/12.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on 10/4/12 at 9:27 AM indicated she just deposited \$2235.00 into client B's checking account on 10/1/12. The QMRP indicated the \$2235.00 were the 5/31/12 withdrawal amounts from the RFMS account. The QMRP indicated the request was put in in 5/31/12 but she had just received the checks on 10/1/12. The QMRP provided documentation of the check was dated 5/31/12. The QMRP did not know why client B just received the money. The QMRP indicated client B had not bought any living room furniture and/or dining room furniture. The QMRP indicated client B's checking account did not have a ledger and/or documentation which indicated the total amount of money client B had in her account. The QMRP indicated she did not have any</p>		Team, Operations Team				

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	<p>recent statements for client B's checking account since 8/12. The QMRP indicated client B should have a savings account versus a checking account and was not sure why the client's account had not been changed.</p> <p>Interview with administrative staff #2 on 10/9/12 at 11:52 AM, by phone, stated client B's "Checks misplaced in office. Not acceptable." Administrative staff #2 indicated the facility's accounts payable staff went to waived services and got the checks misplaced. Administrative staff #2 indicated there was not follow of the checks once they were written. Administrative staff #2 indicated the checks were recently located in a file cabinet in the office.</p> <p>2. Client D's financial records were reviewed on 10/2/12 at 4:51 PM and on 10/4/12 at 8:36 AM. Client D's Cash on Hand (COH) ledger sheet indicated client D had \$64.05 COH as of 10/1/12. Client D's actual COH was \$25.26. The COH ledger sheet did not indicate client D signed/initialed when deposits and/or withdraws were made on her account.</p> <p>Client D's 4/14/12 to 6/30/12 savings account statement indicated client D had a savings account with a balance of \$39.60. Client D's financial records did not</p>			

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	<p>indicate the client had a savings account ledger and/or documentation of the client's current balance, expenditures and/or deposits made from the client's account. Client D's financial records did not indicate the facility was and/or had reconciled the client's account to ensure all client D's funds were accounted for.</p> <p>Interview with the QMRP and staff #1 on 10/4/12 at 9:27 AM could not explain the discrepancy in regard to client D's COH. The QMRP indicated client D's money had been moved from a checking account to a savings account. The QMRP indicated she did not have any additional documentation in regard to the client's savings account and/or balance since 6/12. The QMRP indicated client D did not have a savings account ledger sheet.</p> <p>3. Client C's financial records were reviewed on 10/2/12 at 4:51 PM and on 10/4/12 at 8:36 AM. Client C's COH ledger sheet with the client's financial records indicated client C had a balance of \$467.70 on 3/16/12 (current ledger sheet with the finance book). Client C did not have any additional financial ledger sheets since 3/16/12. The client's actual cash on hand with the facility was \$113.96.</p> <p>Client C's 4/14/12 to 6/30/12 savings</p>						

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	<p>statement indicated client C had a balance of \$530.17. The facility had not additional savings statements and/or documentation of the current balance of client C's savings account, expenditures and/or deposits as client C had no ledger sheet for her savings account. Client C's financial records did not indicate the facility reconciled the client's savings account and/or COH ledgers to ensure a complete accounting of the client's funds.</p> <p>Interview with staff #1 and the QMRP on 10/4/12 at 9:27 AM indicated client C was keeping her own COH ledger sheet in her Individual Support Plan (ISP) book. Staff #1 indicated client C's 9/15/12 to 9/29/12 COH ledger sheet indicated client C had \$143.59. Staff #1 indicated client C just withdrew \$20 on 10/4/12, but it had not been written down on the ledger sheet kept with the client's ISP book. The QMRP indicated she could not locate any additional documentation/ledger sheets for client C's finances from 3/16/12 to 9/15/12 for client C. The QMRP indicated client C did not have a ledger sheet for her savings account. The QMRP indicated she did not have a current savings account statement which indicated the current balance of the client's savings account.</p> <p>4. Client A's financial records were</p>				

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	<p>reviewed on 10/2/12 at 4:51 PM and on 10/4/12 at 8:36 AM. Client A's 10/2/12 COH ledger sheet indicated client A had a balance of \$8.70. The 10/2/12 entry indicated "***balance off**." Client A's actual COH balance was \$9.70. Client A's COH ledger sheet indicated the following entries:</p> <p>-9/27/12 withdrew \$4.28 Balance \$4.37</p> <p>-10/1/12 withdrew \$5.32 Balance -0.95</p> <p>-10/2/12 deposit \$9.65 "***balance off**" Balance \$8.70</p> <p>Client A did not have any receipts for the above mentioned withdrawals.</p> <p>Client A's 9/12/12 checking account statement indicated the client had a balance of \$1.02. Client A did not having a checking account ledger which indicated the client's expenditures and/or deposits made. Client A's financial records did not indicate the facility reconciled the client's account to ensure the client's funds were accounted for.</p> <p>Interview with the QMRP and staff #1 on 10/4/12 at 9:27 AM indicated they did not know why client A's COH balance was off. The PC and staff #1 indicated the client had a negative balance on 10/1/12. Staff #1 indicated the staff who had taken</p>						

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	<p>client A out may still have the receipts. The QMRP indicated she did not have a ledger sheet for client A's checking account. The QMRP indicated client A's checking had not been converted/changed to a savings account.</p> <p>Interview with administrative staff #2 on 10/9/12 at 11:52 AM, by phone, indicated the group home should be following the facility's 12/12/07 policy and procedure in regard to client funds.</p> <p>The facility's policy and procedures were reviewed on 10/4/12 at 9:50 AM. The facility's 12/12/07 policy entitled Individual Finance Management including RFMS indicated "1. The Program Director (PD) (QMRP) has the overall responsibility for maintaining balanced individual finances...10. All money kept in local bank account will be tracked using client finance procedures and the bank statements will be reconciled each month. 11. All client finances must be turned into the Business office by the 5th of each month....20. A 'Resource Ledger' must be maintained for all clients. A new Resource Ledger should be initiated at the beginning of each month for all clients. The ending balance must be carried over from the previous month. 21. All transactions must be recorded in the client checkbook</p>			

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	<p>ledger as well as the Resource Ledger as soon as the transaction takes place...."</p> <p>9-3-2(a)</p>				

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W0149	<p><b>483.420(d)(1)</b> <b>STAFF TREATMENT OF CLIENTS</b> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review for 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the facility failed to implement its policy and procedures to conduct thorough investigations in regard to client A, B, C and D's allegations of client to client abuse, injuries of unknown origin, and/or an allegation in regard to exploitation to ensure the clients were not neglected and/or abused. The facility failed to implement its policy and procedures to prevent neglect of client C in regard to the client's self-injurious/self harm behavior. The facility failed to implement its policy and procedures to conduct investigations with 5 working days for client C. The facility failed to implement its policy and procedures to put in place corrective actions for clients B, C and D.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 10/2/12 at 2:17 PM. The facility's reportable incident reports indicated the following:</p> <p>-5/20/12 Client C became upset due to</p>	W0149	<p><b>CORRECTION:</b> <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically, the facility:</i></p> <p>1.The facility will investigate an incident of client to client aggression between Client A and Client C; an incident of aggression between Client C and Client D on 6/19/12; the origins of injuries sustained by Client B on 5/27/12 and 5/17/12; the origins of injuries sustained by Client D on 9/22/12 and 4/26/12; how Client C obtained an object with which to harm herself while she was being observed 1 to 1 on 9/5/12 and the origin of bruises Client C received at work on 8/4/12, 6/7/12 and 5/10/12. Additionally, the facility will provide documentation of its investigation into allegations of misappropriation/exploitation of Client C's money by Client C's former foster mother.</p> <p>2.The results of the investigation into an incident of aggression between Client C and Client B will be reported to the administrator and outside agencies as required.</p> <p>3.The team will work with Client B and D's Behavioral clinician to develop additional preventative and protective measures with regard to physical aggression. Client C has moved out of the facility.</p> <p><b>PREVENTION:</b> 1.The incoming QDDP will be trained regarding the criteria for</p>	11/16/2012			

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	<p>another client who was having a behavior. The reportable incident report indicated client C sprayed herself with hair spray once the police redirected client C to go to her bedroom and stay there for the remainder of the evening. The reportable incident report indicated "...[Client C] went into her room after a brief period, sprayed herself with hair spray. Staff completed a room sweep per the Behavior Support Plan and she began tearing her clothes...." Staff placed her in Your Safe, I'm safe one and two person holds at intervals, but [client C] was not able to calm herself. She repeatedly attempted to elope, naked from the waste (sic) down and staff again called 911 for assistance...."</p> <p>-6/19/12 Client C was redirected to her bedroom after client C physically attacked staff, removed her helmet and tried to bang her head. The reportable incident report indicated "...[Client C] appeared to become calm and went to her bedroom. A few minutes later, she came out of her bedroom and made several attempts to drink perfume. Staff took the perfume and tried talking to [client C] about her coping skills. [Client C] then tried to smother her face with a blanket and with a sweat shirt. Staff removed the items from her face...."</p>		<p>conducting investigations at the facility and will receive guidance toward developing of a tracking system to assure thorough investigations are conducted within required timeframes.</p> <p><b>ADDENDUM, 11/6/12: the Program Manager and/or Clinical Supervisor will coordinate the completion of facility investigations, providing direction to the QDDP regarding incidents which require investigation and direct oversight through the investigation process.</b></p> <p>2.The QDDP will turn in copies of completed investigations to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up.</p> <p>3.Professional staff will be retrained regarding the criteria for conducting investigations at the facility and will receive guidance toward developing of a tracking system to assure thorough investigations are conducted within required timeframes. The QDDP will assume responsibility for completing follow-up reports to the Bureau of Developmental Disability Services and Adult Protective Services to avoid delays in the reporting of investigation results.</p> <p>4.The QDDP will bring all relevant elements of the interdisciplinary team together after incidents of client to client aggression to review current</p>				

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	<p>-9/4/12 "[Client C] was joking with staff and entered staff's personal space. When redirected to step back, she began throwing the items in her purse at staff. She climbed into a chair and when staff redirected her, she climbed onto the table. She climbed down from the table and attempted to exit the house and when staff blocked her from doing so she became more agitated. She began hitting. (sic) Kicking (sic) and spitting at staff. She ran into the kitchen and threw the waste basket. Staff asked what they could do to help her to stop feeling so upset and she voiced suicidal thoughts. She began placing items in her mouth and spitting them out. Staff accompanied her to her room and began collecting items which she could harm herself, per her behavior support plan. She poured body powder and glitter over self and staff removed these along with her toiletries. She screamed and yelled profanities until 8:00 PM when she requested her medication and took a shower. Client C sustained red marks on her arms as a result of biting herself during the episode...."</p> <p>-9/5/12 One to one staff accompanied [client C] (individual supported by Rescare) to work due to her attempts at elopement and self injury the previous day (9/4/12), as directed by her Behavior Support Plan (BSP). She became upset at</p>		<p>supports and to make adjustments and revisions as needed. The QDDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Behavior Clinician, Quality Assurance Team, Operations Team</p>		

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	<p>intervals during the morning but staff redirected her successfully. Later in the day, [client C's] [name of agency] therapist approached her but [client C] would not engage in conversation with her. [Client C's] therapist noted that [client C] had an object in her hand and gestured for residential staff to approach. [Client C's] one to one staff stepped up behind her and noted that she had a broken hair band in her lwdr (sic) hand that she had been rubbing her wrist on. Staff implemented a Your Safe, I'm Safe one person hold in order to remove the hair band from her hand and remove other jewelry which she could potentially use to injure herself. [Client C] walked into the workshop accompanied by staff who evaluated the environmental factors and re-implemented the one person hold and sat on the floor with her until the workshop supervisor arrived....When she got in the van she took off her shoes and removed her shoe laces. Staff prevented her from tightening the laces around her neck...." The 9/5/12 reportable incident report indicated client C received a scratch on her forearm during the incident which was cleansed. The 9/5/12 reportable incident report indicated the facility neglected to conduct an investigation in regard to how client C managed to obtain/have items which the client could utilize to harm herself after</p>						

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	<p>the client was placed on a one to staffing due to the incident on 9/4/12. The facility's reportable incident report neglected to address/indicate an investigation in regard to how client C was monitored/supervised to ensure the client was not neglected.</p> <p>Client C's record was reviewed on 10/4/12 at 10:05 PM. Client C's 4/18/12 Behavior Support Plan (BSP) indicated client C had a history of self-injurious behavior suicide threats and threats to harm self. Client C's BSP indicated client C's diagnoses included, but were not limited to, Mood Disorder No other Symptoms and Borderline Personality Traits. Client C's 4/18/12 BSP indicated when client C made suicide threats and/or made threats to harm herself, facility staff were to</p> <p>"-...Immediately ensure she is safe -Immediately scan the room for items that can be used as a potential weapon against herself or others. -If there are items in the immediate area that could be used as weapons that she could use, in a subtle manner try to remove the weapons from the home...If she asks to leave, do so but maintain sight of her...." Client C's 4/18/12 BSP neglected to specifically indicate how facility staff were to monitor the client ( and or for how long) once she threatened</p>			

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	<p>to harm herself and/or demonstrated suicidal attempts/threats to prevent additional attempts.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and Behavior Consultant (BC) #1 on 10/4/12 at 11:07 AM indicated the BC was new to the group home. The BC stated he started at the group home at the "tail end of August (2012)." The BC indicated he had reviewed the clients' BSPs and the clients' BSPs were in need of revision. The QMRP indicated client C had a one one staff at the workshop on 9/5/12. The QMRP indicated she was not sure why a sweep was not done at the workshop and/or how client C was able to obtain an item to attempt to harm herself with. The QMRP indicated the facility did not conduct an investigation in regard to the 9/5/12 incident.</p> <p>The facility's policy and procedures were reviewed on 10/9/12 at 2:58 PM. The 9/14/07 facility's policy entitled Abuse, Neglect, Exploitation indicated neglect was defined as "failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need requirements such as food, shelter,</p>						

