

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G493	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/16/2013
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4160 N CAMPBELL AVE INDIANAPOLIS, IN 46220
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W000000	<p>This visit was for a pre-determined full annual recertification and state licensure survey.</p> <p>This visit included the investigation of complaint #IN00127946.</p> <p>Complaint #IN00127946: Substantiated, federal/state deficiencies related to the allegations are cited at W120, W125, W140, W149, W154, W157, W159, W218, W220, W240, W252, W260, W262, W331 and W436.</p> <p>This visit included the investigation of complaint #IN00127998.</p> <p>Complaint #IN00127998: Substantiated, federal/state deficiencies related to the allegations are cited at W120, W125, W140, W149, W154, W157, W159, W218, W220, W240, W252, W260, W262, W331 and W436.</p> <p>This visit included the investigation of complaint #IN00128342.</p> <p>Complaint #IN00128342: Substantiated, federal/state deficiencies related to the allegations are cited at W120, W125, W140, W149, W154, W157, W159, W218, W220, W240, W252, W260,</p>	W000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>W262, W331 and W436.</p> <p>Dates of survey: May 8, 9, 13, 14, 15 and 16, 2013.</p> <p>Facility Number: 001007 Provider Number: 15G493 AIMS Number: 100245090</p> <p>Surveyor: Claudia Ramirez, RN</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed May 24, 2013 by Dotty Walton, QIDP.</p>			

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W000120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client. Based on record review and interview for 3 of 4 sampled clients (B, C and D), the facility failed to ensure the day service provider was included in the development of the clients' ISPs (Individual Support Plans) and (BSPs) Behavior Support Plans and the ISPs and BSPs were at the day program they attended.</p> <p>Findings include:</p> <p>A record review on 05/14/13 at 10:20 AM, of client B, C and D's records at the day program they attended was conducted. The records did not include their current ISPs and BSPs.</p> <p>Client B's day service record was reviewed on 05/14/13 at 10:20 AM. Client B's record indicated the day service provider had an ISP dated 08/07/2011. The day service provider had not been provided with the updated ISP dated 08/07/12.</p> <p>Client C's day service record was reviewed on 05/14/13 at 10:20 AM. Client C's record indicated the day service provider had an ISP dated 11/24/2010. The day service provider had not been</p>	W000120	<p>CORRECTION: <i>The facility must assure that outside services meet the needs of each client. Specifically, the facility has provided copies of Client B, C and D's Individual Support Plans and Behavior Support Plans to Day service staff. Additionally, day service supervisory staff have received copies of current support documents via email to assure all appropriate staff have access to Client B, C and D's current supports.</i></p> <p>PREVENTION: Professional staff will be re-trained regarding the need to assure day service providers have an integral role in the person centered planning and ISP/BSP development process. The Program Manager –Lead has developed a system to track quarterly and annual meetings to assure all members of the interdisciplinary team receive appropriate notice of upcoming team meetings and have the opportunity to participate fully in the development of each client's supports. Facility supervisors will provide the Operations Team with documentation of all attempts to include day service providers in the ISP/BSP development process as well as receipts for all support documents delivered to outside providers. ADDENDUM,</p>	06/15/2013	

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	<p>provided with the updated ISP dated 11/22/12.</p> <p>Client D's day service record was reviewed on 05/14/13 at 10:20 AM. Client D's record indicated the day service provider had an ISP and a BSP both dated 08/05/2011. The day service provider had not been provided with the updated ISP and BSP dated 08/06/12.</p> <p>An interview was conducted on 05/14/12 at 10:25 AM, with staff #1 of the day program. She indicated the day service had not been invited to the ISPs and she did not have the current ISPs and BSPs for clients B, C and D.</p> <p>This federal tag relates to complaints #IN00127946, #IN00127998 and #IN00128342.</p> <p>9-3-1(a)</p>		<p>6/12/13: The QIDP and the Residential Manager will each perform bi-monthly observations of active treatment at all day service locations –assuring at least weekly face to face contact between facility supervisory staff and day service providers. In addition to monitoring active treatment for effectiveness, facility supervisory staff will communicate with day service staff to assure up to date support documents and other necessary materials are present. Facility professional staff will turn in documentation of day service observations to the Program Manager so that the Operations and Quality Assurance Teams may track day service contacts and provide follow-up as needed. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Behavior Therapist, Quality Assurance Team, Operations Team</p>		

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W000125	<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 record review and interview, the facility failed to ensure/protect the rights of 3 of 4 sampled clients (clients B, C and D), by not obtaining a legally sanctioned representative to assist the clients in making informed healthcare or financial decisions.</p> <p>Findings include:</p> <p>1. Client B's records were reviewed on 05/13/13 at 10:00 AM. Client B's Individual Support Plan (ISP) dated 08/07/12 indicated he did not have a legally sanctioned representative. Client B's May 2013 Physician Orders contained his diagnoses diagnoses which included, but were not limited to: "Moderate Mental Retardation, Cerebral Palsy, Depression, Discipline Behavior Disorder, Insomnia, Seizures, Obsessive Compulsive Disorder, Impulse Control Disorder and Dysphagia." Client B's Comprehensive Functional Assessment (CFA) dated 04/10/13 indicated client B required 24 hour supervision and was not able to independently manage his own</p>	W000125	<p>CORRECTION: <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 will update informed consent assessment data to reflect the current need for legal representation for Clients B, C and D and will contact an agency which provides guardian services to initiate the process of obtaining legal guardians for Clients B, C and D.</i></p> <p>PREVENTION: Professional staff will be retrained regarding the need to maintain informed consent assessment data the reflects the current needs of all individuals residing in the facility as well ass the need to work with the Operations Team to assure that each individual has the appropriate level of assistance with decision making up to and including legal guardianship as appropriate. Members of the Operations and Quality Assurance Team will compare observed competency</p>	06/15/2013			

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	<p>finances. The CFA indicated client B required assistance with maintaining personal skills of daily living (bathing, toileting and dressing), making any decisions related to his health care and needed physical assistance to identify money values, to have awareness of the value of money, and to make small purchases. The CFA indicated client B was unable to manage his financial needs independently.</p> <p>On 05/15/13 at 10:00 AM an interview with the Program Manager (PM) was conducted. The PM indicated client B did not have a legal representative and was not able to fully make informed decisions on his own regarding his health needs or finances.</p> <p>2. Client C's records were reviewed on 05/13/13 at 12:11 PM. Client C's ISP dated 11/22/12 indicated he did not have a legally sanctioned representative. Client C's May 2013 Physician Orders contained his diagnoses which included, but were not limited to: "Moderate Mental Retardation, Cerebral Palsy, Spastic Quadriparesis, Wheelchair Bound, Hyperlipidemia, Dysphagia and Contracture Lower Leg Joint." Client C's CFA dated 04/10/13 indicated client C required 24 hour supervision and was not able to independently manage his own</p>		<p>to informed consent data as part of the agency's internal audit process that will occur no less than monthly/ The Operations and QA Teams will make recommendations for changes in the level of representation a client receives based on audit results and observed outcomes.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	

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	<p>finances. The CFA indicated client C required assistance with maintaining personal skills of daily living (bathing, toileting and dressing), making any decisions related to his health care and needed physical assistance to identify money values, to have awareness of the value of money, and to make small purchases. The CFA indicated client C was unable to manage his financial needs independently.</p> <p>On 05/15/13 at 10:00 AM an interview with the PM was conducted. The PM indicated client C did not have a legal representative and was not able to fully make informed decisions on his own regarding his health needs or finances.</p> <p>3. Client D's records were reviewed on 05/13/13 at 1:00 PM. Client D's ISP dated 08/06/12 indicated she did not have a legally sanctioned representative. Client D's May 2013 Physician Orders contained her diagnoses which included, but were not limited to: "Severe Mental Retardation, Fetal Alcohol Syndrome, Seizures and Autism." Client D's CFA dated 08/06/13 indicated client D required 24 hour supervision and was not able to independently manage her own finances. The CFA indicated client D required assistance with maintaining personal skills of daily living (bathing, toileting</p>						

