

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 11/21/2012
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W0000	<p>This visit was for a post-certification revisit survey to the pre-determined full recertification and state licensure survey and for the investigation of complaint #IN00115785 completed on 10/17/12.</p> <p>Complaint #IN00115785-Corrected.</p> <p>Dates of Survey: 11/15, 11/16 and 11/21/12</p> <p>Facility Number: 012632 Provider Number: 15G807 AIMS Number: 201065000</p> <p>Surveyors: Paula Chika, Medical Surveyor III-Team Leader Keith Briner, Medical Surveyor III</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review completed 11/30/12 by Ruth Shackelford, 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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W0140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>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 record review and interview for 2 of 2 sampled clients (A and B), the facility failed to maintain a complete accounting of the clients' cash on hand kept by the group home.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Client A's finances were reviewed on 11/15/12 at 4:04 PM. Client A's November 2012 Cash On Hand (COH) Resource ledger sheet indicated client A had \$52.85 as of 11/12/12 (last entry on the sheet). Client A's actual COH was zero dollars and zero cents. <p>Interview with the Director of Supported Group Home Living (DSGHL) on 11/15/12 at 4:45 PM indicated client A did not have any money in her pouch/zipper file. The DSGHL indicated she did not know why client A's COH did not agree with the client's COH ledger. DSGHL indicated client A's \$52.85 was not accounted for.</p> <ol style="list-style-type: none"> Client B's finances were reviewed on 11/15/12 at 4:04 PM. Client B's November 2012 Resource Ledger sheet 	W0140	<p>CORRECTION: 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 – C, all staff have been retrained on facility accounting practices. The QDDP maintains 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. PREVENTION: The QDDP will maintain responsibility for maintaining client financial records with a cross review by a second QDDP who will audit these records no less than weekly. Supervisory staff are reviewing the facilities financial/cash on hand records no less than twice weekly. 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>	12/21/2012			

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	<p>indicated the client had \$2.08 COH as of 11/12/12 (last entry on sheet). Client B's actual COH was zero dollars and zero cents. Client B's financial records/book also indicated client B did not have a savings account ledger which indicated the balance/funds client B had in her account.</p> <p>Interview with DSGHL on 11/15/12 at 4:45 PM indicated the DSGHL did not know what happened to client B's \$2.08. The DSGHL indicated client B had no COH at the group home. The DSGHL indicated client B did not have a savings account ledger in her book for November 2012. The DSGHL indicated she would have to go to the bank to obtain a statement/balance for client B's savings account.</p> <p>This deficiency was cited on 10/17/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>		<p>RESPONSIBLE PARTIES: QDDP, Team Lead, Direct Support Professionals, Quality Assurance Team, Operations Team</p>		

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W0263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview, the facility failed to obtain the client's or guardian's approval before implementation of a Behavior Support Plan (BSP), behavior medications or modification of client rights for 2 of 2 sampled clients (A and B) with restrictive programs.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 11/15/12 at 2:30 PM. Client A's ISP (Individual Support Plan) dated 1/9/12 indicated client A had a legal guardian. Client A's BSP dated 4/18/12 revised 11/9/12 indicated the use of the following behavior control medications/psychotropic medications:</p> <p>-Bentropine 0.5 MG (Milligrams) to 1.0 MG (Borderline Personality Disorder)</p> <p>-Saphris 10 MG to 20 MG (Borderline Personality Disorder)</p> <p>-Sertraline 50 MG to 200 MG (Borderline Personality Disorder)</p>	W0263	<p>CORRECTION: <i>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Specifically, The QDDPD will obtain written informed consent from Client A and Client B and Client A's guardian for all current restrictive programs.</i></p> <p>PREVENTION: Professional staff will be retrained regarding the need to obtain prior written informed consent for all restrictive programs prior to implementation. Retraining will focus on assuring that the QDDP has a clear understanding of what specifically constitutes a restrictive program and proper preparation for presenting program modifications to the individuals and their legal representatives. 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>RESPONSIBLE PARTIES: QDDP, Team Lead, Direct Support Professionals, Behavior Clinician, Human Rights Committee, Quality Assurance Team, Operations Team</p>	12/21/2012

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	<p>Client A's Consent for Medication (CM) form dated 11/8/12 indicated the use of the following behavior control medications/psychotropic medication:</p> <ul style="list-style-type: none"> -Benztropine 0.5 MG (Milligrams) to 1.0 MG -Saphris 10 MG to 20 MG -Sertraline 50 MG to 200 MG <p>Client A's Modification of Individual Rights (MIR) form dated 10/24/12 indicated restrictions for client A included: personal funds, movement in the community, "healthy eating" diet, self administration of daily medications, the use of behavior control medication and the use of YSIS (You're Safe I'm Safe) advanced physical management techniques. Client A's record did not indicate written informed consent from client A's guardian for the use of psychotropic medications or restrictive programs.</p> <p>2. Client B's record was reviewed on 11/15/12 at 4:30 PM. Client B's ISP dated 11/13/12 indicated client B was an emancipated adult. Client B's BSP dated 4/17/12 revised on 5/8/12, 5/21/12, 10/9/12 and 11/9/12 indicated the use of</p>			