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	<p>clothing and to provide a safe environment...." the 9/14/107 policy indicated failure to implement clients' program plans could also be considered neglect if it failed to prevent harm to a client.</p> <p>3. The facility's policy and procedures were reviewed on 10/9/12 at 2:58 PM. The 9/14/07 facility's policy entitled Abuse, Neglect, Exploitation indicated allegations of neglect, exploitation and/or abuse would be investigated by the facility. The facility's 9/14/07 policy entitled Investigations indicated "In order to ensure the health, safety and welfare of the people we support, events or collections of circumstances that are outside of what is normally expected, cannot be explained and understood by the existence of the event and result in or have the potential to result in injury or abuse, neglect or exploitation to the individual must be investigated. Investigations will be conducted per the protocols listed in the incident management best practices manual. Practices: 1. The primary purpose of an investigation is to describe and explain factors contributing to an incident and to prevent recurrence...." The policy indicated all investigations of abuse, neglect and/or injuries of unknown origin would be "...fully investigated within 5</p>			

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	<p>calendar days from the date the allegation was made and investigation was initiated...." The facility's 9/14/07 policy also indicated the facility's investigations would indicate/include "...Methods (corrective actions) to prevent future incidents."</p> <p>The facility failed to reproduce evidence of a thorough investigation for allegations of abuse, neglect and/or injuries of unknown origin involving clients A, B, C and D. Please see W154.</p> <p>The facility failed to report the results of a client to client allegation of abuse to the administrator within 5 days involving client C. Please see W156.</p> <p>The facility failed to develop corrective actions/asures for client to client incidents of aggression/abuse for clients B, C and D. Please see W157.</p> <p>9-3-2(a)</p>				

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W0154	<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 interview and record review for 9 of 58 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to maintain a reproducible system and/or failed to provide evidence of a thorough investigation regarding allegations of abuse, neglect and/or injuries of unknown origin for clients A, B, C and D.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 10/2/12 at 2:17 PM. The facility's reportable incident reports indicated the following:</p> <p>-9/4/12 "[Client C] was joking with staff and entered staff's personal space. When redirected to step back, she began throwing the items in her purse at staff. She climbed into a chair and when staff redirected her, she climbed onto the table. She climbed down from the table and attempted to exit the house and when staff blocked her from doing so she became more agitated. She began hitting. (sic) Kicking (sic) and spitting at staff. She ran into the kitchen and threw the waste</p>	W0154	<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 client to client aggression between Client A and Client C; an incident of aggression between Client C and Client D on 6/19/12; the origins of injuries sustained by Client B on 5/27/12 and 5/17/12; the origins of injuries sustained by Client D on 9/22/12 and 4/26/12; how Client C obtained an object with which to harm herself while she was being observed 1 to 1 on 9/5/12 and the origin of bruises Client C received at work on 8/4/12, 6/7/12 and 5/10/12. Additionally, the facility will provide documentation of its investigation into allegations of misappropriation/exploitation of Client C's money by Client C's former foster mother.</p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding the criteria for conducting investigations at the facility and will receive guidance toward developing of a tracking system to assure thorough investigations are conducted within required timeframes. The QDDP will turn in copies of completed investigations to the Program Manager and Quality Assurance</p>	11/16/2012			

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	<p>basket. Staff asked what they could do to help her to stop feeling so upset and she voiced suicidal thoughts. She began placing items in her mouth and spitting them out. Staff accompanied her to her room and began collecting items which she could harm herself, per her behavior support plan. She poured body powder and glitter over self and staff removed these along with her toiletries. She screamed and yelled profanities until 8:00 PM when she requested her medication and took a shower. Client C sustained red marks on her arms as a result of biting herself during the episode...."</p> <p>-9/5/12 One to one staff accompanied [client C] (individual supported by Rescare) to work due to her attempts at elopement and self injury the previous day (9/4/12), as directed by her Behavior Support Plan (BSP). She became upset at intervals during the morning but staff redirected her successfully. Later in the day, [client C's] [name of agency] therapist approached her but [client C] would not engage in conversation with her. [Client C's] therapist noted that [client C] had an object in her hand and gestured for residential staff to approach. [Client C's] one to one staff stepped up behind her and noted that she had a broken hair band in her lwdr (sic) hand that she had been rubbing her wrist on.</p>		<p>Manager to allow for appropriate oversight and follow-up. <b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Quality Assurance Team, Operations Team</p>				

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	<p>Staff implemented a Your Safe, I'm Safe one person hold in order to remove the hair band from her hand and remove other jewelry which she could potentially use to injure herself. [Client C] walked into the workshop accompanied by staff who evaluated the environmental factors and re-implemented the one person hold and sat on the floor with her until the workshop supervisor arrived....When she got in the van she took off her shoes and removed her shoe laces. Staff prevented her from tightening the laces around her neck...." The 9/5/12 reportable incident report indicated client C received a scratch on her forearm during the incident which was cleansed. The 9/5/12 reportable incident report indicated the facility failed to conduct an investigation in regard to how client C managed to obtain/have items which the client could utilize to harm herself after the client was placed on a one to staffing due to the incident on 9/4/12. The facility's reportable incident report failed to address/indicate an investigation in regard to how client C was monitored/supervised to ensure the client was not neglected.</p> <p>Client C's record was reviewed on 10/4/12 at 10:05 PM. Client C's 4/18/12 Behavior Support Plan (BSP) indicated client C had a history of self-injurious behavior suicide threats and threats to</p>						

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	<p>harm self. Client C's BSP indicated client C's diagnoses included, but were not limited to, Mood Disorder No other Symptoms and Borderline Personality Traits.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and Behavior Consultant (BC) #1 on 10/4/12 at 11:07 AM indicated the BC was new to the group home. The BC stated he started at the group home at the "tail end of August (2012)." The QMRP indicated client C had a one one staff at the workshop on 9/5/12. The QMRP indicated she was not sure why a sweep was not done at the workshop and/or how client C was able to obtain an item to attempt to harm herself with. The QMRP indicated the facility did not conduct an investigation in regard to the 9/5/12 incident.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 10/2/12 at 2:17 PM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>-8/4/12 "While performing a physical assessment prior to [client C] (Individual supported by Rescare) staff noted that she had a 1/2 cm (centimeter) red bruise on her left forearm and a 1/2 cm purple</p>						

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	<p>bruise on her right thigh. [Client C] told staff that she sustained the injuries at work. [Client C's] current job involves lifting fill boxes off a table and placing them on skids. Therefore the team believes she most likely sustained the injuries in the manner she described." The 8/4/12 reportable incident report did not indicate any additional documentation of an investigation and/or interviews to support client C's statement.</p> <p>-6/21/12 "During a routine physical assessment, staff observed a bright red linear scratch on [client C's] (individual supported by Rescare) right lower leg. She also had two purple bruises measuring one inch and 1.5 inches in diameter on her right upper left leg. The team has initiated an injury follow-up flow chart and will investigate to determine the most likely origin of the injuries." The reportable incident report did not indicate any additional information and/or documentation of an investigation.</p> <p>-6/7/12 "While completing a physical assessment staff discovered that [client C] (individual supported by Rescare) had scratches on the inside of her left forearm, the outside if her right upper arm and an additional scratch on the inside of her left leg below her knee. [Client C] said she</p>			

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	<p>sustained the scratches while working at her job at [name of workshop]...The injuries are consistent with superficial scratches that [client C] has received in the past. The QMRP (Qualified Mental Retardation Professional) will contact [client C's] supervisor to assure the accuracy of [client C's] explanation for how she received the scratches." The 6/7/12 reportable incident report did not indicate any additional information and/or documentation of an investigation.</p> <p>-5/10/12 "While assisting [client C] (Individual supported by Rescare), staff noted a 3 cm scratch on her chest. [Client C] said that a dog belonging to sheltered workshop staff scratched her. [Client C] also has an abrasion on her right thumb which she said occurred while working with boxes at her workshop. The team will check with [name of workshop] staff to investigate the accuracy of [client C's] report." The facility's 5/10/12 reportable incident report did not indicate any additional information and/or documentation of an investigation.</p> <p>Interview with administrative staff #2 on 10/2/12 at 4:00 PM indicated the Program Coordinator (QMRP) would have the investigations in regard to any injuries of unknown origin. Administrative staff #2 indicated the Program Coordinator was to</p>			

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	<p>conduct the investigations for injuries of unknown origin.</p> <p>Interview with workshop staff #1 on 10/3/12 at 11:55 AM indicated it was possible client C could receive injuries from the jobs she worked on at work. Workshop staff #1 indicated he had not been made aware of any injuries and/or interviewed in regard to any injuries of unknown origin.</p> <p>Interview with workshop staff #2 on 10/3/12 at 11:21 AM indicated when asked if client C had problems with receiving injuries while at the workshop, workshop staff #2 stated "Not that I'm aware of." Workshop staff #2 indicated the facility sent a communication book back and forth between the group home and workshop and nothing had been documented in the book. Workshop staff indicated she had not been interviewed by the group home.</p> <p>Interview with Qualified Mental Retardation Professional (QMRP) on 10/4/12 at 11:07 AM indicated she had sent an email to workshop staff #1 when client C indicated she received the injuries at the workshop. The QMRP indicated she did not interview any workshop staff in regard to client C's injuries of unknown origin. The QMRP</p>						

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	<p>did not provide any additional information and/or evidence of an investigation.</p> <p>3. The facility's reportable incident reports and/or investigations were reviewed on 10/2/12 at 2:17 PM. The facility's reportable incident reports and/or investigations indicated on 4/27/12, "[Client C] (individual we support) visited her former foster mother [name of mother] during the weekend of 4/20/12. Staff assisted [client C] in taking \$40 out of her account to use for the visit. When [client C] returned from the visit, [client C] told staff that her 'mom' had taken [client C] to the bank on 4/20/12 and had her withdraw \$90. [Client C] stated her mom kept the money for gas and did not give her any of it when she brought [client C] back home...." The reportable incident report indicated they would conduct an investigation in regard to the incident. The 4/27/12 reportable incident report indicated client C's foster mom was contacted and the foster mom indicated she had explained to client C she would need to give her money to put gas in the car and client C had agreed to do that. The reportable incident report indicated client C went to the day service program provider and complained to them about her money. The 4/27/12 reportable incident report indicated the Bureau of</p>						

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	<p>Developmental Disabilities Services (BDDS) was notified and became involved. The reportable incident report indicated "...Through discussions with [client C], [name of foster mom], residential management staff and BDDS management staff, it was determined that much disinformation was given by [client C] to all parties involved. An IDT (interdisciplinary team) meeting will be scheduled for all parties to attend to determine communication and home visit protocols to keep everyone on the same page to best provide supports for [client C]." The facility's 4/27/12 reportable incident report did not indicate any additional documentation of the investigation and/or interviews.</p> <p>Interview with the QMRP on 10/4/12 at 11:07 AM indicated client C's mother was interviewed and BDDS was contacted and involved in the investigation. The QMRP indicated she had made several attempts to get everyone together without success. The QMRP indicated an investigation was conducted but did not provide any additional documentation of an investigation in regard to the allegation of exploitation and/or misappropriation of client C's funds.</p> <p>4. The facility's reportable incident reports and/or investigations were</p>						

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	<p>reviewed on 10/2/12 at 2:17 PM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>-8/14/12 "...This incident occurred at the workshop while clients were on lunch break. [Client A] went over to [client C] and repeatedly struck her on the head. [Client C] tried to protect herself by covering her head with her arms and hands. Staff intervened quickly asking all clients to move away from the table... [Client C] had redness, discoloration, and a knot on the back of the head. The level of supervision during the time of the incident was two Team Leaders in the direct area..." [Client A] was removed from the area where this event occurred. Rescare staff contacted the QMRP to inform her of this event...Upon [client A's] return she will be placed in a separate work area away from [client C]. Staff will ensure that the two clients go to separate breaks and lunches." The reportable incident report did not indicate any additional information and/or investigation in regard to the client to client allegation of abuse.</p> <p>-6/19/12 "While packing her lunch, [client D] (Individual Supported by Rescare) placed plastic silverware in her lunchbox. Her housemate, [client C] (Individual Supported by Rescare) told</p>				

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	<p>[client D] that she didn't need to pack silverware because day service provided silverware. [Client C] said that she wanted to take her own silverware. When her housemate continued to question her, [client D] left the kitchen area and hit herself in the forehead with her palm. She then laid down on the floor (sic) hit the left side4 (sic) of her head on the floor before staff could intervene. [Client C] ran over to [client D] and hit her on the top of her head 3 times...." The reportable incident report indicated client D was not injured.</p> <p>Interview with administrative staff #2 on 10/2/12 at 4:00 PM indicated the Program Coordinator (QMRP) would have the investigations in regard to the client to client allegations of abuse/incidents. Administrative staff #2 indicated the Program Coordinator was to conduct the investigations for client to client incidents.</p> <p>Interview with the QMRP on 10/4/12 at 11:07 AM indicated she was not sure if investigations were conducted in regard to the above mentioned client to client incidents. The QMRP did not provide any additional documentation and/or evidence of an investigation.</p> <p>5. On 10/2/12 at 11:50am, a review of</p>			

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	<p>the facility's BDDS reportable incidents which documented unknown injuries for clients B and D indicated the following:</p> <p>-A 5/28/12 BDDS report for client B of an incident on 5/27/12 at 7am, indicated client B was released from the psych hospital, became SIB (Self Injurious Behavior), threats to harm self and others, refused her 7am medications, stripped then left the group home AWOL (Absent Without Leave), and staff applied a physical restraint. The report indicated Client B had an unknown bruise on her left forearm, no size was documented, and no investigation was available for review.</p> <p>-A 5/18/12 BDDS report for client B of an incident on 5/17/12 at 4:40pm, indicated bruise both legs. An investigation indicated client had been physically aggressive and no further information was available for review. The investigation did not document witness statements nor have a conclusion.</p> <p>-A 9/22/12 BDDS report for client D of an incident on 9/22/12 at 7pm, indicated staff was assisting client D with a shower and noticed two (2) unknown purple bruises on her left shin. No investigation was available for review.</p> <p>-A 4/26/12 BDDS report for client D of</p>			