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	<p>and dressing), making any decisions related to health care and needed physical assistance to identify money values, to have awareness of the value of money, and to make small purchases. The CFA indicated client D was unable to manage her financial needs independently.</p> <p>On 05/15/13 at 10:00 AM an interview with the PM was conducted. The PM indicated client D did not have a legal representative and was not able to fully make informed decisions on her own regarding her health needs or finances.</p> <p>This federal tag relates to complaints #IN00127946, #IN00127998 and #IN00128342.</p> <p>9-3-2(a)</p>			

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W000140	<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 4 of 4 sample clients (clients A, B, C and D), the facility failed to maintain an accurate accounting system for each client's personal fund account.</p> <p>Findings include:</p> <p>On 05/13/13 at 9:30 AM a petty cash (spending money of the clients kept at the group home) review of client funds was conducted for clients A, B, C and D along with a review of their monthly cash ledgers and receipts for petty cash funds from February 2013 to May 13, 2013. The review of ledgers indicated the following:</p> <p>Client A: The February 2013, March 2013, April 2013 and May 2013 ledgers indicated client A received \$10.00 per week for spending money. There were no receipts to indicate how the weekly \$10.00 was spent.</p> <p>Client B: The February 2013, March 2013, April 2013 and May 2013 ledgers indicated client B received \$10.00 per week for spending money. There were no</p>	W000140	<p>CORRECTION:</p> <p><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.</i></p> <p>Specifically, for Clients A – D, the Residential Manager 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 QIDP will maintain copies of receipts for purchases recorded on the ledgers.</p> <p>PREVENTION:</p> <p>The Residential Manager will maintain responsibility for maintaining client financial records and the QIDP 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 QIDP 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</p>	06/15/2013

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	<p>receipts to indicate how the weekly \$10.00 was spent.</p> <p>Client C: The February 2013, March 2013, April 2013 and May 2013 ledgers indicated client C received \$10.00 per week for spending money. There were no receipts to indicate how the weekly \$10.00 was spent.</p> <p>Client D: The February 2013, March 2013, April 2013 and May 2013 ledgers indicated client D received \$10.00 per week for spending money. There were no receipts to indicate how the weekly \$10.00 was spent.</p> <p>Client A's records were reviewed on 05/09/13 at 9:44 AM. Client A's ISP (Individual Support Plan) dated 03/23/13 indicated client A was not able to independently handle her money and required assistance. An Individual Financial Assessment (IFA) dated 03/23/13 indicated, "Individual requires total assistance..." and "Individual requires assistance. Individual will have access to weekly spending money not to exceed \$10.00 without receipts...."</p> <p>Client B's records were reviewed on 05/12/13 at 10:00 AM. Client B's ISP dated 08/07/12 indicated client B was not able to independently handle his money</p>		<p>an ongoing facility audit process</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>		

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	<p>and required assistance. An Individual Financial Assessment dated 07/26/11 indicated, "Individual requires total assistance..." and "Individual requires assistance. Individual will have access to weekly spending money not to exceed \$10.00 without receipts...."</p> <p>Client C's records were reviewed on 05/13/13 at 12:11 PM. Client C's ISP dated 11/22/12 indicated client C was not able to independently handle his money and required assistance. An Individual Financial Assessment dated 11/22/12 indicated client C was not independent in handling his finances. The area of a weekly spending amount was blank in the IFA.</p> <p>Client D's records were reviewed on 05/13/13 at 1:00 PM. Client D's ISP dated 08/06/12 indicated client D was not able to independently handle her money and required assistance. An Informed Consent Assessment dated 08/2011, under the area of finance, indicated client D "Does not have the ability to understand" and required supervision.</p> <p>On 05/15/13 at 10:00 AM an interview with the Program Manager (PM) was conducted. The PM indicated clients A, B, C and D were not independent in handling their money and required total</p>				

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	<p>assistance from the agency/staff. The PM indicated the Financial Assessment contraindicated itself by indicating the clients required total assistance and also allowed them to have funds up to \$10.00 without receipts. He indicated, without any receipts, the agency was not able to accurately account for client funds. He indicated in the past, the staff would write down where they spent the money, but if it was less than \$10.00 they did not keep the receipt. He indicated the agency was changing their policy and now there would be receipts for all purchases to ensure an accurate accounting of client funds.</p> <p>This federal tag relates to complaints #IN00127946, #IN00127998 and #IN00128342.</p> <p>9-3-2(a)</p>			

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 6 of 11 BDDS (Bureau of Developmental Disabilities Services) reports, the facility neglected to implement the facility's policy and procedure prohibiting client neglect by neglecting to provide adequate supervision for 4 of 8 clients living in the group home (clients A, C, E and F).</p> <p>Findings include:</p> <p>On 05/08/13 at 2:15 PM the facility's BDDS Reports and investigations were reviewed from 07/01/12 through 05/07/13 and indicated the following:</p> <p>For Client A:</p> <p>1. 04/24/13: A BDDS report submitted 04/25/13 for an incident dated 04/24/13 at 6:43 PM indicated, "Staff was giving 7p (sic) meds (medications) when she heard [client A] (individual supported by ResCare), screaming in her bedroom. Staff went in to [client A's] bedroom and discovered blood on her pillow case, clothes and sheets. Staff stood [client A] up and saw that her left ear had a split in the back about 1 1/2 inches long and it was bleeding. Staff immediately tried to</p>	W000149	<p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically:</i></p> <p>1. The facility will investigate injuries of unknown origin that were discovered for Client A on 10/27/12, 2/11/13, 3/19/13 and 4/24/13. Additionally, the facility will re-open an investigation into alleged consensual sexual activity between Client E and Client F on 12/30/12. The investigation will focus on details of client interviews, level of informed consent and staff response to the incident.</p> <p>2. The interdisciplinary team will evaluate current assessment and incident data and meet to develop revised strategies to increase personal safety for Client A and protect Client A from further injury to the maximum extent possible.</p> <p>3. <i>The individual program plan must describe relevant interventions to support the individual toward independence.</i> Specifically, the team will work with the facility nurse to incorporate specific one to one observation procedures into Client A's Comprehensive High Risk plan for falls.</p> <p>PREVENTION: Professional staff will be retrained</p>	06/15/2013			

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	<p>stop the bleeding and called the nurse on call. [Client A] was then transported to the ER (Emergency Room). Staff will monitor clients closely to ensure their safety."</p> <p>2. 03/19/13: A BDDS report submitted 03/20/13 for an incident dated 03/19/13 at 4:30 PM indicated, "During a routine physical assessment of [client A], staff noted bruising at the base of the fingers on her left hand. The nurse examined the affected area and noted no swelling and that [client A] had complete range of motion in her hand. Staff on duty were unsure of how [client A] sustained the injury."</p> <p>3. 02/11/13: A BDDS report submitted 02/13/13 for an incident dated 02/11/13 at 2:00 PM indicated, "[Client A] (Individual supported by ResCare) fell out of bed and hit her head on dresser, causing her head to bleed excessively. Staff called 911 and she was transported to [hospital name] ER. Facility Nurse was informed as well as administration staff. [Client A] was seen in the ER her Diagnoses (sic) was Contusion to head and Laceration to head... Team will also meet to discuss the use of room monitor and also one to one assistance. Staff will continue to follow high risk plan. Falls are addressed."</p>		<p>regarding the criteria for conducting investigations at the facility and will receive an updated copy of the agency's incident-investigation tracking spreadsheet no less than to assure thorough investigations are conducted within required timeframes. The QIDP will turn in copies of completed investigations to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up. Additionally, the facility's Clinical Supervisor will meet with the Quality Assurance Manager weekly to review incidents that require follow-up and investigation to assure timely completion. The Executive Director will monitor the facility's incident – investigation tracking spreadsheet and follow-up as needed with the clinical Supervisor and Program Manager to provide for increased accountability</p> <p>The QIDP will bring all relevant elements of the interdisciplinary team together after incidents of resulting in significant injury to review current supports and to make adjustments and revisions as needed. The QIDP 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>The QIDP will receive training</p>		