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	<p>the following behavior control medications/psychotropic medications:</p> <ul style="list-style-type: none"> -Invega 117 MG to 156 MG (Intermittent Explosive Disorder) -Chlorpromazine 25 MG to 900 MG (Intermittent Explosive Disorder and Disruptive Behavior Disorder) -Sertraline 50 MG to 200 MG (Depressive Disorder) -Benztropine 1 MG to 4 MG (Extrapyramidal Symptoms) -Ativan .05 MG to 10 MG (Intermittent Explosive Disorder and Disruptive Behavior) -Topiramate 25 MG to 1600 MG (Intermittent Explosive Disorder, Disruptive Behavior and Depressive Disorder) <p>Client B's CM form dated 11/8/12 indicated the use of the following behavior control medications/psychotropic medication:</p> <ul style="list-style-type: none"> -Invega 117 MG to 156 MG -Chlorpromazine 25 MG to 900 MG 				

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	<p>-Sertraline 50 MG to 200 MG</p> <p>-Benztropine 1 MG to 4 MG</p> <p>-Ativan .05 MG to 10 MG</p> <p>-Topiramate 25 MG to 1600 MG</p> <p>Client B's MIR form dated 10/23/12 indicated restrictions for client B included: personal funds, movement in the community, "healthy eating" diet, self administration of daily medications, the use of behavior control medication, the use of YSIS advanced physical management techniques, the use of sharps, access to chemicals, restriction from the kitchen, from personal belongings/space, use of a "soft helmet", use of a surgical face shield and the use of window covering/frosting.</p> <p>Client B's record did not indicate written informed consent from client B for the use of psychotropic medications or restrictive programs.</p> <p>On 11/15/12 at 5:45 PM an interview with the Director of Supported Group Home Living (DSGL) #1 was conducted. The DSGL #1 indicated written informed consent from the client or the client's guardian was needed prior to the use of psychotropic medications and/or the</p>						

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	<p>implementation of a restrictive program. DSGL #1 indicated client A's BSP, CM and MIR should have been signed by client A's guardian to indicate written informed consent was obtained. DSGL #1 indicated client B's BSP, MIR and/or CM should have been signed by client B to indicate written informed consent was obtained.</p> <p>9-3-4(a)</p>			

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W0264	<p>483.440(f)(3)(iii) PROGRAM MONITORING & 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 record review and interview for 1 of 2 sampled clients (B) plus one additional client (C), the facility's HRC (Human Rights Committee) failed to review, monitor and approve restricting client B's use of personal funds, freedom from movement while in the community, access to sharps, access to the kitchen area/space, access to client B's personal space/belongings, and the use of a surgical face shield. The facility's HRC failed to review, monitor and approve restricting client C's access to the group home kitchen and access to client C's personal bedroom.</p> <p>Findings include:</p> <p>1. Client B's record was reviewed on 11/15/12 at 4:30 PM. Client B's Modification of Individual Rights (MIR's) form dated 10/23/12 indicated client B would be restricted from the use of personal funds, the freedom from movement while in the community,</p>	W0264	<p>CORRECTION: <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 has reviewed and approved the following rights restrictions for Client B: use of personal funds, freedom of movement while in the community, access to sharps, access to kitchen area/space, access to Client B's personal belongings and the use of a surgical face shield. Additionally, the committee has reviewed the restrictions of Client C's access to the kitchen and Client C's bedroom.</i></p> <p>PREVENTION: The incoming QDDP will be trained regarding the need to obtain prior written informed consent and Human Rights Committee approval for all restrictive programs for all clients prior to implementation. Training</p>	12/21/2012			

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	<p>access to sharps, access to the kitchen area/space, access to client B's personal space/belongings, and the use of a surgical face shield.</p> <p>Client B's record did not indicate HRC review or approval for the restriction from access to personal funds, movement in the community, the use of sharps, restriction from the kitchen, from personal belongings/space, and use of a surgical face shield.</p> <p>2. Client C's record was reviewed on 11/15/12 at 5:33 PM. Client C's MIR's form dated 10/25/12 indicated client C would be restricted from use of personal funds and access to the group home kitchen and personal bedroom.</p> <p>Client C's record did not indicate HRC review or approval for client C to be restricted from personal funds, the group home kitchen and/or client C's personal bedroom.</p> <p>On 11/15/12 at 5:45 PM an interview with the Director of Supported Group Home Living (DSGL) #1 was conducted. The DSGL #1 indicated the facility's HRC should review and approve restrictive programs for clients B and C. DSGL #1 indicated clients B and C's MIR's had not been HRC reviewed or approved.</p>		<p>will focus on assuring 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 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>RESPONSIBLE PARTIES: QDDP, Team Lead, Direct Support Professionals, Human Rights Committee, Behavior Clinician, Health Services Team, Quality Assurance Team, Operations Team</p>				

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	<p>This deficiency was cited on 10/17/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>				