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	<p>an incident on 4/26/12 at 8pm, indicated "discovered" unknown dime size bruise on right forearm. No investigation was available for review.</p> <p>Interview with administrative staff #2 on 10/2/12 at 4:00 PM indicated the Program Coordinator would have the investigations in regard to any injuries of unknown origin. Administrative staff #2 indicated the Program Coordinator was to conduct the investigations for injuries of unknown origin.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on 10/4/12 at 11:07 AM indicated she had conducted investigations in regard to the above mentioned incidents. The QMRP did not provide any additional information and/or documentation of an investigation.</p> <p>9-3-2(a)</p>						

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W0156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on interview and record review for 1 of 58 allegations reviewed regarding, the facility failed to report the results of a client to client allegation of abuse to the administrator within 5 days for client C.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/2/12 at 2:17 PM. The facility's 9/11/12 reportable incident report indicated "...[Client C] targeted a housemate and scratched her. Staff placed [client C] in a You're Safe, I'm Safe (physical restraint) two person hold to give the housemate an opportunity to leave the area...."</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on 10/4/12 at 11:07 AM indicated she was still investigating the 9/11/12 client to client incident. The QMRP "I took notes for investigation. Still doing." The QMRP indicated the 9/11/12 investigation was not completed within 5 days.</p>	W0156	<p><b>CORRECTION:</b> <i>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Specifically, the results of the investigation into an incident of aggression between Client C and Client B will be reported to the administrator and outside agencies as required.</i></p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding the criteria for conducting investigations at the facility and will receive guidance toward developing of a tracking system to assure thorough investigations are conducted within required timeframes. The QDDP will assume responsibility for completing follow-up reports to the Bureau of Developmental Disability Services and Adult Protective Services to avoid delays in the reporting of investigation results.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Quality Assurance Team, Operations Team</p>	11/16/2012	

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W0157	<p><b>483.420(d)(4)</b> <b>STAFF TREATMENT OF CLIENTS</b> If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on interview and record review for 2 of 58 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to develop/put in place corrective actions for client to client incidents of aggression/abuse for clients B, C and D.</p> <p>Findings include:</p> <p>On 10/2/12 at 11:50am, a review of the facility's BDDS reportable incidents of client to client physical aggression without effective corrective action completed:</p> <p>-A 6/20/12 BDDS report for an incident on 6/19/12 at 7:15pm, client D was hit in the head by client C. No injury and no corrective action was documented.</p> <p>-A 4/30/12 BDDS report for an incident on 4/30/12 at 10am, client D hit client B in the back. No injury and no corrective action was documented.</p> <p>On 10/2/12 at 3:30pm, an interview was conducted with Administrative Staff (AS) #2. AS #2 indicated no corrective action was available for review.</p>	W0157	<p><b>CORRECTION:</b> <i>If the alleged violation is verified, appropriate corrective action must be taken. Specifically, the team will work with Client B and D's Behavioral clinician to develop additional preventative and protective measures with regard to physical aggression. Client C has moved out of the facility.</i></p> <p><b>PREVENTION:</b> The QDDP will bring all relevant elements of the interdisciplinary team together after incidents of client to client aggression to review current supports and to make adjustments and revisions as needed. The QDDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP Team Lead, Support Associates, Behavior Clinician, Quality Assurance Team, Operations Team</p> <p><b>Corrections completed by:</b> 11/16/12</p>	11/16/2012			

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W0159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on observation, interview and record review for 2 of 2 sampled clients (A and B) and for 2 additional clients (C and D), the Qualified Mental Retardation Professional (QMRP) failed to monitor clients' data in regard to completing monthly summaries for clients A and B to determine if the clients had met, lost skill, regressed and/or should be moved on toward new training. The QMRP failed to develop an active treatment schedule which encompassed client B's total day to ensure active treatment/training. The QMRP failed to monitor/coordinate clients' programs in ensuring all day service providers/workshops participated as members in team meetings and documented/coordinated information in regard to client B's attendance at a workshop and/or ensured a team process was involved when it was decided the client would no longer attend. The QMRP failed to assess client A, B, C and D's needs in regards to locking cleaning supplies and the need for frosted windows. The QMRP failed to conduct accurate assessments of clients in regard to their vocational needs, informed</p>	W0159	<p><b>CORRECTION:</b> <i>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. ADDENDUM 11/6/12: Specifically, the QDDP has resigned effective 11/16/12. Administrative staff will maintain a presence in the home while during the interim, while the Governing Body recruits a qualified replacement. The Operations and Quality Assurance Teams will work together to provide additional training, mentorship and guidance to the QDDP to assure the QDDP has the resources necessary to properly integrate, coordinate and monitor each client's active treatment program. Initial training will focus on:</i></p> <ol style="list-style-type: none"> <li>1. Monthly monitoring of Clients' progress and maintaining a reproducible record of all monitoring and change.</li> <li>2. Modification of Active Treatment Schedules to reflect Clients' current training and support needs.</li> <li>3. Inclusion of all relevant interdisciplinary team members in decision making.</li> <li>4. The need to maintain current assessment data for all clients.</li> <li>5. The need to assure that rights restrictions occur based on assessed</li> </ol>	11/16/2012

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	<p>consent assessments and to coordinate/obtain an a communication assessment for clients A and B. The QMRP failed to ensure comprehensive functional assessments were completed, refusals of needed adaptive equipment was addressed, and to address clients identified behavior al needs for clients A and B. The QMRP failed to coordinate with the facility's Human Rights Committee to ensure the specially constituted committee review and/or approved all facility blanket practices to ensure the protection of client A, B, C and D's rights.</p> <p>Findings include:</p> <p>1. On 10/3/12 from 10:30am until 11:45am, the facility's outside contracted workshop was visited and client B was not present. At 10:45am, Workshop Staff (WKS) #1 was interviewed and WKS #1 stated client B "no longer attended the (outside contracted) workshop because of [client B's] behaviors." WKS #1 provided an email dated 4/4/12 which indicated from WKS #2 at 8:40am: "[Group Home Staff #5] asked [WKS #1] today if [client B] could start spending full days in GE (General Education class). Is this something you would like for her to do?... [WKS #1] said that she doesn't work down in the workshop so it would be</p>		<p>needs.</p> <p>6. The need to address all clients' behavioral needs.</p> <p>7. The need to train clients to make informed decisions about the use of adaptive equipment.</p> <p>8. The need to obtain Human Rights Committee Approval for all restrictive programs and to maintain records of all Human Rights Committee decisions.</p> <p>PREVENTION: ADDENDUM 11/6/12: Members of the Operations and Quality Assurance Teams will conduct weekly audits of facility support documents and conduct active treatment observations for the first 90 days after a new QDDP joins the team. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly observations designed to assure that the QDDP integrates, coordinates and monitors, the active treatment program effectively and will provide guidance, mentorship and corrective measures as needed.</p> <p>RESPONSIBLE PARTIES: QDDP, Quality Assurance Team, Operations Team</p>				

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	<p>beneficial for her to stay in GE." WKS #1's response on 4/4/12 at 9:07am: "In the future, we need to discuss program changes with you prior to being implemented. I would rather us discuss program placement, time changes, etc. prior to the clients being informed that a change will occur..." QMRP (Qualified Mental Retardation Professional) responded on 4/4/12 at 11:09am: "Most definitely! Sometimes the staff gets ahead of me on things I am trying to accomplish with the girls. I had no idea they had told the girls yesterday...that they were staying all day...staff were not suppose to make that decision without me...I did not know [client B] went today until just a few minutes ago...."</p> <p>During an interview on 10/3/12 at 10:45am, WKS #1 stated client B had not attended workshop services at the contracted workshop "since 3/6/12." WKS #1 indicated client B had Absent With Out Leave (AWOL) behaviors. WKS #1 stated the contracted workshop staff "was not involved with the decision" of client B no longer attending the workshop. WKS #1 stated "one day she didn't come and I found out later" the group home made the decision "we weren't asked."</p> <p>On 10/3/12 at 12:45pm, client B's record</p>			

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	<p>was reviewed. On 10/3/12 at 12:45pm, client B's 5/17/12 "Interdisciplinary Team Meeting" progress note indicated client B had "behaviors during [name of contracted service] day program/workshop...[Name of Workshop] to provide community Mon-Fri (Monday - Friday) for 1 hour. Team feels 9am-10am would be a good time to avoid anxiety of waiting through the afternoon...group home to be prepared when sending staff tentatively to start the first week of June (2012)." Client B's record did not indicate documentation of when the client no longer attended the workshop, no workshop attendance records and no QMRP entries/information were available for review.</p> <p>On 10/4/12 at 8:40am, an interview was conducted with the QMRP. The QMRP indicated no further information regarding client B's vocational placement was available for review. The QMRP stated "I can't remember when [client B] stopped attending workshop." The QMRP stated "March of 2012, sounds right." The QMRP stated client B stopped attending workshop when "I pulled her out." The QMRP indicated a meeting with workshop was held on 5/17/12 and it was decided that she would attend day services in the classroom. The QMRP stated she could not recall the dates or if</p>						

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	<p>client B "ever attended." The QMRP stated client B "currently stayed home all day."</p> <p>2. The QMRP failed to ensure the workshop/day service provider participated in team meetings and decisions made about client B's employment status. Please see W208.</p> <p>3. The QMRP failed to to assess client A's communication skills within 30 days of being admitted to the group home. Please see W210.</p> <p>4. The QMRP failed to assess to clients A, B, C and D to ensure the clients had a need for frosted windows. Please see W214.</p> <p>5. The QMRP failed to accurately complete client B's CFA (Comprehensive Functional Assessment) for the need of a guardian. Please see W224.</p> <p>6. The QMRP failed to reassess client B's vocational needs/skills. Please see W225.</p> <p>7. The QMRP failed to address the client A's identified behavioral needs in regard to pinching her arms and medication refusals and to address client B's behavior in regard to refusals to participate in evacuation drills. Please see W227.</p>			

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	<p>8. The QMRP failed to develop an active treatment schedule for clients B and D. Please see W250.</p> <p>9. The QMRP failed to review/monitor client A, B, C and D's objectives to determine if the clients had successfully completed/achieved the objectives. Please see W255.</p> <p>10. The QMRP failed to review/monitor client A, B, C and D's objectives to determine if the clients had regressed and/or lost skills obtained. Please see W256.</p> <p>11. The QMRP failed to review/monitor clients A, B, C and D's objective to determine if clients had failed to progress after a reasonable period of time. Please see W257.</p> <p>12. The QMRP failed to review/monitor client A, B, C and D's objectives to determine if they were ready for training towards new objectives. Please see W258.</p> <p>13. The QMRP failed to complete an annual comprehensive functional assessment (CFA) of the client A's needs. Please see W259.</p>				

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	<p>14. The QMRP failed to coordinate/ensure the facility's HRC (Human Rights Committee) failed to review, monitor, and approve the restrictive practices for the blanket restriction of frosted window glass in the group home for clients A, B, C, and D. The QMRP also failed to have its HRC review the systemic practice of locking cleaning supplies to ensure clients' rights were protected for clients A, B, C and D. Please see W264.</p> <p>15. The QMRP failed to monitor client A's program to ensure the client was taught to wear her eyeglasses which had been determined to be needed by the client's interdisciplinary team. Please see W436.</p> <p>This federal tag relates to complaint #IN00115785.</p> <p>9-3-3(a)</p>			

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W0208	<p>483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by other agencies serving the client is encouraged.</p> <p>Based on interview and record review for 1 of 2 sampled clients (B), the facility failed to ensure the workshop/day service provider participated in team meetings and decisions made about a client's employment status.</p> <p>Findings include:</p> <p>1. On 10/3/12 from 10:30am until 11:45am, the facility's outside contracted workshop was visited and client B was not present. At 10:45am, Workshop Staff (WKS) #1 was interviewed and WKS #1 stated client B "no longer attended the (outside contracted) workshop because of [client B's] behaviors." WKS #1 provided an email dated 4/4/12 which indicated from WKS #2 at 8:40am: "[Group Home Staff #5] asked [WKS #1] today if [client B] could start spending full days in GE (General Education class). Is this something you would like for her to do?... [WKS #1] said that she doesn't work down in the workshop so it would be beneficial for her to stay in GE." WKS #1's response on 4/4/12 at 9:07am: "In the future, we need to discuss program changes with you prior to being implemented. I would rather us discuss</p>	W0208	<p><b>CORRECTION:</b> <i>Participation by other agencies serving the client is encouraged.</i> Specifically, the interdisciplinary team met with Anthony Wayne Services on 10/29/12 to discuss Client B's current vocational and pre-vocational needs. Client B has been targeted for a move into a new residential setting. The interdisciplinary team will communicate Client B's assessed vocational and pre-vocational needs to the new residential provider. <b>PREVENTION:</b> Professional staff will be trained regarding the need to bring the interdisciplinary team together to reach consensus prior to making changes in a client's level of day service participation. The QDDP will report results of IDT discussions with the Clinical Supervisor and Program Manager prior to implementation of changes. <b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Behavior Clinician, day service staff, Quality Assurance Team, Operations Team</p>	11/16/2012			

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	<p>program placement, time changes, etc. prior to the clients being informed that a change will occur..." QMRP (Qualified Mental Retardation Professional) responded on 4/4/12 at 11:09am: "Most definitely! Sometimes the staff gets ahead of me on things I am trying to accomplish with the girls. I had no idea they had told the girls yesterday...that they were staying all day...staff were not suppose to make that decision without me...I did not know [client B] went today until just a few minutes ago...."</p> <p>During an interview on 10/3/12 at 10:45am, WKS #1 stated client B had not attended workshop services at the contracted workshop "since 3/6/12." WKS #1 indicated client B had Absent With Out Leave (AWOL) behaviors. WKS #1 stated the contracted workshop staff "was not involved with the decision" of client B no longer attending the workshop. WKS #1 stated "one day she didn't come and I found out later" the group home made the decision "we weren't asked."</p> <p>On 10/3/12 at 12:45pm, client B's record was reviewed. Client B's 11/29/11 CFA (Comprehensive Functional Assessment) and 11/27/11 Vocational Skills assessment both indicated client B had the skills to attend the sheltered workshop.</p>			