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	<p>A BDDS follow-up report dated 02/19/13 indicated, "...The environment was rearranged. The team has also decided to have one on one indefinitely for [client A]. Also the team will further discuss a bed monitor/alarm. The Clinical Supervisor, Facility Nurse and staff will continue to assure all health and safety issues are addressed as needed."</p> <p>4. 10/27/12: A BDDS report submitted 10/28/12 for an incident dated 10/27/12 at 8:00 PM indicated, "[Client A] (individual we support) came into the kitchen. Staff noted [client A's] hand appeared red. Upon checking [client A's] left had, staff discovered a 1" (inch) cut. The cut was bleeding. [Client A] did not complain of pain. Staff completed first aid by cleaning the wound...[Client A] is not able to indicate what occurred...."</p> <p>For client C:</p> <p>5. 03/04/13: A BDDS report submitted 03/05/13 for an incident dated 03/04/13 at 4:45 PM indicated, "Program Manager New Clinical Supervisor was (sic) touring home (sic) and in the process observed [client C] (Individual Supported by ResCare) crawling naked from one bathroom to the next and staff member [staff #7] was walking behind him...[Staff #7] suspended pending investigation."</p>		<p>regarding the need to develop specific supports to address health and safety issues as assessed by the interdisciplinary team. Enhanced supervision procedures will be incorporated into Comprehensive High Risk Plans and Behavior Support Plans as appropriate. Members of the Operations and Quality Assurance Teams will review risk plans and Behavior Supports no less than monthly to assure protocols to ensure health and safety are in place –providing guidance, oversight and follow-up as needed.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Behavior Therapist, Quality Assurance Team, Operations Team</p>				

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	<p>A BDDS follow-up report dated 03/24/13 indicated, "...After investigation staff will be receiving corrective action for not supporting [client C's] privacy...."</p> <p>A "Report of Serious Incident" investigation dated 03/04/13 indicated, "... [Program Manager (PM) contacted [QAM] (Quality Assurance Manager) and reported that while observing active treatment at [group home], he and [CS] (Clinical Supervisor) saw [staff #7] allowing [client C] crawl (sic) from one bathroom to another while not wearing any clothing. He further alleged that when he questioned [staff #7] about her actions she said that [client C] was getting his exercise. On 03/04/13, at 5:22 PM, [PM] suspended [staff #7] pending investigation of the allegations...[staff #7] said that she worked at [group home] on 03/04/13. She said she was cleaning the toilet in the bathroom with the shower while [client C] was getting ready for his shower in his bedroom. [Staff #7] said that while she was returning the toilet bowl cleaner to the cabinet where chemicals are stored and was getting his towels, [client C] had crawled into the bathroom with the bathtub and he was urinating. She said [client C] did not have any clothes on. [Staff #7] said that she told [client C] he needed to go to where he gets his shower. She said [staff</p>			

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	#7] always gets his shower in the other bathroom. She said [client C] sits in the shower chair and staff does everything for him. [Staff #7] said [client C] crawled into the other bathroom for his shower and that he was naked. [Staff #7] said that when [PM] asked her why [client C] was crawling through the hallway naked, she told him it was exercise. [Staff #7] said [client C] is supposed to exercise for 10 minutes a day and that (sic) does it in the living room and he has his clothes on. [Client #7] said that on the evening [PM] and [CS] came to the house, [staff #7] helped him with his shower. He said [PM] was mad at her (staff #7) because she let him crawl to the shower when he was naked. He said only [PM], [CS] and [staff #7] saw him crawling. [Client C's] ISP (Individual Support Plan) indicated that he is not capable of arranging for his own privacy and he has a learning object to close the door when dressing and when in the bathroom. Per his 5/15/12 Physical Therapy Evaluation, [client C] has daily arm and back strengthening exercises to improve his ability to transfer safely in and out of his wheelchair...The evidence substantiates that [staff #7] encouraged [client C] to crawl from one bathroom to another at [group home] while not wearing any clothes on the evening of 3/4/13. The evidence does not substantiate that the actions of [staff #7]			

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	<p>resulted in [client C] experiencing mental anguish on the evening of 3/4/13. By her own admission [staff #7] asked [client C] to crawl into home's other bathroom when he already had taken off his clothing. [Client C] did not display any signs of distress when interviewed about the incident. And supervisors addressed the issue promptly upon discovery."</p> <p>For clients E and F:</p> <p>6. 12/30/12: There was not a BDDS report to reflect an incident report dated 12/30/12 at 8:45 PM written by staff #11 that indicated, "When [staff #10] was passing meds (medications), she notice (sic) [client D] still sitting on the couch after she got her meds. Staff didn't see [client E] so staff went to look for him in his room, [client E] was in [client F's] bedroom. Staff went into [client F's] room and saw [client E] on top of [client F] with the covers on both. [Client F] and [client E] were fully clothe (sic). Staff (staff #10) redirected [client E] to the living room."</p> <p>12/30/12: Incident report dated 12/30/12 at 8:45 PM written by staff #10 indicated, "I [staff #10] was passing meds. I notice (sic) that [client D] was still sitting on the couch. She usually goes to bed after she gets her meds. [Client E] wasn't sitting in</p>						

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	<p>the chair that he was in (sic). Staff (staff #12) was vacuuming the floor. So I stopped what I was doing to check on everybody (sic) I saw that [client F's] and [client D's] door was shut. I knocked on it then I open (sic) it (sic) I saw [client E] on top of [client F] possibly having sex, I told [client E] to come out of her room redirected both client (sic) to the living room. "</p> <p>12/30/12: Agency internal e-mails for incident 12/30/12 at 11:16 PM authored by the QAM indicated, "I spoke to [staff #10], [client E] and [client F]....[staff #10] went back to [client D's] and [client F's] bedroom opened the door and found [client D] in bed with [client F]. She said there was a cover over them and [client E] was moving. She said she redirected them both to come to the living room and she strayed (sic) in the hallway with the door cracked open. She said [client E] came out of the room fully clothed within 10 to 15 seconds. She said [client F] was wearing a night shirt. [Client F] said they were only kissing and that she wanted [client E] to be in bed with her. [Client E] said they were only kissing and that he did not take off his clothes. He said he was just trying to have some fun and that they both wanted to do it."</p> <p>1. Client A's records were reviewed on</p>						

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	<p>05/09/13 at 9:44 AM. Client A's ISP (Individual Support Plan) was dated 03/23/13. The ISP indicated client A's diagnoses included, but were not limited to: "Profound [Intellectual Disability], Psychotic Disorder Not Otherwise Specified (NOS), Autistic Tendencies, Tardive Dyskinesia, Nonverbal, Depression, Anxiety Disorder NOS, Mild Scoliosis, Mild Cardiomegaly and Seizures." The ISP indicated she was at risk for falls. An Interdisciplinary Team Meeting dated 07/17/12 indicated, "Staff will continue to follow [client A's] BSP (Behavior Support Plan) at all times... [client A] has a one-on-one (one staff to one client ratio) that was put in place on 7-13-12, this will/should prevent not only aggression toward her housemates, but injuries of unknown origin." Client A's BSP dated 07/13/12 indicated client A's behaviors included Self-Injurious Behaviors and indicated, "...[Client A] will have a 1:1 staff at all times...1:1 MUST FOCUS COMPLETE ATTENTION ON [CLIENT A]. IF ANOTHER INDIVIDUAL NEEDS ASSISTANCE, CALL FOR ANOTHER STAFF TO HELP THAT PERSON. The purpose of [client A's] 1:1 status is to protect her housemates from her aggressive behavior, to protect [client A] when housemates become aggressive toward her and to prevent her from</p>						

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	<p>injuring herself..." Client A's BSP dated 03/23/13 indicated client A's behaviors included Self-Injurious Behaviors and indicated, "...One to one attention: Once [client A] begins to become upset, it is essential that only one person at a time work with her...." The BSP did not contain the same instructions for staff regarding client A being one-on-one.</p> <p>2. Client C's records were reviewed on 05/13/13 at 12:11 PM. Client C's ISP was dated 11/22/12. The ISP indicated client C was not able to care for his own needs and was dependent on staff for his activities of daily living (bathing, toileting, grooming and dressing). His diagnoses included but were not limited to: "Moderate [Intellectual Disability], Cerebral Palsy, Spastic Quadriplegia, Wheelchair Bound, Hyperlipidemia, Dysphagia and Contracture Lower Leg Joint."</p> <p>3. Client E's records were reviewed on 05/14/13 at 11:00 AM. Client E's ISP was dated 08/01/12. Client E's BSP (Behavioral Support Plan) was dated 07/01/12. The BSP indicated client E was emancipated and his targeted behaviors included, "Inappropriate Sexual Behavior...This behavior occurs when [client E] sees a female who draws his sexual interest...[Client E] will sometimes</p>						