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	<p>Client B's 11/29/11 CFA indicated "Can perform simple work." Client B's 1/5/12 ISP (Individual Support Plan) indicated client B attended the contracted workshop daily and completed "half days." Client B's Active Treatment Schedule did not indicate her activity scheduled from 8am until 2pm Monday through Friday. No documentation for client B's workshop/day services attendance was available for review.</p> <p>On 10/3/12 at 12:45pm, client B's 5/17/12 "Interdisciplinary Team Meeting" progress note indicated client B had "behaviors during [name of contracted service] day program/workshop...[Name of Workshop] to provide community Mon-Fri (Monday - Friday) for 1 hour. Team feels 9am-10am would be a good time to avoid anxiety of waiting through the afternoon...group home to be prepared when sending staff tentatively to start the first week of June (2012)." No workshop attendance records, no QMRP entries, and no further information was available for review.</p> <p>On 10/4/12 at 8:40am, an interview was conducted with the QMRP. The QMRP indicated no further information regarding client B's vocational placement was available for review. The QMRP stated "I can't remember when [client B] stopped</p>			

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	<p>attending workshop." The QMRP stated "March of 2012, sounds right." The QMRP stated client B stopped attending workshop when "I pulled her out." The QMRP indicated a meeting with workshop was held on 5/17/12 and it was decided that she would attend day services in the classroom. The QMRP stated she could not recall the dates or if client B "ever attended." The QMRP stated client B "currently stayed home all day."</p> <p>9-3-4(a)</p>			

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W0210	<p><b>483.440(c)(3)</b> <b>INDIVIDUAL PROGRAM PLAN</b> Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on interview and record review for 1 of 2 sampled clients (A), the client's interdisciplinary team (IDT) failed to assess the client's communication skills within 30 days of being admitted to the group home.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 10/3/12 at 12:55 PM. Client A's undated face sheet indicated client A was admitted to the group home on 12/13/11. Client A's 2/1/12 Individual Support Plan (ISP) and/or record did not indicate the client's communication skills were assessed after client A was admitted to the group home.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on 10/4/12 at 11:07 AM indicated the QMRP did not think client A's communication skills had been assessed since client A was admitted to the group home in 12/11. The QMRP indicated she had sent the client's doctor a request an order to get the communication/speech evaluation. The QMRP indicated she had not received the</p>	W0210	<p><b>CORRECTION:</b> <i>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Specifically, the team will assure that an assessment of Client A's communication skills has been completed.</i></p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding assessment requirements for new admissions to the facility. The QDDP and Team Lead will be provided with a tracking system to assure that all required assessments are completed within 30 days of admission. Members of the Operations, Quality Assurance and/or Health Services Teams will review assessment data during and after the initial assessment period to assure assessments occur as needed and required.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Behavior Clinician, Quality Assurance Team, Operations Team</p>	11/16/2012			

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	<p>recommendation/order back from the doctor.</p> <p>9-3-4(a)</p>			

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W0214	<p><b>483.440(c)(3)(iii)</b> <b>INDIVIDUAL PROGRAM PLAN</b> The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>Based on observation, interview and record review for 2 of 2 sampled clients (A and B) and for 2 additional clients (C and D), the clients' assessment failed to indicate the clients had a need for frosted windows.</p> <p>Findings include:</p> <p>On 10/2/12 from 4:55pm until 6:30pm, clients A, B, C, and D were at the group home and the living room windows, dining room windows, kitchen windows, and each of the four client bedroom windows were frosted and not clear glass. At 5:30pm, the QMRP (Qualified Mental Retardation Professional) stated each window was frosted "from the bottom to approximately six inches (6)" from the top of each window.</p> <p>On 10/4/12 at 8:10am, client B stated "I can't look out my windows, I feel like I'm in jail."</p> <p>On 10/3/12 at 12:45pm, client B's record was reviewed. Client B's record indicated she was admitted on 11/2011. Client B's</p>	W0214	<p><b>CORRECTION:</b> <i>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. Specifically, assessments for Clients A, B and D have been updated and the interdisciplinary team consensually agrees that frosted windows need to remain in place to support the dignity and privacy of the individuals who reside in the home. Client C no longer resides at the facility.</i></p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding the fact that rights restrictions can only be initiated when assessment data demonstrates a clear and present need for the restriction. Members of the Operations and Quality Assurance Teams will review support documents and related materials data as needed but no less than monthly to assure restrictions occur only as a result of appropriate assessment and interdisciplinary team consensus.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Behavior Clinician, Quality Assurance Team, Operations Team</p>	11/16/2012

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	<p>11/29/11 CFA (Comprehensive Functional Assessment) did not identify the need for frosted windows. No assessment for the restriction of frosted windows was available for review.</p> <p>On 10/4/12 at 8:50am, client D's record was reviewed. Client D's record indicated she was admitted on 11/17/2011. Client B's 11/29/11 CFA did not identify the need for frosted windows. No assessment for the restriction of frosted windows was available for review.</p> <p>Client A's record was reviewed on 10/3/12 at 12:55 PM. Client A's 2/1/12 ISP (Individual Support Plan) did not indicate the client had been assessed for the need for frosted windows.</p> <p>Client C's record was reviewed on 10/4/12 at 10:05 AM. Client C's 11/29/11 ISP did not indicate the client had been assessed for the need for frosted windows.</p> <p>Interview with the QMRP on 10/3/12 at 11:07 AM and Behavior Consultant (BC) #1 indicated the group home had half frosted windows. The BC and the QMRP indicated the clients could not see out of the windows as they were not tall enough to see over the frosted part of the windows. The QMRP indicated the frosted windows were in place to protect</p>			

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	<p>the clients' privacy. BC #1 indicated he questioned why the windows were frosted when he came to the group home in 8/12. The BC and the QMRP indicated the clients had not been assessed for the need of the frosted windows.</p> <p>9-3-4(a)</p>			

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W0224	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community.</p> <p>Based on record review and interview, for 1 of 2 sampled client (client B), the facility failed to accurately complete client B's CFA (Comprehensive Functional Assessment) for the need of a guardian.</p> <p>Finding include:</p> <p>On 10/3/12 at 12:45pm, client B's record was reviewed. Client B's 11/29/11 CFA and 1/5/12 ISP (Individual Support Plan) indicated client B was an emancipated adult and did not indicate if she needed a guardian. Client B's record indicated she had an advocate who lived in the Virgin Islands and who was contacted by e-mail. Client B's record indicated she was admitted 11/2011. Client B's 11/29/11 CFA and 4/17/12 BSP (Behavior Support Plan) both indicated she had behaviors of Self Injurious Behaviors (SIB), Physical Aggression, Verbal Aggression, Property Disruption/Destruction, Run/Wanders Away, Non Compliance with medications, No Compliance with Programmatic Task, and False</p>	W0224	<p><b>CORRECTION:</b> <i>The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community.</i> Specifically, the team will complete an Informed Consent Assessment for Client B.</p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding the components of the Comprehensive Functional Assessment including but not limited to assessing individuals' ability to give informed consent and/or the level of assistance needed with decision making. Members of the Quality Assurance and Operations Teams will review assessment data during routine visits to the facility which will occur no less than monthly as part of the agency's formal internal audit process.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Behavior Clinician, Quality Assurance Team, Operations Team</p>	11/16/2012			

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	<p>Allegations of Abuse and Neglect. Client B's BSP outlines behaviors of attacking staff, running away and stripping her clothing then laying down in the street and yards nude. Client B's BSP included the use of physical restraint holds during behaviors. Client B's record indicated client B signed her records for consent and did not indicate the advocate was involved with decision making for medications, medical care, restrictions within the group home, and physical restraints used during behaviors. Client B's assessment record did not indicate if client B recognized the dangers resulting from her behaviors.</p> <p>On 10/4/12 at 11am, an interview was conducted with the QMRP (Qualified Mental Retardation Professional). The QMRP indicated client B was emancipated and had an advocate. The QMRP indicated client B signed her own consents for medications, medical care, restrictions within the group home, and the use of physical restraints during behaviors. The QMRP stated "I'm not sure, if [client B] needs a guardian." The QMRP indicated client B did not recognize dangers of running away from the group home, stripping her clothing, and then laying down in the middle of the street. The QMRP stated when client B had behaviors "these (behaviors) were</p>			

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	aggressive and someone could get hurt."  9-3-4(a)			

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W0225	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills.</p> <p>Based on observation, record review, and interview, for 1 of 2 sampled clients (client B) the facility failed to reassess client B's vocational needs/skills.</p> <p>Findings include:</p> <p>On 10/3/12 from 10:30am until 11:45am, the facility's outside contracted workshop was visited and client B was not present. At 10:45am, Workshop Staff (WKS) #1 was interviewed and WKS #1 stated client B "no longer attended the (outside contracted) workshop because of [client B's] behaviors." WKS #1 provided an email dated 4/4/12 which indicated from WKS #2 at 8:40am: "[Group Home Staff #5] asked [WKS #1] today if [client B] could start spending full days in GE (General Education class). Is this something you would like for her to do?... [WKS #1] said that she doesn't work down in the workshop so it would be beneficial for her to stay in GE." WKS #1's response on 4/4/12 at 9:07am: "In the future, we need to discuss program changes with you prior to being implemented. I would rather us discuss program placement, time changes, etc. prior to the clients being informed that a</p>	W0225	<p><b>CORRECTION:</b> <i>The comprehensive functional assessment must include, as applicable, vocational skills.</i> Specifically, the team will complete a re-assessment of Client B's current vocational skills. Client B has been targeted for a move into a new residential setting. The interdisciplinary team will communicate Client B's assessed vocational and pre-vocational needs to the new residential provider.</p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding the components of the Comprehensive Functional Assessment including but not limited to vocational and pre-vocational skills and needs. Members of the Quality Assurance and Operations Teams will review assessment data during routine visits to the facility which will occur no less than monthly as part of the agency's formal internal audit process.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Behavior Clinician, Quality Assurance Team, Operations Team</p>	11/16/2012			

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	<p>change will occur...." QMRP (Qualified Mental Retardation Professional) responded on 4/4/12 at 11:09am: "Most definitely! Sometimes the staff gets ahead of me on things I am trying to accomplish with the girls. I had no idea they had told the girls yesterday...that they were staying all day...staff were not suppose to make that decision without me...I did not know [client B] went today until just a few minutes ago...."</p> <p>During an interview on 10/3/12 at 10:45am, WKS #1 stated client B had not attended workshop services at the contracted workshop "since 3/6/12." WKS #1 indicated client B had Absent With Out Leave (AWOL) behaviors. WKS #1 stated the contracted workshop staff "was not involved with the decision" of client B no longer attending the workshop. WKS #1 stated "one day she didn't come and I found out later" the group home made the decision "we weren't asked."</p> <p>On 10/3/12 at 12:45pm, client B's record was reviewed. Client B's 11/29/11 CFA (Comprehensive Functional Assessment) and 11/27/11 Vocational Skills assessment both indicated client B had the skills to attend the sheltered workshop. Client B's 11/29/11 CFA indicated "Can perform simple work." Client B's 1/5/12</p>			

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	<p>ISP (Individual Support Plan) indicated client B attended the contracted workshop daily and completed "half days." Client B's Active Treatment Schedule did not indicate her activity scheduled from 8am until 2pm Monday through Friday. No reassessment of client B's vocational needs was available for review. No documentation for client B's workshop/day services attendance was available for review.</p> <p>On 10/3/12 at 12:45pm, client B's 5/17/12 "Interdisciplinary Team Meeting" progress note indicated client B had "behaviors during [name of contracted service] day program/workshop...[Name of Workshop] to provide community Mon-Fri (Monday - Friday) for 1 hour. Team feels 9am-10am would be a good time to avoid anxiety of waiting through the afternoon...group home to be prepared when sending staff tentatively to start the first week of June (2012)." No reassessment of client B's vocational needs was available for review. No workshop attendance records, no QMRP entries, and no further information was available for review.</p> <p>On 10/4/12 at 8:40am, an interview was conducted with the QMRP. The QMRP indicated no further information regarding client B's vocational placement was</p>						

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	<p>available for review. The QMRP stated "I can't remember when [client B] stopped attending workshop." The QMRP stated "March of 2012, sounds right." The QMRP stated client B stopped attending workshop when "I pulled her out." The QMRP indicated a meeting with workshop was held on 5/17/12 and it was decided that she would attend day services in the classroom. The QMRP stated she could not recall the dates or if client B "ever attended." The QMRP stated client B "currently stayed home all day." The QMRP indicated no reassessment for client B's vocational needs and skills were available for review.</p> <p>9-3-4(a)</p>				

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W0227	<p>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 interview and record review for 2 of 2 sampled clients (A and B), the clients' Individual Support Plans (ISPs) failed to address the client A's identified behavioral needs in regard to pinching her arms and medication refusals and to address client B's behavior in regard to refusals to participate in evacuation drills.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 10/2/12 at 9:46 AM. The facility's 8/30/12 reportable incident report indicated "[Client A] (individual supported by ResCare) was standing in the dining room with her assigned staff one to one staff and two other staff in close proximity. She ran around the corner of the dining room table to the window and placed the cord for the blinds around and began pulling. Staff immediately removed the cord from her hands and guided her away from the window. [Client A] began crying but displayed no further self-injurious behavior. At 4 PM, [Client A's] one to</p>	W0227	<p><b>CORRECTION:</b> <i>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. Specifically Client A's Behavior Support Plan will be revised to include proactive and reactive strategies that address pinching herself and the team will develop interventions that address Client B's refusals to participate in evacuation drills.</i></p> <p><b>PREVENTION:</b> The behavioral clinician has completed the initial evaluation of the individuals who reside in the facility since he assumed behavior support coordination responsibilities in August 2012. Revisions of behavior supports to reflect current assessed needs will be developed and revised as needed.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Behavior Clinician, Quality Assurance Team, Operations Team</p>	11/16/2012			