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	<p>attempt to touch a female's private areas without their consent. In the past, [client E] has been intimate with females before being placed within a group home...."</p> <p>4. Client F's records were reviewed on 05/14/13 at 11:30 AM. Client F's ISP was dated 10/01/12. Her ISP indicated client F was emancipated and was not able to give informed consent on major life issues. Client F's BSP dated 10/01/12 indicated client F has a diagnosis of Depressive Disorder and is on medications for the diagnosis. The BSP indicated, "...This was diagnose (sic) sometime after [client F's] mom passed away in 05/2012. In the past [client F] has shown to be depressed in the month of May, which is the month that her mother passed away and in December, which is her mother's birthday. [Client F] tends to cry sometimes when there isn't interaction shown towards her...[client F] likes to have attention..."</p> <p>On 05/14/13 at 12:50 PM, a review of the facility's 09/14/07 Policy on "Abuse, Neglect, Exploitation" indicated, "Adept employees actively advocate for the rights and safety of all individuals...Sexual Abuse: the act or failure to act that results or could result in emotional injury to an individual...A non-consensual act of a sexual nature upon or with an individual.</p>			

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	<p>The act may be used for sexual gratification of the perpetrator or a third party. Anyone who allows or encourages forced sexual activity.</p> <p>Intimidation/emotional abuse: the act or failure to act that results or could result in emotional injury to an individual. The act of insulting or coarse language or gestures directed toward an individual that subject him/her to humiliation or degradation.</p> <p>Discouraging or inhibiting behavior by threatening both actual or implied.</p> <p>Attitude or acts that interfere with the psychological and social well being of an individual. Exploitation: an act that deprives an individual of real or personal property by fraudulent or illegal means.</p> <p>Utilization of another person for selfish purposes. Emotional/physical neglect: 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.</p> <p>Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment. Program intervention neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to implement a support plan...Medical neglect: failure to provide goods and/or services necessary for the individual to</p>			

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	<p>avoid physical harm. Failure to provide necessary medical attention, proper nutritional support or administering medications as prescribed. 3. All employees will be trained on the types of incidents that are reportable to BDDS...The incident types are: Suspected abuse, neglect or exploitation...Injuries of unknown origin, Significant injuries...Inadequate staff support...."</p> <p>On 05/15/13 at 10:00 AM an interview with the Program Manager (PM) was conducted. The PM indicated staff failed to follow the policy/procedure as they failed to monitor client A 1:1 and failed to protect client A from repeated injuries, failed to ensure client C's privacy and prevent potential humiliation and failed to protect client F from sexual advances by client E who has a known history of inappropriate sexual behavior.</p> <p>This federal tag relates to complaints #IN00127946, #IN00127998 and #IN00128342.</p> <p>9-3-2(a)</p>						

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 5 of 11 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed for clients A, E and F, to conduct an investigation and/or conduct thorough investigations in regard to repeated injuries to client A, and clients E and F for alleged engagement in sexual activity, and lack of supervision.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, incident reports and investigations were reviewed on 05/08/13 at 2:15 PM. The reports indicated the following:</p> <p>For Client A:</p> <p>1. 04/24/13: A BDDS report submitted 04/25/13 for an incident dated 04/24/13 at 6:43 PM indicated, "Staff was giving 7p (sic) meds (medications) when she heard [client A] (individual supported by ResCare), screaming in her bedroom. Staff went in to [client A's] bedroom and discovered blood on her pillow case, clothes and sheets. Staff stood [client A]</p>	W000154	<p>CORRECTION: <i>The facility must have evidence that all alleged violations are thoroughly investigated. Specifically, the facility will investigate injuries of unknown origin that were discovered for Client A on 10/27/12, 2/11/13, 3/19/13 and 4/24/13. Additionally, the facility will re-open an investigation into alleged consensual sexual activity between Client E and Client F on 12/30/12. The investigation will focus on details of client interviews, level of informed consent and staff response to the incident.</i></p> <p>PREVENTION: Professional staff will be retrained regarding the criteria for conducting investigations at the facility and will receive an updated copy of the agency's incident-investigation tracking spreadsheet no less than to assure thorough investigations are conducted within required timeframes. The QIDP will turn in copies of completed investigations to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up. Additionally, the facility's Clinical Supervisor will meet with the Quality Assurance Manager</p>	06/15/2013
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	<p>up and saw that her left ear had a split in the back about 1 1/2 inches long and it was bleeding. Staff immediately tried to stop the bleeding and called the nurse on call. [Client A] was then transported to the ER (Emergency Room). Staff will monitor clients closely to ensure their safety." There was not a thorough investigation of this incident which investigated as to why client A was alone in her room unsupervised during the daytime hours.</p> <p>2. 03/19/13: A BDDS report submitted 03/20/13 for an incident dated 03/19/13 at 4:30 PM indicated, "During a routine physical assessment of [client A], staff noted bruising at the base of the fingers on her left hand. The nurse examined the affected area and noted no swelling and that [client A] had complete range of motion in her hand. Staff on duty were unsure of how [client A] sustained the injury." There was not an investigation of unknown injury for this incident.</p> <p>3. 02/11/13: A BDDS report submitted 02/13/13 for an incident dated 02/11/13 at 2:00 PM indicated, "[Client A] (Individual supported by ResCare) fell out of bed and hit her head on dresser, causing her head to bleed excessively. Staff called 911 and she was transported to [hospital name] ER. Facility Nurse</p>		<p>weekly to review incidents that require follow-up and investigation to assure timely completion. The Executive Director will monitor the facility's incident – investigation tracking spreadsheet and follow-up as needed with the clinical Supervisor and Program Manager to provide for increased accountability.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>				

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	<p>was informed as well as administration staff. [Client A] was seen in the ER her Diagnoses (sic) was Contusion to head and Laceration to head... Team will also meet to discuss the use of room monitor and also one to one assistance. Staff will continue to follow high risk plan. Falls are addressed."</p> <p>A BDDS follow-up report dated 02/19/13 indicated, "...The environment was rearranged. The team has also decided to have one on one indefinitely for [client A]. Also the team will further discuss a bed monitor/alarm. The Clinical Supervisor, Facility Nurse and staff will continue to assure all health and safety issues are addressed as needed." There was not an investigation of this incident.</p> <p>4. 10/27/12: A BDDS report submitted 10/28/12 for an incident dated 10/27/12 at 8:00 PM indicated, "[Client A] (individual we support) came into the kitchen. Staff noted [client A's] hand appeared red. Upon checking [client A's] left hand, staff discovered a 1" (inch) cut. The cut was bleeding. [Client A] did not complain of pain. Staff completed first aid by cleaning the wound...[Client A] is not able to indicate what occurred...." There was not an investigation of this incident.</p> <p>For clients E and F:</p>						

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	<p>5. 12/30/12: An incident report dated 12/30/12 at 8:45 PM written by staff #11 indicated, "When [staff #10] was passing meds (medications), she notice (sic) [client D] still sitting on the couch after she got her meds. Staff didn't see [client E] so staff went to look for him in his room, [client E] was in [client F's] bedroom. Staff went into [client F's] room and saw [client E] on top of [client F] with the covers on both. [Client F] and [client E] were fully clothe (sic). Staff (staff #10) redirected [client E] to the living room."</p> <p>12/30/12: Incident report dated 12/30/12 at 8:45 PM written by staff #10 indicated, "I [staff #10] was passing meds. I notice (sic) that [client D] was still sitting on the couch. She usually goes to bed after she gets her meds. [Client E] wasn't sitting in the chair that he was in (sic). Staff (staff #12) was vacuuming the floor. So I stopped what I was doing to check on everybody (sic) I saw that [client F's] and [client D's] door was shut. I knocked on it then I open (sic) it (sic) I saw [client E] on top of [client F] possibly having sex, I told [client E] to come out of her room redirected both client (sic) to the living room. "</p> <p>12/30/12: Agency internal e-mails for</p>						