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	<p>one staff noted five deep purple bruises on her upper left bicep. When asked how she received the injuries she said that QMRP (Qualified Mental Retardation Professional) [name of the QMRP] 'did it.' She would not say what happened and did not make eye contact with staff when she made the allegation. [Client A] typically pinches herself on her arms when she is upset and has received bruises in the past from engaging in this behavior...."</p> <p>The facility's 9/1/12 follow-up report indicated "The allegation that QMRP [name of QMRP] caused a pattern of bruises on [client A's] arm was not substantiated. The investigators determined that no one observed [name of Program Coordinator-PC] behaves towards [client A] in any manner that could have resulted in [client A] receiving bruises. [Client A] was receiving one to one direct support staff supervision and therefore [name of QMRP] was never alone with [client A]. Additionally [client A] was unable to describe how [name of QMRP] injured her and her (client A) body language was evasive during attempts to interview her. [Client A] began refusing food, fluids, and medication 24 hours prior to the discovery of her injuries. The team has determined that [client A] most likely sustained the bruises as a result of</p>			

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	<p>pinching herself, a activity which is addressed in her Behavior Support Plan. [Client A] was hospitalized on 8/31/12 due to her ongoing refusals to eat, drink, and take medication...."</p> <p>The facility's 8/31/12 reportable incident report indicated client A refused her 5 PM medications. The reportable incident report indicated the behavior specialist was present when the client refused and worked with the client throughout the day on 8/30/12. The reportable incident report indicated client A refused to eat, drink and take her medications. The reportable incident report indicated client A's psychiatrist was contacted and the client was taken to the hospital for evaluation and admittance. The reportable incident report indicated client A was admitted to the hospital after the client pulled her intravenous (IV) fluids to the behavioral unit. The 8/31/12 reportable incident report indicated "...Her combative behaviors increased...On the morning of 9/1/12, [client A] continue refused her morning, food, liquids, medication and blood draw...[Name of psychiatrist's] intention is to start [client A] on an injection because of her frequent medication refusals...."</p> <p>Client A's record was reviewed on 10/3/12 at 12:55 PM. Client A's 9/7/12</p>			

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	<p>Record of Visit indicated client A's psychiatrist ordered the client to receive an Intramuscular injection of Invega (behavior) Sustention 1 milliliter (156 milligrams) 1 week after 234 milligrams injection. The record indicated the injection was administered on 10/2/12.</p> <p>Client A's 5/3/12 Behavior Support Plan (BSP) indicated client A demonstrated self injurious behavior defined as "any non-suicidal act that causes injury to self (e.g. bang head, scratch self that leaves a mark)...." Client A's defined self-injurious behavior did not specifically include/address pinching her arms. Client A's 5/3/12 BSP also did not address client A's medication refusals.</p> <p>Interview with staff #2 on 10/3/12 at 7:55 AM when asked how often client A pinched her arms, staff #2 stated "Kind of depends if she is nervous or agitated. Very sneaky." Staff #2 stated client A would "cross her arms a lot and will do it at that time." Staff #2 indicated client A pinched the inside of her arms, her stomach folds and inner legs.</p> <p>Interview with the QMRP and Behavior Consultant (BC) #1 on 10/4/12 at 11:07 AM indicated client A would pinch her arms. BC #1 indicated he had observed client A pinch the inside of her arms.</p>				

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	<p>When asked how often the behavior occurred, BC #1 stated "Variable from what I observed." BC #1 indicated the client would demonstrate the behavior when she became sad, nervous and/or agitated. BC #1 and the QMRP indicated client A's current BSP did to specifically address the client's pinching behavior. The QMRP and BC #1 indicated client A received the Invega Injections due to refusing her oral medications. The BC stated client A was "Refusing to take oral medications with history leading to decompensation of mood." The QMRP and BC #1 indicated client A continued to receive other oral medications. The QMRP and BC #1 indicated client A's 5/3/12 BSP did not address the client's identified need in regard to medication refusals.</p> <p>2. On 10/4/12 at 10am, the facility's emergency evacuation drills were reviewed and indicated client B refused to exit twenty-two (22) times from 11/2011 through 10/4/12. Drills reviewed and client B refused to exit were: on 9/29/12 no time documented, 9/4/12 at 7pm, on 9/3/12 at 5:50am, on 8/23/12 at 5:45am, on 8/15/12 at 5:45am, on 7/24/12 at 5:20am, on 7/16/12 at 5:30am, on 7/10/12 at 6:05am, on 6/21/12 at 7:45am, on 6/8/12 at "3rd shift," on 5/3/12 7pm, on 5/2/12 at 7pm, on 5/1/12 at 5am, on</p>						

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	<p>4/15/12 at 10pm, on 4/11/12 at 6:45am, on 3/9/12 at 2:50pm, on 3/7/12 at 10:25pm, on 2/19/12 at 6:35am, on 1/23/12 at 1am, on 1/20/12 at 8pm, and on 11/29/11 at 1:30am.</p> <p>On 10/3/12 at 12:45pm, client B's record was reviewed. Client B's 1/5/12 ISP (Individual Support Plan) did not indicate a training objective to evacuate the group home during an emergency drill.</p> <p>On 10/4/12 at 11am, an interview was conducted with the QMRP. The QMRP indicated client B refused to exit the group home during evacuation drills and did not have a training objective developed.</p> <p>This federal tag relates to complaint #IN00115785.</p> <p>9-3-4(a)</p>						

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W0250	<p><b>483.440(d)(2) PROGRAM IMPLEMENTATION</b> The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>Based on observation, interview and record review for 1 of 2 sampled clients (B) and for 1 additional client (D), the facility failed to develop an active treatment schedule which included what staff were to do with the client during the day and/or indicated what training was to occur with the clients.</p> <p>Findings include:</p> <p>1. On 10/3/12 from 12noon until 2:55pm observation at the group home was completed. Client B went into the community with her one on one assigned staff person from the group home, played table games, and talked to her staff person.</p> <p>On 10/3/12 at 12:45pm, client B's record was reviewed. Client B's 11/29/11 CFA (Comprehensive Functional Assessment) and 11/27/11 Vocational Skills assessment both indicated client B had the skills to attend the sheltered workshop. Client B's 11/29/11 CFA indicated "Can perform simple work." Client B's 1/3/12 ISP (Individual Support Plan) indicated</p>	W0250	<p><b>CORRECTION:</b> <i>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Specifically, Client B's Active Treatment Scheduled will be revised to reflect Client B's current daily training activities.</i></p> <p><b>PREVENTION:</b> Professional staff will be trained regarding the need to revise Active Treatment Schedules when the team changes a client's active treatment program. Members of the Quality Assurance and Operations Teams will review assessment data during routine visits to the facility which will occur no less than monthly as part of the agency's formal internal audit process.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Quality Assurance Team, Operations Team</p>	11/16/2012			

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	<p>client B attended the contracted workshop daily and completed "half days." Client B's Active Treatment Schedule did not indicate her activity scheduled from 8am until 2pm Monday through Friday and documented the name of the staff person assigned for client B's one on one supervision. Client B's 1/5/12 ISP indicated goals/objectives to name her klopin and topamax medications, to wake up in the morning for medications, to identify her weekly account balance, and to shower daily.</p> <p>On 10/4/12 at 8:40am, an interview was conducted with the QMRP (Qualified Mental Retardation Professional). The QMRP stated "I can't remember when [client B] stopped attending workshop." The QMRP stated client B stopped attending workshop when "I pulled her out." The QMRP stated client B "currently stayed home all day." The QMRP stated client B's active treatment schedule was "hand written because she did not have one before 10/4/12." The QMRP indicated client B's active treatment schedule did not reflect client B's normal daily rhythms and was not available for the staff on duty with client B.</p> <p>2. On 10/4/12 at 8:50am, client D's record was reviewed. Client D's record</p>				

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	<p>indicated she was admitted on 11/17/2011. Client D's "Active Treatment Schedule" was hand written and indicated the following:</p> <p>6am - 8am-wake up, take meds, breakfast, get dressed, toileting/hygiene, make bed. 8am - 1pm- Contracted workshop 1pm - 2pm- Choices, activity. 2pm - 3pm- Watch TV. 3pm - 4pm- Free time. 4pm - 5pm- Meds (medications). 5pm - 6pm- Dinner and goals. 6pm - 7pm- Snack. 7pm - 8pm- Meds. 8pm - 9pm- Shower. 9pm - Bed.</p> <p>On 10/4/12 at 8:40am, an interview was conducted with the QMRP. The QMRP stated client D's active treatment schedule was "hand written because she did not have one before 10/4/12." The QMRP indicated client D's active treatment schedule did not reflect client D's normal daily rhythms and was not available for the staff on duty with client D.</p> <p>9-3-4(a)</p>						

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W0255	<p>483.440(f)(1)(i) PROGRAM MONITORING &amp; CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.</p> <p>Based on interview and record review for 2 of 2 sampled clients (A and B), the Qualified Mental Retardation Professional (QMRP) failed to review/monitor the clients' objectives to determine if the clients had successfully completed/achieved the objectives.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 10/3/12 at 12:55 PM. Client A's 2/1/12 ISP (Individual Support Plan) indicated the client had the following objectives:</p> <ul style="list-style-type: none"> <li>-To name at least 4 side effects of her Topamax (behavior) with verbal prompts 65% of the opportunities per month for 6 consecutive months.</li> <li>-Will perform her kitchen duties 65 of the opportunities for 6 consecutive months.</li> <li>-Will brush her teeth every night 65% of the opportunities with no more than 2 verbal prompts for 6 consecutive months.</li> <li>-Will attend day services 65% of opportunities for 6 consecutive months.</li> </ul>	W0255	<p><b>CORRECTION:</b> <i>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.</i></p> <p>Specifically, the QDDP has located copies of monthly progress summaries for Clients A and B, which will be available for review at the survey revisit. Client A and B's learning objectives will be modified as indicated in the progress summaries. Additionally, the Behavioral Clinician has completed summaries of behavior data and will make revisions to Client A and B's behavior supports, as needed, based on current assessment data.</p> <p><b>PREVENTION:</b> The QDDP will receive training regarding the need to maintain copies of monthly/quarterly summaries in each client's record to be available for review by appropriate parties upon request, as well as the need to revise</p>	11/16/2012			

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	<p>-Will maintain a weekly balance every weekend 65% of opportunities for 6 consecutive months.</p> <p>-Will perform her laundry duties 65% of opportunities for 6 consecutive months.</p> <p>-Will apply deodorant every morning 65% with 2 verbal prompts for 6 consecutive months.</p> <p>-Will take a shower every morning 65% with 2 verbal prompts for 6 consecutive months.</p> <p>-Will wake up 65% of opportunities with 3 verbal prompts to take 6 AM medications. for 6 consecutive months.</p> <p>Client A's 5/3/12 Behavior Support Plan (BSP) indicated the client had the following objectives:</p> <p>-Engage in no more than 3 or less occurrences of self-injury for 12 consecutive months.</p> <p>-Engage in no more than 3 or less occurrences of suicide threats for 12 consecutive months.</p> <p>-Engage in zero occurrences of suicide attempts for 12 consecutive months.</p> <p>-Engage in zero occurrences of physical aggression for 12 consecutive months.</p> <p>-Engage in zero occurrences of elopement for 12 consecutive months.</p> <p>-Engage in no more than 5 occurrences of reporting hallucinations.</p>		<p>objectives no less than quarterly based on current assessment data. The Behavioral Clinician will meet weekly with the Program Manager to discuss current behavioral issues at the facility and to review behavior summaries upon completion. Additionally, members of the Operations and Quality Assurance Teams will conduct periodic reviews of individual support plans and monthly/quarterly ISP reviews on an ongoing basis to assure the QDDP and Behavioral clinician are monitoring progress on client's learning objectives behavior trends and making appropriate modifications as needed. <b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Behavior Clinician, Quality Assurance Team, Operations Team</p>		

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	<p>Client A's record indicated the QMRP had not monitored client A's above mentioned objectives as there were no monthly summaries to review to determine if client A had achieved the objectives since client A's objectives were started 2/1/12.</p> <p>Interview with the QMRP and Behavior Consultant (BC) #1 on 10/4/12 at 11:07 AM indicated there was no behavior data/behavioral monthlies in regard to the client's behavior data. BC #1 indicated he had just started on 8/1/12. BC #1 indicated he would be doing monthly summaries in regard to the client's behavioral objectives. The QMRP indicated she had completed monthly reviews for client A's above mentioned objectives. The QMRP did not provide documentation of client A's monthly summaries to determine if the client had achieved the above mentioned objectives.</p> <p>2. Client B ' s record was reviewed on 10/3/12 at 12:45pm. Client B's 1/5/12 ISP indicated goals/objectives for client B to:</p> <ul style="list-style-type: none"> <li>perform her kitchen duties 95% of the opportunities per month</li> <li>brush her teeth every night 95% of the opportunities with no more than 2 verbal prompts.</li> <li>wear her glasses " y or n. "</li> <li>wear her helmet " y or n. "</li> </ul>			

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	<p>wake up 95% of the opportunities to take 6am medications with 3 verbal prompts apply deodorant every morning 95% of the opportunities with 2 verbal prompts. brush teeth every morning 95% of the opportunities with no more than 2 verbal prompts. take a shower every morning 95% of opportunities within 2 verbal prompts. shave her armpits with verbal prompts 95% of the opportunities per month perform laundry duties 95% of the opportunities per month name the purpose of medication specified " Topamax " and " Klonpin " with verbal prompts 95% of the opportunities per month wake up promptly 95% of the opportunities to take her medications per month. demonstrate the correct portion sizes with verbal prompts 95% of the opportunities per month. identify her weekly balance with verbal prompts 95% of the opportunities per month.</p> <p>Client B's record did not contain monthly reviews of program data to determine if</p>				

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	<p>client B had achieved the objectives since client B's ISP was implemented on 1/5/12.</p> <p>Interview with the QMRP on 10/4/12 at 11:07 AM indicated she had completed monthly reviews for client B's above mentioned objectives. The QMRP did not provide documentation of client B's monthly summaries to determine if the client had achieved the above mentioned objectives.</p> <p>9-3-4(a)</p>				