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	<p>incident 12/30/12 at 11:16 PM authored by the QAM indicated, "I spoke to [staff #10], [client E] and [client F]....[staff #10] went back to [client D's] and [client F's] bedroom opened the door and found [client D] in bed with [client F]. She said there was a cover over them and [client E] was moving. She said she redirected them both to come to the living room and she strayed (sic) in the hallway with the door cracked open. She said [client D] came out of the room fully clothed within 10 to 15 seconds. She said [client F] was wearing a night shirt. [Client F] said they were only kissing and that she wanted [client E] to be in bed with her. [Client E] said they were only kissing and that he did not take off his clothes. He said he was just trying to have some fun and that they both wanted to do it." There was not a thorough investigation available for review of this incident which clearly documented if/why staff #10 left the bedroom after prompting client E to get off of client F. The internal e-mails did not address client interviews, informed consent issues, staff supervision and a lack of body assessments.</p> <p>On 05/15/13 at 10:00 AM an interview with the Program Manager (PM) and the Quality Assurance Manager (QAM) was conducted. The PM indicated there was no additional investigative information</p>			

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	<p>related to these incidents for review. The QAM indicated the agency had recently changed the way they were conducting investigations to ensure investigations were conducted and they were thorough.</p> <p>This federal tag relates to complaints #IN00127946, #IN00127998 and #IN00128342.</p> <p>9-3-2(a)</p>				

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 4 of 11 BDDS (Bureau of Developmental Disabilities Services) reports regarding allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility neglected to initiate and document effective corrective action to prevent neglect of client A, by failing to supervise the client to prevent her from receiving additional injuries.</p> <p>Findings include:</p> <p>On 05/08/13 at 2:15 PM the facility's BDDS Reports and investigations were reviewed from 07/01/12 through 05/07/13 and indicated the following:</p> <p>1. 04/24/13: A BDDS report submitted 04/25/13 for an incident dated 04/24/13 at 6:43 PM indicated, "Staff was giving 7p (sic) meds (medications) when she heard [client A] (individual supported by ResCare), screaming in her bedroom. Staff went in to [client A's] bedroom and discovered blood on her pillow case, clothes and sheets. Staff stood [client A] up and saw that her left ear had a split in the back about 1 1/2 inches long and it was bleeding. Staff immediately tried to stop the bleeding and called the nurse on</p>	W000157	<p>CORRECTION: <i>If the alleged violation is verified, appropriate corrective action must be taken. Specifically, the interdisciplinary team will evaluate current assessment and incident data and meet to develop revised strategies to increase personal safety for Client A and protect Client A from further injury to the maximum extent possible.</i></p> <p>PREVENTION: The QIDP will bring all relevant elements of the interdisciplinary team together after incidents of resulting in significant injury to review current supports and to make adjustments and revisions as needed. The QIDP 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>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	06/15/2013			

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	<p>call. [Client A] was then transported to the ER (Emergency Room). Staff will monitor clients closely to ensure their safety." No record of how staff were monitoring and supervising client A was available for review in regard to prevent client A from additional injuries.</p> <p>2. 03/19/13: A BDDS report submitted 03/20/13 for an incident dated 03/19/13 at 4:30 PM indicated, "During a routine physical assessment of [client A], staff noted bruising at the base of the fingers on her left hand. The nurse examined the affected area and noted no swelling and that [client A] had complete range of motion in her hand. Staff on duty were unsure of how [client A] sustained the injury." No record was available for review in regard to staff monitoring or supervising to prevent client A from additional injuries.</p> <p>3. 02/11/13: A BDDS report submitted 02/13/13 for an incident dated 02/11/13 at 2:00 PM indicated, "[Client A] (Individual supported by ResCare) fell out of bed and hit her head on dresser, causing her head to bleed excessively. Staff called 911 and she was transported to [hospital name] ER. Facility Nurse was informed as well as administration staff. [Client A] was seen in the ER her Diagnoses (sic) was Contusion to head</p>			

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	<p>and Laceration to head... Team will also meet to discuss the use of room monitor and also one to one assistance. Staff will continue to follow high risk plan. Falls are addressed."</p> <p>A BDDS follow-up report dated 02/19/13 indicated, "...The environment was rearranged. The team has also decided to have one on one indefinitely for [client A]. Also the team will further discuss a bed monitor/alarm. The Clinical Supervisor, Facility Nurse and staff will continue to assure all health and safety issues are addressed as needed." No record of methods was available for review in regard to staff monitoring or supervision to prevent client A from additional injuries.</p> <p>4. 10/27/12: A BDDS report submitted 10/28/12 for an incident dated 10/27/12 at 8:00 PM indicated, "[Client A] (individual we support) came into the kitchen. Staff noted [client A's] hand appeared red. Upon checking [client A's] left hand, staff discovered a 1" (inch) cut. The cut was bleeding. [Client A] did not complain of pain. Staff completed first aid by cleaning the wound...[Client A] is not able to indicate what occurred...." No record of was available for review in regard to staff monitoring or supervising to prevent client A from additional injuries.</p>						

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	<p>On 05/15/13 at 10:00 AM an interview with the Program Manager (PM) was conducted. The PM indicated client A was at risk for falls and had behaviors which included self-injurious behavior. He indicated client A is currently to be monitored 1:1 during waking hours but he indicated the agency neglected to implement and document effective corrective action for the incidents.</p> <p>This federal tag relates to complaints #IN00127946, #IN00127998 and #IN00128342.</p> <p>9-3-2(a)</p>			
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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview, the facility's QIDP (Qualified Intellectual Disabilities Professional) failed to monitor, coordinate and integrate each client's active treatment program by failing: for 3 of 4 sampled clients (B, C and D), to ensure the day service provider was included in the development of the clients ISPs (Individual Support Plan) and (BSPs) Behavior Support Plans and the current ISPs and BSPs were provided to the day program they attended; for 3 of 4 sampled clients (clients B, C and D), failed to ensure their rights by failing to provide legally sanctioned representatives; for 4 of 4 sample clients (clients A, B, C and D), to maintain an accurate accounting system for each client's personal fund account; for 1 of 4 sampled clients (client B), to conduct a sensorimotor assessment of his ambulation needs; for 2 of 4 sample clients (clients A and D), to ensure speech assessments were completed for clients with identified communication needs; for 1 of 4 sampled clients (clients A) and 1 additional client (client E), to ensure the clients' Individual Support Plans (ISPs) specifically indicated what staff were to</p>	W000159	<p>CORRECTION:</p> <p><i>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. The Operations and Quality Assurance Teams will work together to provide additional training, mentorship and guidance to the QIDP to assure the QIDP has the resources necessary to properly integrate, coordinate and monitor each client's active treatment program. This training and oversight training will focus on but not be limited to:</i></p> <ol style="list-style-type: none"> 1. Appropriate assessment of clients' level of informed consent and need for legal representation. 2. Inclusion of all relevant interdisciplinary team members in decision making. 3. The need to maintain all relevant current assessments including but not limited to speech and physical therapy assessments. 4. The need to revise Individual Support Plans no less than annually. 5. The need to maintain current assessment data for all clients. 6. The need to maintain an accurate accounting of all client finances. 7. The need to address all clients' behavioral needs including but not limited to the development of specific one to one observation procedures. 8. The need to train clients to 	06/15/2013