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W0256	<p>483.440(f)(1)(ii) PROGRAM MONITORING &amp; CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is regressing or losing skills already gained. Based on interview and record review for 2 of 2 sampled clients (A and B), the Qualified Mental Retardation Professional (QMRP) failed to review/monitor the clients' objectives to determine if the clients had regressed and/or lost skills obtained.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 10/3/12 at 12:55 PM. Client A's 2/1/12 ISP (Individual Support Plan) indicated the client had the following objectives:</p> <ul style="list-style-type: none"> <li>-To name at least 4 side effects of her Topamax (behavior) with verbal prompts 65% of the opportunities per month for 6 consecutive months.</li> <li>-Will perform her kitchen duties 65 of the opportunities for 6 consecutive months.</li> <li>-Will brush her teeth every night 65% of the opportunities with no more than 2 verbal prompts for 6 consecutive months.</li> <li>-Will attend day services 65% of opportunities for 6 consecutive months.</li> <li>-Will maintain a weekly balance every</li> </ul>	W0256	<p><b>CORRECTION:</b> <i>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is regressing or losing skills already gained. Specifically, the QDDP has located copies of monthly progress summaries for Clients A and B, which will be available for review at the survey revisit. Client A and B's learning objectives will be modified as indicated in the progress summaries including but not limited to situations in which Client A and Client B are regressing.</i></p> <p><b>PREVENTION:</b> The QDDP will receive training regarding the need to maintain copies of monthly/quarterly summaries in each client's record to be available for review by appropriate parties upon request, as well as the need to revise objectives no less than quarterly based on current assessment data. Additionally, members of the Operations and Quality Assurance Teams will conduct periodic reviews of individual support plans and monthly/quarterly ISP reviews on an ongoing basis to assure the</p>	11/16/2012	

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	<p>weekend 65% of opportunities for 6 consecutive months.</p> <p>-Will perform her laundry duties 65% of opportunities for 6 consecutive months.</p> <p>-Will apply deodorant every morning 65% with 2 verbal prompts for 6 consecutive months.</p> <p>-Will take a shower every morning 65% with 2 verbal prompts for 6 consecutive months.</p> <p>-Will wake up 65% of opportunities with 3 verbal prompts to take 6 AM medications. for 6 consecutive months.</p> <p>Client A's 5/3/12 Behavior Support Plan (BSP) indicated the client had the following objectives:</p> <p>-Engage in no more than 3 or less occurrences of self-injury for 12 consecutive months.</p> <p>-Engage in no more than 3 or less occurrences of suicide threats for 12 consecutive months.</p> <p>-Engage in zero occurrences of suicide attempts for 12 consecutive months.</p> <p>-Engage in zero occurrences of physical aggression for 12 consecutive months.</p> <p>-Engage in zero occurrences of elopement for 12 consecutive months.</p> <p>-Engage in no more than 5 occurrences of reporting hallucinations.</p> <p>Client A's record indicated the QMRP had</p>		<p>QDDP and Behavioral clinician are monitoring progress on client's learning objectives behavior trends and making appropriate modifications as needed.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Support Associates, Behavior Clinician, Health Services Team, Quality Assurance Team, Operations Team</p>				

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	<p>not monitored client A's above mentioned objectives to determine if client A had regressed/lost skills since the 2/1/12 ISP was started.</p> <p>Interview with the QMRP and Behavior Consultant (BC) #1 on 10/4/12 at 11:07 AM indicated there was no behavior data/behavioral monthlies in regard to the client's behavior data. BC #1 indicated he had just started on 8/1/12. BC #1 indicated he would be doing monthly summaries in regard to the client's behavioral objectives. The QMRP indicated she had completed monthly reviews for client A's above mentioned objectives. The QMRP did not provide documentation of client A's monthly summaries to determine if she had monitored client A's objectives in regard to regression and/or lost of skills.</p> <p>2. Client B ' s record was reviewed on 10/3/12 at 12:45pm. Client B's 1/5/12 ISP indicated goals/objectives for client B to:</p> <ul style="list-style-type: none"> <li>perform her kitchen duties 95% of the opportunities per month</li> <li>brush her teeth every night 95% of the opportunities with no more than 2 verbal prompts.</li> <li>wear her glasses " y or n. "</li> <li>wear her helmet " y or n. "</li> <li>wake up 95% of the opportunities</li> </ul>			

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	<p>to take 6am medications with 3 verbal prompts apply deodorant every morning 95% of the opportunities with 2 verbal prompts. brush teeth every morning 95% of the opportunities with no more than 2 verbal prompts. take a shower every morning 95% of opportunities within 2 verbal prompts. shave her armpits with verbal prompts 95% of the opportunities per month perform laundry duties 95% of the opportunities per month name the purpose of medication specified " Topamax " and " Klonpin " with verbal prompts 95% of the opportunities per month wake up promptly 95% of the opportunities to take her medications per month. demonstrate the correct portion sizes with verbal prompts 95% of the opportunities per month. identify her weekly balance with verbal prompts 95% of the opportunities per month.</p> <p>Client B's record did not contain monthly reviews of program data to determine if client B had lost and/or regressed in skill</p>						

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	<p>obtained since client B's ISP was implemented on 1/5/12.</p> <p>Interview with the QMRP on 10/4/12 at 11:07 AM indicated she had completed monthly reviews for client B's above mentioned objectives. The QMRP did not provide documentation of client B's monthly summaries to determine if the client had regressed and/or lost skills obtained.</p> <p>9-3-4(a)</p>			
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W0257	<p>483.440(f)(1)(iii) PROGRAM MONITORING &amp; CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. Based on interview and record review for 2 of 2 sampled clients (A and B), the Qualified Mental Retardation Professional (QMRP) failed to review/monitor the clients' objectives to determine if the clients had failed to progress after a reasonable period of time.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 10/3/12 at 12:55 PM. Client A's 2/1/12 ISP (Individual Support Plan) indicated the client had the following objectives:</p> <ul style="list-style-type: none"> <li>-To name at least 4 side effects of her Topamax (behavior) with verbal prompts 65% of the opportunities per month for 6 consecutive months.</li> <li>-Will perform her kitchen duties 65 of the opportunities for 6 consecutive months.</li> <li>-Will brush her teeth every night 65% of the opportunities with no more than 2 verbal prompts for 6 consecutive months.</li> <li>-Will attend day services 65% of opportunities for 6 consecutive months.</li> <li>-Will maintain a weekly balance every</li> </ul>	W0257	<p><b>CORRECTION:</b> <i>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. Specifically, the QDDP has located copies of monthly progress summaries for Clients A and B, which will be available for review at the survey revisit. Client A and B's learning objectives will be modified as indicated in the progress summaries including but not limited to situations in which Client A and Client B are failing to progress toward identified goals.</i></p> <p><b>PREVENTION:</b> The QDDP will receive training regarding the need to maintain copies of monthly/quarterly summaries in each client's record to be available for review by appropriate parties upon request, as well as the need to revise objectives no less than quarterly based on current assessment data. Additionally, members of the Operations and Quality</p>	11/16/2012	

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	<p>weekend 65% of opportunities for 6 consecutive months.</p> <p>-Will perform her laundry duties 65% of opportunities for 6 consecutive months.</p> <p>-Will apply deodorant every morning 65% with 2 verbal prompts for 6 consecutive months.</p> <p>-Will take a shower every morning 65% with 2 verbal prompts for 6 consecutive months.</p> <p>-Will wake up 65% of opportunities with 3 verbal prompts to take 6 AM medications. for 6 consecutive months.</p> <p>Client A's 5/3/12 Behavior Support Plan (BSP) indicated the client had the following objectives:</p> <p>-Engage in no more than 3 or less occurrences of self-injury for 12 consecutive months.</p> <p>-Engage in no more than 3 or less occurrences of suicide threats for 12 consecutive months.</p> <p>-Engage in zero occurrences of suicide attempts for 12 consecutive months.</p> <p>-Engage in zero occurrences of physical aggression for 12 consecutive months.</p> <p>-Engage in zero occurrences of elopement for 12 consecutive months.</p> <p>-Engage in no more than 5 occurrences of reporting hallucinations.</p> <p>Client A's record indicated the QMRP had</p>		<p>Assurance Teams will conduct periodic reviews of individual support plans and monthly/quarterly ISP reviews on an ongoing basis to assure the QDDP and Behavioral clinician are monitoring progress on client's learning objectives behavior trends and making appropriate modifications as needed. <b>RESPONSIBLE PARTIES:</b> QDDP, Support Associates, Behavior Clinician, Health Services Team, Quality Assurance Team, Operations Team</p>				

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	<p>not monitored client A's above mentioned objectives, since 2/12/12, as there were no monthly summaries to review to determine if client A had progressed after a reasonable effort had been made.</p> <p>Interview with the QMRP and Behavior Consultant (BC) #1 on 10/4/12 at 11:07 AM indicated there was no behavior data/behavioral monthlies in regard to the client's behavior data. BC #1 indicated he had just started on 8/1/12. BC #1 indicated he would be doing monthly summaries in regard to the client's behavioral objectives. The QMRP indicated she had completed monthly reviews for client A's above mentioned objectives. The QMRP did not provide documentation of client A's monthly summaries to determine if the client had failed to progress on the above mentioned objectives after a reasonable effort had been made.</p> <p>2. Client B ' s record was reviewed on 10/3/12 at 12:45pm. Client B's 1/5/12 ISP indicated goals/objectives for client B to:</p> <ul style="list-style-type: none"> <li>perform her kitchen duties 95% of the opportunities per month</li> <li>brush her teeth every night 95% of the opportunities with no more than 2 verbal prompts.</li> </ul>				

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	<p>wear her glasses " y or n. "</p> <p>wear her helmet " y or n. "</p> <p>wake up 95% of the opportunities to take 6am medications with 3 verbal prompts</p> <p>apply deodorant every morning 95% of the opportunities with 2 verbal prompts.</p> <p>brush teeth every morning 95% of the opportunities with no more than 2 verbal prompts.</p> <p>take a shower every morning 95% of opportunities within 2 verbal prompts.</p> <p>shave her armpits with verbal prompts 95% of the opportunities per month</p> <p>perform laundry duties 95% of the opportunities per month</p> <p>name the purpose of medication specified " Topamax " and " Klonpin " with verbal prompts 95% of the opportunities per month</p> <p>wake up promptly 95% of the opportunities to take her medications per month.</p> <p>demonstrate the correct portion sizes with verbal prompts 95% of the opportunities per month.</p> <p>identify her weekly balance with verbal prompts 95% of the opportunities per month.</p>			

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	<p>Client B's record did not contain monthly reviews of program data to determine if client B had failed to progress after a reasonable efforts had been made since the client's ISP was implemented on 1/5/12.</p> <p>Interview with the QMRP on 10/4/12 at 11:07 AM indicated she had completed monthly reviews for client B's above mentioned objectives. The QMRP did not provide the documentation of client B's monthly summaries to determine if client B had failed to progress after reasonable efforts had been made.</p> <p>9-3-4(a)</p>			

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W0258	<p>483.440(f)(1)(iv) PROGRAM MONITORING &amp; CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is being considered for training towards new objectives.</p> <p>Based on interview and record review for 2 of 2 sampled clients (A and B), the Qualified Mental Retardation Professional (QMRP) failed to review/monitor the clients' objectives to determine if they were ready for training towards new objectives.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 10/3/12 at 12:55 PM. Client A's 2/1/12 ISP (Individual Support Plan) indicated the client had the following objectives:</p> <ul style="list-style-type: none"> <li>-To name at least 4 side effects of her Topamax (behavior) with verbal prompts 65% of the opportunities per month for 6 consecutive months.</li> <li>-Will perform her kitchen duties 65 of the opportunities for 6 consecutive months.</li> <li>-Will brush her teeth every night 65% of the opportunities with no more than 2 verbal prompts for 6 consecutive months.</li> <li>-Will attend day services 65% of opportunities for 6 consecutive months.</li> <li>-Will maintain a weekly balance every</li> </ul>	W0258	<p><b>CORRECTION:</b> <i>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is being considered for training towards new objectives. Specifically, the QDDP has located copies of monthly progress summaries for Clients A and B, which will be available for review at the survey revisit. Client A and B's learning objectives will be modified as indicated in the progress summaries including but not limited to situations in which Client A and Client B are ready for training towards new objectives.</i></p> <p><b>PREVENTION:</b> The QDDP will receive training regarding the need to maintain copies of monthly/quarterly summaries in each client's record to be available for review by appropriate parties upon request, as well as the need to revise objectives no less than quarterly based on current assessment data. Additionally, members of the Operations and Quality Assurance Teams will conduct periodic reviews of individual support plans and</p>	11/16/2012

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	<p>weekend 65% of opportunities for 6 consecutive months.</p> <p>-Will perform her laundry duties 65% of opportunities for 6 consecutive months.</p> <p>-Will apply deodorant every morning 65% with 2 verbal prompts for 6 consecutive months.</p> <p>-Will take a shower every morning 65% with 2 verbal prompts for 6 consecutive months.</p> <p>-Will wake up 65% of opportunities with 3 verbal prompts to take 6 AM medications. for 6 consecutive months.</p> <p>Client A's 5/3/12 Behavior Support Plan (BSP) indicated the client had the following objectives:</p> <p>-Engage in no more than 3 or less occurrences of self-injury for 12 consecutive months.</p> <p>-Engage in no more than 3 or less occurrences of suicide threats for 12 consecutive months.</p> <p>-Engage in zero occurrences of suicide attempts for 12 consecutive months.</p> <p>-Engage in zero occurrences of physical aggression for 12 consecutive months.</p> <p>-Engage in zero occurrences of elopement for 12 consecutive months.</p> <p>-Engage in no more than 5 occurrences of reporting hallucinations.</p> <p>Client A's record indicated the QMRP had</p>		<p>monthly/quarterly ISP reviews on an ongoing basis to assure the QDDP and Behavioral clinician are monitoring progress on client's learning objectives behavior trends and making appropriate modifications as needed.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Support Associates, Behavior Clinician, Health Services Team, Quality Assurance Team, Operations Team</p>		

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	<p>not monitored client A's 2/1/12 above mentioned objectives as there were no monthly summaries to review to determine if client A required training toward new objectives.</p> <p>Interview with the QMRP and Behavior Consultant (BC) #1 on 10/4/12 at 11:07 AM indicated there was no behavior data/behavioral monthlies in regard to the client's behavior data. BC #1 indicated he had just started on 8/1/12. BC #1 indicated he would be doing monthly summaries in regard to the client's behavioral objectives. The QMRP indicated she had completed monthly reviews for client A's above mentioned objectives. The QMRP did not provide documentation of client A's monthly summaries to determine if the client should be considered for training toward new objectives.</p> <p>2. Client B ' s record was reviewed on 10/3/12 at 12:45pm. Client B's 1/5/12 ISP indicated goals/objectives for client B to:</p> <ul style="list-style-type: none"> <li>perform her kitchen duties 95% of the opportunities per month</li> <li>brush her teeth every night 95% of the opportunities with no more than 2 verbal prompts.</li> <li>wear her glasses " y or n. "</li> <li>wear her helmet " y or n. "</li> </ul>				

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	<p>wake up 95% of the opportunities to take 6am medications with 3 verbal prompts                      apply deodorant every morning                      95% of the opportunities with 2 verbal prompts.                      brush teeth every morning 95% of the opportunities with no more than 2 verbal prompts.                      take a shower every morning 95% of opportunities within 2 verbal prompts.                      shave her armpits with verbal prompts 95% of the opportunities per month                      perform laundry duties 95% of the opportunities per month                      name the purpose of medication specified " Topamax " and " Klonpin " with verbal prompts 95% of the opportunities per month                      wake up promptly 95% of the opportunities to take her medications per month.                      demonstrate the correct portion sizes with verbal prompts 95% of the opportunities per month.                      identify her weekly balance with verbal prompts 95% of the opportunities per month.</p> <p>Client B's record did not contain monthly reviews of program data to determine if</p>			

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	<p>client B required training toward new objectives since the client's ISP was implemented on 1/5/12.</p> <p>Interview with the QMRP on 10/4/12 at 11:07 AM indicated she had completed monthly reviews for client B's above mentioned objectives. The QMRP did not provide the documentation of client B's monthly summaries to determine if client B required training toward new objectives.</p> <p>9-3-4(a)</p>			

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W0259	<p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on interview and record review for 1 of 2 sampled clients (A), the client's interdisciplinary team (IDT) failed to complete an annual comprehensive functional assessment (CFA) of the client's needs.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 10/3/12 at 12:55 PM. Client A's undated face sheet indicated client A was admitted to the group home on 12/30/11. Client A's record did not indicate the client's IDT completed an annual CFA in regard to the client's skills and needs.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and the Behavior Consultant (BC) on 10/4/12 at 11:07 AM indicated they were unable to locate client A's CFA. The QMRP indicated it should have been completed and placed in client A's record.</p> <p>9-3-4(a)</p>	W0259	<p><b>CORRECTION:</b> <i>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Specifically, the team has completed an updated Comprehensive Consent Assessment for Client A.</i></p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding the need to include an annually updated Comprehensive Functional Assessment included in each individual's record. Members of the Quality Assurance and Operations Teams will review assessment data during routine visits to the facility which will occur no less than monthly as part of the agency's formal internal audit process.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Behavior Clinician, Health Services Team, Quality Assurance Team, Operations Team</p>	11/16/2012	

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W0264	<p>483.440(f)(3)(iii) PROGRAM MONITORING &amp; CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, record review, and interview for 2 of 2 sampled clients (clients A and B) and for 2 additional clients (clients C and D), the facility's HRC (Human Rights Committee) failed to review, monitor, and approve the restrictive practices for the blanket restriction of frosted window glass in the group home for clients A, B, C, and D. The facility also failed to have its HRC review the systemic practice of locking cleaning supplies to ensure clients' rights were protected for clients A, B, C and D.</p> <p>Finding include:</p> <p>1. On 10/2/12 from 4:55pm until 6:30pm, clients A, B, C, and D were at the group home and the living room windows, dining room windows, kitchen windows, and each of the four client bedroom windows were frosted and not clear glass. At 5:30pm, the QMRP (Qualified Mental Retardation Professional) stated each</p>	W0264	<p><b>CORRECTION:</b> <i>The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Specifically, The Human Rights Committee will review the use of frosted window for Clients A – D and determine if the rights restriction is necessary to protect the privacy and dignity of Clients A – D. Additionally, the facility has reassessed Clients A – D and consensually agrees that there is no current need to keep cleaning supplies in a locked cabinet and the household chemicals are no longer secured.</i></p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding the need to obtain prior written informed consent and Human Rights Committee approval for all restrictive programs prior to implementation. Retraining will focus on assuring</p>	11/16/2012	

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	<p>window was frosted "from the bottom to approximately six inches (6)" from the top of each window.</p> <p>On 10/4/12 at 8:10am, client B stated "I can't look out my windows, I feel like I'm in jail."</p> <p>On 10/3/12 at 12:45pm, client B's record was reviewed. Client B's record indicated she was admitted on 11/2011. Client B's 11/29/11 CFA (Comprehensive Functional Assessment) did not identify the need for frosted windows. No assessment for the restriction of frosted windows was available for review.</p> <p>On 10/4/12 at 8:50am, client D's record was reviewed. Client D's record indicated she was admitted on 11/17/2011. Client B's 11/29/11 CFA (Comprehensive Functional Assessment) did not identify the need for frosted windows. No assessment for the restriction of frosted windows was available for review.</p> <p>Client A's record was reviewed on 10/3/12 at 12:55 PM. Client A's 2/1/12 ISP (Individual Support Plan) did not indicate the client had an identified need for frosted windows, and/or indicate the facility's Human Rights Committee reviewed and/or approved the restrictive</p>		<p>that the QDDP has a clear understanding of what specifically constitutes a restrictive program and proper preparation for presenting program modifications to the Human Rights Committee. The training will also focus on helping professional staff develop adequate record keeping practices to assure that HRC approval records are available for review. 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.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Human Rights Committee, Behavior Clinician, Health Services Team, Quality Assurance Team, Operations Team</p>		

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	<p>practice.</p> <p>Client C's record was reviewed on 10/4/12 at 10:05 AM. Client C's 11/29/11 ISP did not indicate the client had an identified need for frosted windows, and/or indicate the facility's Human Rights Committee (HRC) reviewed and/or approved the restrictive practice.</p> <p>On 10/4/12 at 11am, a review of the facility's HRC minutes were reviewed with the QMRP (Qualified Mental Retardation Professional). The QMRP and the HRC documents both indicated HRC had not reviewed the restriction for the frosted windows inside the group home.</p> <p>2. During the 10/3/12 observation period between 5:23 AM and 8:05 AM, at the group home, cleaning supplies were locked in the office area of the group home and in a cabinet under the kitchen sink. Interview with staff #3 on 10/3/12 at 5:40 AM indicated the cleaning supplies were kept locked in the office at the back of the home. Staff #3 indicated clients A, B, C and D did not have a key to access the chemicals. When asked why the cleaning supplies were locked, staff #3 stated "They have always been locked." Staff #3 then indicated she thought the cleaning supplies were locked</p>			

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	<p>as client A may drink the chemicals.</p> <p>Client A's record was reviewed on 10/3/12 at 12:55 PM. Client A's 5/3/12 Behavior Support Plan (BSP) indicated client A demonstrated "Suicide Attempts" which was defined as using sharps or other items to cause bodily harm (i.e. rubbing off skin, cutting open her skin, picking at healing wounds, using items to strangle herself), this also includes if she is attempting to ingest chemicals." Client A's 5/3/12 BSP and/or 2/1/12 Individual Support Plan (ISP) did not indicate the cleaning supplies in the home should be locked. Client A's 2/1/12 ISP and/or 4/17/12 BSP did not indicate the facility's HRC reviewed and approved the systemic restriction.</p> <p>Client C's record was reviewed on 10/4/12 at 10:05 AM. Client C's 11/29/11 ISP and/or 4/18/12 BSP did not indicate client C had a need to have cleaning supplies locked. Client C's 4/18/12 BSP did not indicate the facility's HRC reviewed and/or approved the systemic restriction of locking the cleaning supplies.</p> <p>Client B's record was reviewed on 10/3/12 at 12:45pm. Client B's 1/5/12 ISP did not indicate the need for locked cleaning supplies. Client B's 4/17/12 BSP</p>				

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	<p>(Behavior Management Plan) did not identify the need for locked cleaning supplies. Client B's 12/2/11 "Chemical Safety Assessment" indicated "...Has rubbed cleaning wipes on face before...Recommendations: Supervision with all cleaning supplies." The client's BSP and/or ISP did not indicate the facility's HRC reviewed the blanket restriction of locking the cleaning supplies.</p> <p>Interview with the Behavior Consultant (BC) and the Qualified Mental Retardation Professional on 10/4/12 at 11:07 AM indicated the locking of the cleaning supplies had not been reviewed and/or approved by the facility's HRC.</p> <p>9-3-4(a)</p>			

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W0312	<p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 1 of 2 sampled, who received behavior controlling medication, the facility failed to incorporate the client's Intramuscular injection into the client's behavior plan, failed to include an active treatment program which addressed the client's behavior, and/or failed to include a plan of reduction for its use.</p> <p>Findings include:</p> <p>The facility's 8/31/12 reportable incident report indicated client A refused her 5 PM medications. The reportable incident report indicated the behavior specialist was present when the client refused and worked with the client throughout the day on 8/30/12. The reportable incident report indicated client A refused to eat, drink and take her medications. The reportable incident report indicated client A's psychiatrist was contacted and the client was taken to the hospital for evaluation and admittance. The reportable incident report indicated client A was admitted to the hospital after the</p>	W0312	<p><b>CORRECTION:</b></p> <p><i>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Specifically, Client A's Behavior Support Plan will be updated to address medication refusals, include the use of Invega intramuscular injections, as well as a plan for reduction and removal of the Invega injections.</i></p> <p><b>PREVENTION:</b></p> <p>The behavioral clinician has completed the initial evaluation of the individuals who reside in the facility since he assumed behavior support coordination responsibilities in August 2012. Revisions of behavior supports to reflect current assessed needs will be developed and revised as needed. Members of the Operations and Quality Assurance Teams will review Behavior Support Plans as part of an ongoing internal audit process that will include assuring that behavior controlling drugs are used only as an integral part of each individual program.</p>	11/16/2012	

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	<p>client pulled her intravenous (IV) fluids to the behavioral unit. The 8/31/12 reportable incident report indicated "...Her combative behaviors increased...On the morning of 9/1/12, [client A] continue refused her morning, food, liquids, medication and blood draw...[Name of psychiatrist's] intention is to start [client A] on an injection because of her frequent medication refusals...."</p> <p>Client A's record was reviewed on 10/3/12 at 12:55 PM. Client A's 9/7/12 Record of Visit indicated client A's psychiatrist ordered the client to receive an Intramuscular (IM) injection of Invega (behavior) Sustention 1 milliliter (156 milligrams) 1 week after 234 milligrams injection. The record indicated the injection was administered on 10/2/12.</p> <p>Client A's 5/3/12 Behavior Support Plan (BSP) indicated the facility did not address client A's medication refusals, did not include the use of the IM injection of Invega, and did not include a plan of reduction based on the behaviors for which the medication was prescribed.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and Behavior Consultant (BC) #1 on 10/4/12 at 11:07 AM indicated client A received the Invega Injections due to refusing her</p>		<p>Operations and Quality Assurance Team members will conduct site visits that incorporate BSP reviews no less than monthly.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Support Associates, Behavior Clinician, Health Services Team, Quality Assurance Team, Operations Team</p>	

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	<p>oral medications. BC #1 stated client A was "Refusing to take oral medications with history leading to decompensation of mood." The QMRP and BC #1 indicated client A continued to receive other oral medications. The QMRP and BC #1 indicated client A did not have an active treatment program for the client's medication refusals for which the client was received the IM injections. The QMRP and BC #1 indicated the use of the IM injections were not part of the client's BSP, nor did the client have a plan of reduction for the use of the behaviors for which the client received the medications.</p> <p>9-3-5(a)</p>			

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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 2 of 2 sampled clients (A and B), the facility's nursing services failed to meet the health needs of clients. The facility's nursing services failed to develop risk plans/nursing protocols for client A's edema and when to call the nurse in regard to the client's low blood pressure, and for client B's diabetes.</p> <p>Findings include:</p> <p>1. During the 10/3/12 observation period between 5:23 AM and 8:05 AM, at the group home, client A's ankles were observed to be swollen when the client removed her socks to apply Ammonia Lactate lotion (dryness) to her feet. During the 10/3/12 observation period, client A did not elevate her legs, nor did staff prompt/encourage the client to elevate her legs.</p> <p>Client A's record was reviewed on 10/3/12 at 12:55 AM. Client A's 9/24/12 Record of Visit (ROV) indicated "Swelling in legs." The 9/24/12 (ROV) indicated client A had "Bilateral edema" with a diagnosis of Lymphedema. The 9/24/12 ROV indicated client A was seen at a local hospital and referred to her</p>	W0331	<p><b>CORRECTION:</b></p> <p><i>The facility must provide clients with nursing services in accordance with their needs. Specifically, the facility nurse will develop risk plans to address Client A's edema as well as when staff should contact the nurse regarding Client A's low blood pressure. Additionally the team is coordinating with Client B's doctors to clarify the diagnostic reasoning for client B's prescription for Metformin and will develop appropriate nursing protocols accordingly.</i></p> <p><b>PREVENTION:</b></p> <p>The facility nurse will be retrained regarding the need to include specific care procedures as appropriate when developing comprehensive high risk and care plans. The Nurse Manager will review all revisions to facility nursing care plans for the next ninety days and thereafter will perform spot checks of facility nursing care plans as needed but no less than quarterly. Additionally, Operations and Quality Assurance Team members will review medical documentation while auditing active treatment sessions, no less than monthly, and make recommendations to the Health Services Team as appropriate.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support</p>	11/16/2012			