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	<p>do regarding client A's 1:1 (one-to-one staff to client ratio) and regarding client E's Inappropriate Sexual Behaviors; for 4 of 4 sampled clients (clients A, B, C and D), to document and/or collect data on the objectives outlined in the Individual Support Plan (ISP); for 2 of 4 sampled clients (clients A and D), to revise the Individual Support Plan (ISP) within 365 days of the previous ISP; for 3 of 3 sampled clients with behavior plans (clients A, B and D), to ensure the facility's Human Rights Committee (HRC) reviewed, approved, and monitored restrictive practices, (psychotropic medications) in the clients BSPs (Behavioral Support Plans) and for 3 of 4 sampled clients (clients A, B and D), who wore glasses, to ensure and/or train clients A, B and D to use their eyeglasses.</p> <p>Findings include:</p> <p>Please refer to W120. The QIDP failed for 3 of 4 sampled clients (B, C and D), to ensure the day service provider was included in the development of the clients ISPs (Individual Support Plan) and (BSPs) Behavior Support Plans and the current ISPs and BSPs were provided to the day program they attended.</p> <p>Please refer to W125. The QIDP failed to</p>		<p>make informed decisions about the use of adaptive equipment.</p> <p>9. 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: Members of the Operations and Quality Assurance Teams will conduct weekly audits of facility support documents and conduct active treatment observations for the next 90 days. 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 QIDP integrates, coordinates and monitors, the active treatment program effectively and will provide guidance, mentorship and corrective measures as needed.</p> <p>RESPONSIBLE PARTIES: QIDP, Quality Assurance Team, Operations Team</p>	

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	<p>protect the rights for 3 of 4 sampled clients (clients B, C and D), by failing to provide legally sanctioned representatives.</p> <p>Please refer to W140. The QIDP failed for 4 of 4 sample clients (clients A, B, C and D), to maintain an accurate accounting system for each client's personal fund account.</p> <p>Please refer to W218. The QIDP failed for 1 of 4 sampled clients (client B), to conduct a sensorimotor assessment of his ambulation needs.</p> <p>Please refer to W220. The QIDP failed for 2 of 4 sample clients (clients A and D), to ensure speech assessments were completed for clients with identified communication needs.</p> <p>Please refer to W240. The QIDP failed for 1 of 4 sampled clients (clients A) and 1 additional client (client E), to ensure the clients' Individual Support Plans (ISPs) specifically indicated what staff were to do regarding client A's 1:1 (one-to-one staff to client ratio) and regarding client E's Inappropriate Sexual Behaviors.</p> <p>Please refer to W252. The QIDP failed for 4 of 4 sampled clients (clients A, B, C and D), to document and/or collect data</p>						

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	<p>on the objectives outlined in the Individual Support Plans (ISPs).</p> <p>Please refer to W260. The QIDP failed for 2 of 4 sampled clients (clients A and D), to revise the Individual Support Plans (ISPs) within 365 days of the previous ISP.</p> <p>Please refer to W262. The QIDP failed for 3 of 3 sampled clients with behavior plans (clients A, B and D), to ensure the facility's Human Rights Committee (HRC) reviewed, approved, and monitored restrictive practices, (psychotropic medications) in the clients' BSPs (Behavioral Support Plans).</p> <p>Please refer to W436. The QIDP failed for 3 of 4 sampled clients (clients A, B and D), who wore glasses, to ensure and/or train clients A, B and D to use their eyeglasses.</p> <p>This federal tag relates to complaints #IN00127946, #IN00127998 and #IN00128342.</p> <p>9-3-3(a)</p>				

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W000218	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, record review, and interview, the facility failed for 1 of 4 sampled clients (client B) to conduct a sensorimotor assessment of his ambulation needs.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 05/08/13 from 4:00 PM until 5:30 PM and on 05/09/13 from 6:27 AM until 8:15 AM. During the observation times, client B was observed to be leaning to the right and ambulating slowly around the house without assistance.</p> <p>Client B's record was reviewed on 05/13/13 at 10:00 AM. Client B's April 2013 Physician Orders contained the diagnosis of Cerebral Palsy. Client B's 08/07/12 Individual Plan indicated he was at risk for falls related to his diagnosis and unsteady gait. The record contained a Physical Therapy Evaluation (PT) dated 06/04/08 with a home exercise program. There was not an updated PT Evaluation to indicate if the exercise program was still adequate for his diagnosis and condition.</p> <p>On 05/15/13 at 10:00 AM an interview</p>	W000218	<p>CORRECTION: <i>The comprehensive functional assessment must include sensorimotor development. Specifically, the facility will assist Client B with obtaining an updated Physical Therapy assessment.</i></p> <p>PREVENTION: The QIDPD will be retrained regarding the need to assure all clients receive ongoing assessment consistent with their current needs. The facility nurse will consult tracking data and review the medical charts to assure that all clients have current sensorimotor assessments included in their record. The interdisciplinary team will analyze incidents as needed but no less than quarterly to assure needed assessments are scheduled and completed.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	06/15/2013

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	<p>with the Program Manager (PM) was conducted. The PM indicated client B had not had an updated PT evaluation since 06/04/08. He indicated an updated PT evaluation should be obtained.</p> <p>This federal tag relates to complaints #IN00127946, #IN00127998 and #IN00128342.</p> <p>9-3-4(a)</p>			

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W000220	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development.</p> <p>Based on observation, record review and interview for 2 of 4 sample clients (clients A and D), the facility failed to ensure speech assessments were completed for clients with identified communication needs.</p> <p>Findings include:</p> <p>1. Observations were conducted in the group home on 05/08/13 from 4:00 PM until 5:30 PM and on 05/09/13 from 6:27 AM until 8:15 AM. During the observation time on 05/09/13 from 6:48 AM until 7:10 AM, client A was observed to not speak and made 21 short, loud "ah-ah" sounds.</p> <p>Client A's records were reviewed on 05/09/13 at 9:44 AM. Client A's Individual Support Plan (ISP) dated 03/23/13 contained a BSP (Behavior Support Plan) dated 03/23/13 which indicated her targeted behaviors included screaming and yelling. The BSP indicated, "...she has not learned how to express herself when she is frustrated, and how to get along with others..." Client A's record contained a Speech Therapy (ST) Evaluation dated 07/18/11. The</p>	W000220	<p>CORRECTION: <i>The comprehensive functional assessment must include speech and language development. Specifically, the facility will assist Client A and Client D with obtaining updated speech assessments.</i></p> <p>PREVENTION: The QIDP will be retrained regarding the need to assure all clients receive ongoing assessment consistent with their current needs. The facility nurse will consult tracking data and review the medical charts to assure that all clients with communication needs have current speech assessments included in their record. Members of the Operations and Quality Assurance Teams will audit assessment data and support documents no less than monthly to assure that the comprehensive functional assessment includes data relevant to speech and language development. Additionally, the interdisciplinary team will include monitoring communication assessment data as part of its quarterly review process.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	06/15/2013			

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	<p>record did not contain an updated ST evaluation regarding the screaming/yelling and ways for her to communicate.</p> <p>On 05/15/13 at 10:00 AM an interview with the Program Manager (PM) was conducted. The PM indicated there was not an updated speech evaluation for client A. He indicated client A needed to have an updated speech evaluation with training methods and recommendations.</p> <p>2. Observations were conducted in the group home on 05/08/13 from 4:00 PM until 5:30 PM and on 05/09/13 from 6:27 AM until 8:15 AM. During the observation times, client D was observed to not speak.</p> <p>Client D's records were reviewed on 05/13/13 at 1:00 PM. Client D's ISP dated 08/06/12 indicated she did not initiate conversation and was difficult to understand. Client D's record contained a speech evaluation dated 08/06/07.</p> <p>On 05/15/13 at 10:00 AM an interview with the PM was conducted. The PM indicated there was not an updated speech evaluation for client D. He indicated client D needed to have an updated speech evaluation with training methods and recommendations.</p>				

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	<p>This federal tag relates to complaints #IN00127946, #IN00127998 and #IN00128342.</p> <p>9-3-4(a)</p>			