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	<p>primary care doctor any medication adjustments.</p> <p>An attached 9/24/12 Emergency Department (ED) note indicated "...The staff states that her legs do swell from time to time. She is on Lasix (swelling and fluid retention), and she has had instructions to elevate her legs. They stated it is very hard to get her to cooperate with these instructions...." The 9/24/12 "...Plan: All emergency causes have been ruled out. I (doctor) think it is safe for primary provider to make any necessary medicine changes."</p> <p>Client A's 9/27/12 Record of Visit indicated client A was seen for follow-up of her 9/24/12 hospital visit. The 9/27/12 ROV indicated client A's extremities had pitting edema. The ROV indicated "Unable to increase diuretic due to low blood pressure (96/66)...increase fluid intake to 2000 cc (cubic centimeters)/ (per) day...." The 9/27/12 ROV indicated client A's doctor ordered TED hose for the client's edema.</p> <p>Client A's 9/7/12 physician's orders indicated client A's blood pressure was being monitored weekly. The 9/7/12 physician's orders indicated the client received Lasix 20 milligrams daily for edema.</p>		<p>Associates, Health Services Team, Quality Assurance Team, Operations Team</p>				

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	<p>Client A's nursing notes from 5/1/2 to 9/23/12 did not indicate the facility's nurse monitored the client's edema as the nurse did not document any physical assessment in regard to the client's edema.</p> <p>Client A's 2/1/12 Individual Support Plan (ISP) and/or risk plans indicated client A did not have a risk plan for edema and/or have a risk plan for when staff were to call the nurse in regard to the client's low blood pressure.</p> <p>The facility's Visitor Log (all support staff and visitors) sign in and out sheets were reviewed on 10/4/12 at 10:45 AM. The visitors logs from 6/12 to 10/12 indicated RN #1 was at the group home on 6/14/12. The logs did not indicate any additional documentation of the nurse being in the group home.</p> <p>Interview with RN (registered nurse) #1 on 10/4/12 at 10:35, by phone, indicated she had took over being the nurse for the group home since the first of June 2012. RN #1 indicated client A took Lasix for the client's edema. When asked when RN #1 last saw client A's ankles, RN #1 stated "Looked at last week. Much better last week." RN #1 stated she told staff to "ensure [client A's] feet are propped up." RN #1 indicated</p>			

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	<p>she visited the group home at least 2 times a week. RN #1 indicated she documented her assessments in the nurse notes. RN #1 indicated client A did not have a risk plan for edema. When asked how client A's blood pressure was doing, RN #1 indicated she was not sure how client A's blood pressure had been doing. R#1 indicated client A's blood pressure was monitored weekly. RN #1 indicated client A did not have a protocol in regard to the client's low blood pressure.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on 10/4/12 at 9:40 AM when asked how often the nurse came to the group home, the QMRP stated "Not sure, she works part time."</p> <p>Interview with the QMRP and Behavior Consultant (BC) #1 on 10/4/12 at 11:07 am indicated client A was waiting for an appointment to get measured for the TED hose. The QMRP and BC #1 indicated they did not know if the client had a risk plan for edema and/or the client's low blood pressure.</p> <p>Interview with administrative staff #2 on 10/9/12 at 11:52 AM, by phone, indicated he had been made aware there was no documentation of when the nurse was in the group home. Administrative staff #2</p>				

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	<p>indicated he was sure the nurse had been at the group home and they were in the process of trying to get that resolved as all visitors and support staff were to sign in and out of the group home.</p> <p>2. On 10/3/12 at 12:45pm, client B's record was reviewed. Client B's record indicated she was admitted on 11/2011. Client B's 9/7/12 "Physician's Orders" indicated client B was on the Metformin medication for Non Insulin Dependent Diabetes Mellitus (NIDDM). Client B's record did not indicate a nursing protocol for her Diabetes.</p> <p>An interview was conducted on 10/4/12 at 10:35am, with the RN #1. RN #1 indicated client B's Metformin medication was for client B's diagnosis of Non Insulin Dependent Diabetes Mellitus. RN #1 indicated client B did not have a nursing protocol developed for a course of action to monitor client B ' s Diabetes.</p> <p>9-3-6(a)</p>				

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W0336	<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 (A and B), the facility's nursing services failed to conduct quarterly nursing assessments of clients health status and medical needs.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 10/3/12 at 12:55 PM. Client A's record indicated the client was not in need of a medical care plan. Client A's record indicated no nursing quarterly assessments had been completed in regards to the client's health since 3/22/12. Client A's record indicated the nurse completed quarterly assessment of the client's health 12/30/11 and 3/22/12. Client A's 2/1/12 Individual Support Plan (ISP) indicated client A's diagnosis included, but were not limited to, Major Depression with recurrent features, Schizoaffective Disorder, Constipation, Hypercholestrolemia, Seizures, Acne, and Hypothyroidism. Client A's 9/7/12 physician orders indicated client A received routine medications.</p>	W0336	<p><b>CORRECTION:</b> <i>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. Specifically, the facility has located records of quarterly nursing evaluations for Client A and Client B that were completed in June and September 2012, which will be available for review at the survey revisit.</i></p> <p><b>PREVENTION:</b> Copies of quarterly nursing physical examinations will be placed in the each individual's medical chart upon completion. Additionally, Operations and Quality Assurance Team members will review medical documentation while auditing active treatment sessions, no less than monthly, to assure records of quarterly nursing evaluations are completed and filed appropriately.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Support Associates, Behavior Clinician, Health Services Team, Quality Assurance Team, Operations Team</p>	11/16/2012			

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	<p>Interview with RN #1 on 10/4/12 at 10:35 AM (by phone), when asked if any nurse quarterlies had been competed since 3/22/12, RN #1 stated "No."</p> <p>Interview with the Qualified Mental Retardation Professional on 10/4/12 at 9:40 AM indicated RN #1 worked part-time.</p> <p>Interview with administrative staff #2 on 10/9/12 at 11:52 AM, by phone, indicated the facility's nurse should be conducting quarterly nursing assessments of clients.</p> <p>2. On 10/3/12 at 12:45pm, client B's record was reviewed. Client B's record indicated she was admitted on 11/2011. Client B's record indicated a nursing quarterly reviews on 1/10/12, 3/22/12, and no further information was available for review.</p> <p>3. On 10/4/12 at 8:50am, client D's record was reviewed. Client D's record indicated she was admitted on 11/17/11. Client D's record indicated a nursing quarterly review on 1/10/12, 9/30/12, and no further information was available for review.</p> <p>Interview with RN #1 on 10/4/12 at 10:35 AM (by phone), when asked if any nurse quarterlies had been competed since</p>			

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	<p>3/22/12, RN #1 stated "No."</p> <p>Interview with the Program Coordinator on 10/4/12 at 9:40 AM RN #1 worked part-time.</p> <p>Interview with administrative staff #2 on 10/9/12 at 11:52 AM, by phone, indicated the facility's nurse should be conducting quarterly nursing assessments of clients.</p> <p>9-3-6(a)</p>			

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W0436	<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, interview and record review for 1 of 2 sampled clients (A), the facility failed to teach the client wear her eyeglasses which had been determined to be needed by the interdisciplinary team.</p> <p>Findings include:</p> <p>During the 10/3/12 observation period between 5:23 AM and 8:05 AM, at the group home, client A did not wear eyeglasses.</p> <p>Client A's record was reviewed on 10/3/12 at 12:55 PM. Client A's 9/26/12 Visual Care progress Report indicated client A needed to "Wear eyeglasses full time except when sleeping or showering."</p> <p>Client A's 2/1/12 Individual Support Plan (ISP) did not indicate the client had an objective to teach the client to wear her eyeglasses.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on</p>	W0436	<p><b>CORRECTION:</b></p> <p><i>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. Specifically, the team will develop a learning objective to support Client A with wearing her eyeglasses.</i></p> <p><b>PREVENTION:</b></p> <p>Facility professional staff will be expected to observe no less than two morning and two evening active treatment sessions per week to assess direct support staff interaction with clients and to provide hands on coaching and training toward proper implementation of learning objectives including but not limited to adaptive equipment goals. Additionally, members of the Operations and Quality Assurance Teams will conduct periodic active treatment observations on an ongoing basis to assure that clients are utilizing adaptive equipment as recommended.</p>	11/16/2012			

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	<p>10/4/12 at 11:07 AM indicated client A was to wear her eyeglasses full time. The QMRP indicated client A would refuse to wear her eyeglasses. The QMRP indicated the client's ISP did not address the client's refusals to wear the identified needed adaptive equipment/eyeglasses.</p> <p>9-3-7(a)</p>		<p><b>RESPONSIBLE PARTIES:</b> QDDP, Support Associates, Behavior Clinician, Health Services Team, Quality Assurance Team, Operations Team</p>	

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W0455	<p>483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation, record review, and interview for 4 of 4 clients (clients A, B, C, and D) who lived in the group home, the facility failed to teach and encourage hand washing.</p> <p>Findings include:</p> <p>1. On 10/2/12 from 4:55pm until 6:30pm, clients A, B, C, and D were at the group home with facility staff (FS) #1, FS #4, FS #5, and FS #6. At 5:50pm, clients A, C, and D sat down at the dining room table and did not wash their hands before the meal. From 5:50pm until 6:30pm, clients A, C, and D held their bread with their hands, spread their butter onto bread with their spoons, scooped their meatloaf onto their utensils with their fingers, and no handwashing was taught nor encouraged.</p> <p>On 10/3/12 at 12:45pm, client B's record was reviewed. Client B's 11/29/11 CFA (Comprehensive Functional Assessment) indicated she had the skill to wash her hands.</p> <p>On 10/4/12 at 8:50am, client D's record</p>	W0455	<p><b>CORRECTION:</b> <i>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</i> Specifically, Staff will be retrained regarding the need to encourage clients to wash their hands to prevent the spread of infection at appropriate times, including but not limited to during meal preparation and prior to eating.</p> <p><b>PREVENTION:</b> The QDDP will observe active treatments sessions on all shifts as needed but no less than twice weekly to assure staff are implementing infection control protocols as necessary. Members of the Operations and Quality Assurance Teams will perform active treatment observations no less than monthly to assure infection control is maintained.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Support Associates, Behavior Clinician, Health Services Team, Quality Assurance Team, Operations Team</p>	11/16/2012	

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	<p>was reviewed. Client D's 1/9/12 ISP indicated goals/objectives to demonstrate control during meals/snacks and to wash hands before and after restroom use.</p> <p>2. During the 10/3/12 observation period between 5:23 AM and 8:05 AM, at the group home, clients A, B, C and D did not wash their hands before sitting down to eat breakfast. Facility staff #1, #2, #3 and #4 did not encourage the clients to wash their hands before sitting down to eat.</p> <p>Interview with the Qualified Mental Retardation Professional and Behavior Consultant (BC) #1 on 10/4/12 at 11:07 AM indicated facility staff should have encouraged clients A, B, C and D to wash their hands prior to eating and after eating to prevent spread of germs.</p> <p>9-3-7(a)</p>				

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W0475	<p>483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils. Based on observation, interview and record review for 2 of 2 sampled clients (A and B) and for 2 additional clients (C and D), the facility failed to provide and/or offer the clients butter knives at the evening and breakfast meals.</p> <p>Findings include:</p> <p>1. During the 10/3/12 observation period between 5:23 AM and 8:05 AM, at the group home, client B set the table for breakfast. The client placed bowls and saucers on the table. The client also placed spoons on the table for the breakfast meal. Clients A, B, C and D had cereal, cheese sticks/rolls, bagels and cream cheese for breakfast. Staff #2 placed a spoon in the cream cheese and sat it on the table. Facility staff did not encourage client B to place butter knives on the table for clients A, B, C and D to use. During the morning meal observation, clients A, B, C and D used a spoon to spread the cream cheese onto their bagel. Staff #1, #2, # and #4 did not encourage/teach clients A, B, C and D to obtain and/or use a butter knife for spreading.</p> <p>Interview with the Qualified Mental</p>	W0475	<p><b>CORRECTION:</b> <i>Food must be served with appropriate utensils. Specifically, Butter knives are now part of place settings at all meals.</i></p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding the need to implement rights restrictions, only after appropriate due process, based on assessed needs. Members of the Operations and Quality Assurance Teams will conduct meal time observations on an ongoing basis, no less than monthly to assure appropriate utensils are in use.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDP, Team Lead, Support Associates, Quality Assurance Team, Operations Team</p>	11/16/2012			

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	<p>Professional (QMRP) and the Behavior Consultant (BC) #1 on 10/4/12 at 11:07 AM indicated the group home had butter knives. The QMRP and BC #1 indicated facility staff should have allowed/offered the clients butter knives to use. The QMRP indicated butter knives were located in the kitchen drawer.</p> <p>2. On 10/2/12 from 4:55pm until 6:30pm, clients A, B, C, and D were at the group home with facility staff (FS) #1, FS #4, FS #5, and FS #6. At 5:50pm, clients A, C, and D sat down at the dining room table with the four facility staff to eat their dinner of meatloaf, bread and butter, gravy, mashed potatoes, and fruit. From 5:50pm until 6:30pm, clients A, C, and D spread their butter onto bread with their spoons and no knives were taught nor encouraged.</p> <p>On 10/3/12 at 12:45pm, client B's record was reviewed. Client B's 11/29/11 CFA (Comprehensive Functional Assessment) indicated client B had the skill to use a table knife. Client B's 1/5/12 ISP (Individual Support Plan) indicated client B did not indicate a dining objective.</p> <p>On 10/4/12 at 8:50am, client D's record was reviewed. Client D's 1/9/12 ISP indicated goals/objectives to demonstrate control during meals/snacks. Client D's</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2012
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	<p>11/2011 CFA (Comprehensive Functional Assessment) indicated she had the skill to use table knives.</p> <p>Interview with the QMRP and the BC #1 on 10/4/12 at 11:07 AM indicated the group home had butter knives. The QMRP and BC #1 indicated facility staff should have allowed/offered the clients butter knives to use. The QMRP indicated butter knives were located in the kitchen drawer.</p> <p>9-3-8(a)</p>			