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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on interview and record review for 1 of 4 sampled clients (client A) and 1 additional client (client E), the clients' Individual Support Plans (ISPs) failed to specifically indicate what staff were to do regarding client A's 1:1 (one-to-one staff to client supervision ratio) for self injurious behaviors, falls, and to prevent unknown injuries and regarding client E's Inappropriate Sexual Behaviors.</p> <p>Findings include:</p> <p>1. Client A's records were reviewed on 05/09/13 at 9:44 AM. A BDDS (Bureau of Developmental Disabilities Services) report for an incident dated 04/24/13 at 6:43 PM indicated, "Staff was giving 7p (sic) meds (medications) when she heard [client A] (individual supported by ResCare), screaming in her bedroom. Staff went in to [client A's] bedroom and discovered blood on her pillow case, clothes and sheets. Staff stood [client A] up and saw that her left ear had a split in the back about 1 1/2 inches long and it was bleeding. Staff immediately tried to stop the bleeding and called the nurse on call. [Client A] was then transported to the ER (Emergency Room). Staff will</p>	W000240	<p>CORRECTION: <i>The individual program plan must describe relevant interventions to support the individual toward independence. Specifically, the team will work with the facility nurse to incorporate specific one to one observation procedures into Client A's Comprehensive High Risk plan for falls. Additionally, interventions for Client E's history of inappropriate sexual behavior will be developed.</i></p> <p>PREVENTION: The QIDP will receive training regarding the need to develop specific supports to address health and safety issues as assessed by the interdisciplinary team. Enhanced supervision procedures will be incorporated into Comprehensive High Risk Plans and Behavior Support Plans as appropriate. Members of the Operations and Quality Assurance Teams will review risk plans and Behavior Supports no less than monthly to assure protocols to ensure health and safety are in place –providing guidance, oversight and follow-up as needed.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	06/15/2013			

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	<p>monitor clients closely to ensure their safety."</p> <p>Client A's ISP (Individual Support Plan) was dated 03/23/13. The ISP indicated client A's diagnoses, included but were not limited to: "Profound [Intellectual Disability], Psychotic Disorder Not Otherwise Specified (NOS), Autistic Tendencies, Tardive Dyskinesia, Nonverbal, Depression, Anxiety Disorder NOS, Mild Scoliosis, Mild Cardiomegaly and Seizures." The ISP indicated she was at risk for falls. An Interdisciplinary Team Meeting dated 07/17/12 indicated, "Staff will continue to follow [client A's] BSP at all times...[client A] has a one-on-one (one staff to one client ratio) that was put in place on 7-13-12, this will/should prevent not only aggression toward her housemates, but injuries of unknown origin." Client A's BSP (Behavior Support Plan) dated 07/13/12 indicated client A's behaviors included Self-Injurious Behaviors and indicated, "...[Client A] will have a 1:1 staff at all times...1:1 MUST FOCUS COMPLETE ATTENTION ON [CLIENT A]. IF ANOTHER INDIVIDUAL NEEDS ASSISTANCE, CALL FOR ANOTHER STAFF TO HELP THAT PERSON. The purpose of [client A's] 1:1 status is to protect her housemates from her aggressive behavior, to protect [client A]</p>			

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	<p>when housemates become aggressive toward her and to prevent her from injuring herself..." Client A's BSP dated 03/23/13 indicated client A's behaviors included Self-Injurious Behaviors and indicated, "...One to one attention: Once [client A] begins to become upset, it is essential that only one person at a time work with her..." The BSP did not contain the same instructions for staff regarding client A being one-on-one.</p> <p>On 05/15/13 at 10:00 AM an interview with the Program Manager (PM) was conducted. The PM indicated client A was at risk for falls and had behaviors which included self-injurious behavior. He indicated client A was currently to be monitored 1:1 during waking hours but he indicated the BSP failed to have specific instructions for how staff were to carry out the 1:1 and how the nighttime monitoring was to occur.</p> <p>2. An incident report dated 12/30/12 at 8:45 PM written by staff #10 indicated, "I [staff #10] was passing meds. I notice (sic) that [client D] was still sitting on the couch. She usually goes to bed after she gets her meds. [Client E] wasn't sitting in the chair that he was in (sic). Staff (staff #12) was vacuuming the floor. So I stopped what I was doing to check on everybody (sic) I saw that [client F's] and</p>			

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	<p>[client D's] door was shut. I knocked on it then I open (sic) it (sic) I saw [client E] on top of [client F] possibly having sex, I told [client E] to come out of her room redirected both client (sic) to the living room. "</p> <p>Client E's records were reviewed on 05/14/13 at 11:00 AM. Client E's ISP was dated 08/01/12. Client E's BSP (Behavioral Support Plan) was dated 07/01/12. The BSP indicated client E was emancipated and his targeted behaviors included, "Inappropriate Sexual Behavior...This behavior occurs when [client E] sees a female who draws his sexual interest...[Client E] will sometimes attempt to touch a female's private areas without their consent. In the past, [client E] has been intimate with females before being placed within a group home...Precursor Behaviors (behaviors that typically occur before target behaviors...Inappropriate Sexual Behavior: Starting a conversation with women and ending with conversation inappropriately...." The BSP failed to indicate how client E was to be monitored around the females in the group home or how often he was monitored in the evening while preparing for bed and at nighttime while sleeping.</p> <p>On 05/15/13 at 10:00 AM an interview</p>			

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	<p>with the Program Manager (PM) was conducted. The PM indicated client E's behaviors included inappropriate sexual behavior. He indicated client E's BSP failed to have specific instructions for how staff were to monitor client E around the females in the home and failed to indicate how staff were to monitor him at night.</p> <p>This federal tag relates to complaints #IN00127946, #IN00127998 and #IN00128342.</p> <p>9-3-4(a)</p>			

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W000252	<p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on record review and interview for 4 of 4 sampled clients (clients A, B, C and D), the facility failed to document and/or collect data on the objectives outlined in the Individual Support Plan (ISP).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Client A's records were reviewed on 05/09/13 at 9:44 AM. Client A's ISP (Individual Support Plan) was dated 03/23/13. Client A moved into the group home on 03/23/12. There were no monthly goal tracking sheets of client A's ISP objectives from 07/2012 through 05/08/13. Client B's records were reviewed on 05/12/13 at 10:00 AM. Client B's ISP was dated 08/07/12. There were no monthly goal tracking sheets of client #2's ISP objectives from 8/2011 through 05/08/13. Client C's records were reviewed on 05/13/13 at 12:11 PM. Client C's ISP was dated 11/22/12. There were no monthly goal tracking sheets of client C's 	W000252	<p>CORRECTION: <i>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</i> Specifically, supervisory staff will be retrained regarding the need to assure data collection materials are present with all clients' support documents at all times, direct support staff will be retrained regarding the need to collect data on learning objectives as instructed by the Implementation schedule.</p> <p>PREVENTION: The QIDP will be retrained regarding the need to track and monitor progress on all client learning objectives. As part of a monthly audit process, members of the Operations and Quality Assurance Team will review support documents to assure data collection grids are in place for all learning objectives and that direct support staff collect data as required.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	06/15/2013

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	<p>ISP objectives from 11/2011 through 05/08/13.</p> <p>4. Client D's records were reviewed on 05/13/13 at 1:00 PM. Client D's ISP was dated 08/06/12. There were no monthly goal tracking sheets of client D's ISP objectives from 08/2012 through 05/08/13.</p> <p>On 05/15/13 at 10:00 AM an interview with the Program Manager (PM) was conducted. The PM indicated the agency had a problem with the previous QIDP (Qualified Intellectual Disabilities Professional) in the home and there was no data for any of the goals.</p> <p>This federal tag relates to complaints #IN00127946, #IN00127998 and #IN00128342.</p> <p>9-3-4(a)</p>			

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W000260	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on interview and record review for 2 of 4 sampled clients (clients A and D), the QIDP (Qualified Intellectual Disabilities Professional) failed to revise the Individual Support Plan (ISP) within 365 days of the previous ISP.</p> <p>Findings include:</p> <p>1. Client B's records were reviewed on 05/13/13 at 10:00 AM. Client B's ISP was dated 08/07/12. The record contained 3 previous ISP dates 08/05, 06, 07/11.</p> <p>Client D's record was reviewed on 05/13/13 at 1:00 PM. Client B's ISP was dated 08/06/12. The record contained a previous ISP dated 08/05/11.</p> <p>On 05/15/13 at 10:00 AM an interview with the Program Manager (PM) was conducted. The PM indicated ISPs were to be completed within 365 days of the previous ISP. He indicated the QIDP failed to complete client B and D's ISPs timely and they were late.</p> <p>This federal tag relates to complaints</p>	W000260	<p>CORRECTION: <i>At least annually, the individual program plan must be revised, as appropriate. Specifically, ISPs for Client A and Client D will be revised.</i></p> <p>PREVENTION: The QIDP will be retrained regarding the fact that Individual Support Plans need to be modified no less than annually. Members of the Operations and Quality Assurance Team will monitor facility support documents as needed but no less than monthly to assure all ISPs are current. The Program Manager –Lead has developed a system to track quarterly and annual meeting due dates and will provide follow-up and oversight to assure updates occur as scheduled.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	06/15/2013	

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W000262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview, the facility's Human Rights Committee (HRC) failed for 3 of 3 sampled clients with behavior plans (clients A, B and D) to review, approve, and monitor restrictive practices, (psychotropic medications) in the clients BSPs (Behavioral Support Plans).</p> <p>Findings include:</p> <p>1. Client A's records were reviewed on 05/09/13 at 9:44 AM. Client A's BSP (Behavior Support Plan) dated 03/23/13 indicated client A was on behavioral medications which included: Haldol, Cogentin, Diazepam and Paxil for the following behaviors: non-compliance, physical aggression, self-injurious behavior and screaming/yelling. The BSP signature page was not signed by the HRC. Client A's record did not indicate the HRC (Human Rights Committee) reviewed/approved client A's BSP.</p> <p>On 05/15/13 at 10:00 AM an interview with the Program Manager (PM) was</p>	W000262	<p>CORRECTION: <i>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Specifically, Client A, B and D's restrictive programs will be reviewed and approved consensually by the Human Rights Committee.</i></p> <p>PREVENTION: The QIDP will be retrained regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Administrative staff will conduct visits to the facility as needed but no less than monthly. The Program Manager –Lead will incorporate monitoring of annual HRC approvals of restrictive programs into the current tracking process.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Human Rights Committee, Quality Assurance Team, Operations Team</p>	06/15/2013

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	<p>conducted. The PM indicated client A's current BSP did not indicate HRC approval.</p> <p>2. Client B's record was reviewed on 05/13/13 at 10:00 AM. Client B's BSP dated 08/06/12 indicated client B was on behavioral medications which included: Abilify and Paxil for the following behaviors: physical aggression, self-injurious behavior and rocking rolling/jumping. The BSP signature page was not signed by the HRC. Client B's record did not indicate the HRC (Human Rights Committee) reviewed/approved client B's BSP.</p> <p>On 05/15/13 at 10:00 AM an interview with the PM was conducted. The PM indicated client B's current BSP did not indicate HRC approval.</p> <p>3. Client D's record was reviewed on 05/13/13 at 1:00 PM. Client D's BSP dated 08/05/12 indicated client D was on behavioral medications which included: Tegretol (also used to treat her seizures) and she had the following behaviors: physical aggression and self-injurious behavior. The BSP signature page was not signed by the HRC. Client B's record did not indicate the HRC (Human Rights Committee) reviewed/approved client B's BSP.</p>			

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	<p>On 05/15/13 at 10:00 AM an interview with the PM was conducted. The PM indicated client D's current BSP did not indicate HRC approval.</p> <p>This federal tag relates to complaints #IN00127946, #IN00127998 and #IN00128342.</p> <p>9-3-4(a)</p>			
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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview, the facility nursing services failed for 2 of 4 sampled clients (clients A and B), by not ensuring the clients medical needs were met, as they related to the administration of specific medications which required specific orders for their administration.</p> <p>Findings include:</p> <p>On 05/09/13 from 6:27 AM until 8:15 AM observations were conducted at the group home. At 7:33 AM, staff #4 prepared and administered client B's medications which included Inderal (blood pressure). At 7:52 AM staff #4 took client B's blood pressure. Staff #4 was interviewed at 7:53 AM and she indicated she gave all the medications and then would check the blood pressures. The May 2013 MAR (Medication Administration Record) contained the following orders: "Propranolol Tab (tablet) 60 mg (milligram) -Sub (substitution) For: Inderal - Give one tablet by mouth once daily for behavioral disorder. Take B/P (blood pressure) first. Call nurse if B/P is less than 100/60."</p> <p>On 05/09/13 at 7:50 AM, staff #4</p>	W000331	<p>CORRECTION:</p> <p><i>The facility must provide clients with nursing services in accordance with their needs. Specifically, the facility nurse has obtained a change in the ordered timing for administration of Client A's Levothyroxine to eliminate staff confusion over when the medication must be administered. The nurse will provide additional training to direct support staff regarding the process for administering Client A's Levothyroxine and the need to check Client A's blood pressure prior to administering Propranolol.</i></p> <p>PREVENTION:</p> <p>Under the supervision of the facility nurse, supervisory staff will conduct formal medication administration observations of all staff as needed but no less than quarterly. Additionally, the Training Coordinator will incorporate annual staff medication observations into the training compliance data base.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Quality Assurance Team, Operations Team</p>	06/15/2013
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	<p>prepared and administered client A's medications which included Norvasc (blood pressure) and Synthroid (thyroid). At 7:59 AM staff #4 took client B's blood pressure with an automatic wrist cuff first. Staff #4 indicated the reading was high (210/98). She then repeated the blood pressure with a manual cuff. Staff #4 was interviewed at 8:00 AM and she indicated she gave all the meds and then would check the blood pressures. The May 2013 MAR (Medication Administration Record) contained the following orders: "Amlodipine Tab 10 mg - Sub For: Norvasc - Give one tablet by mouth once daily. Do not give if systolic (top number) is less than 120. Use manual cuff." The May 2013 MAR also contained the order, "Levothyroxine Tab 200 mcg (microgram) - Sub For: Synthroid 200 mcg = 0.2 mg. Give one tablet my mouth once daily. Give one hour before other meds/meals for hypothyroidism."</p> <p>An interview with the LPN (Licensed Practical Nurse) on 05/09/13 at 10:46 AM was conducted. The LPN indicated there are certain medical considerations related to specific medications. She indicated the Synthroid was to be given by itself and on an empty stomach to ensure its best effective action. She further indicated when giving BP medications staff needed</p>			

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	<p>to take the BP first in case it was too low and the medication needed to be held and not given.</p> <p>This federal tag relates to complaints #IN00127946, #IN00127998 and #IN00128342.</p> <p>9-3-6(a)</p>						

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT 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. Based on observation, interview and record review for 3 of 4 sampled clients (clients A, B and D), who wore glasses, the facility failed to train clients A, B and D to use their eyeglasses.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 05/08/13 from 4:00 PM until 5:30 PM and on 05/09/13 from 6:27 AM until 8:15 AM. During both observations client A was not wearing her eyeglasses nor were any verbal prompts made to client A to put on her eyeglasses. During both observations, client B was not wearing his eyeglasses nor were any verbal prompts made to client B to put on his eyeglasses. During both observations, client D was not wearing her eyeglasses nor were any verbal prompts made to client D to put on her eyeglasses.</p> <p>Client A's record was reviewed on 05/09/13 at 9:44 AM. Client A's vision examination dated 07/01/11 indicated client A was prescribed eyeglasses.</p>	W000436	<p>CORRECTION: <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 learning objectives to train Clients A, B and D to make informed decisions about the use of eyeglasses.</i></p> <p>PREVENTION: 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 and that</p>	06/15/2013			

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	<p>Client A's 03/23/13 ISP (Individual Support Plan) did not indicate a formal training objective for wearing the eyeglasses.</p> <p>Client B's record was reviewed on 05/13/13 at 10:00 AM. Client B's vision examination dated 05/03/12 indicated client B was prescribed eyeglasses. Client B's 08/07/12 ISP did not indicate a formal training objective for wearing the eyeglasses.</p> <p>Client D's record was reviewed on 05/13/13 at 1:00 PM. Client D's vision examination dated 12/03/12 indicated client D was prescribed eyeglasses. Client D's 08/06/12 ISP did not indicate a formal training objective for wearing the eyeglasses.</p> <p>On 05/15/13 at 10:00 AM an interview with the Program Manager (PM) was conducted. The PM indicated clients A, B and D should be wearing their glasses. He indicated their ISPs did not contain any formal training in this area.</p> <p>This federal tag relates to complaints #IN00127946, #IN00127998 and #IN00128342.</p> <p>9-3-7(a)</p>		<p>appropriate training supports are in place.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>		

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