STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G274		01/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUTNAM COUNTY COMPREHENSIVE SERVICES INC	1222 BLOOMINGTON GREENCASTLE, IN 46135

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W 0000 Bldg. 00	This visit was for an extended recertification and state licensure survey. Survey Dates: January 5, 6, 7, 8 and 11, 2016 Facility Number: 000794 Provider Number: 15G274 AIM Number: 100234880 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/13/16.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility's governing body failed to exercise operating direction over the facility by failing to ensure the group home remained in good repair.	W 0104	A walk through of the house was conducted to identify areas which require maintenance and repairs. The following areas were repaired: 1. Kitchen cabinet doors repaired 2. Common walls as you enter the kitchen dents repaired and painted 3. Bed of client 3 & 6 hole patched and painted 4. Trim in client 3 & 6 bedroom has been	01/25/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Findings include: Observations were conducted at the group home on 1/5/16 from 3:00 PM to 5:50 PM and 1/6/16 from 6:19 AM to 8:21 AM. During the observations, the common area walls were scuffed, marked, discolored and dented. Client #3 and #6's bedroom wall next to the door had a 3 inch hole approximately 12 inches off the floor. The wall had previously been patched but the wall was not painted to match the rest of the paint. Client #3 and #6's bedroom wooden trim was discolored, dented and scratched. The hallway walls outside of the clients' bedrooms was dented, scratched, discolored, scuffed and missing paints in several areas. The trim around the doors leading to the entrance of the group home was dented, scratched, marked, discolored and scuffed. There were two cabinet doors in the kitchen with holes in the doors. This affected clients #1, #2, #3, #4, #5 and #6. On 1/6/16 at 1:16 PM, a review of the facility's maintenance requests was conducted. There were no requests made to address the environmental issues noted at the group home from 1/6/15 to 1/6/16. On 1/6/16 at 12:21 PM, the Qualified Intellectual Disabilities Professional		puttied and re-stained 5. Hallway to bedroom area has been patched and painted 6. Door trim leading to the entrance of the group home has been repaired and painted. A review of the Maintenance procedure was reviewed with House Manager and direst support staff. The House Manager and Direct Support Professionals have been re-trained on how to complete the site inspection form and site inspection form. The House Manager has been directed to utilize the Maintenance Request form instead of using text messages and phone calls which do not provide a paper trail. Furthermore the house manager is to provide a monthly update to the Residential Director on repairs requested as well as repairs completed and outstanding. The House Manager is responsible for ensuring the maintenance and repairs in the home. (see attached site inspection form, updated Monthly Management Report)	

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	(QIDP) stated there were "definitely areas in the home needing to be painted." The QIDP indicated the main area was the entrance to the home where the walls were scuffed, marked and discolored. The QIDP indicated there were areas in the home where the walls had been previously patched but not painted. The QIDP indicated the patched areas needed to be painted. The QIDP indicated the wall in client #3 and #6's bedroom needed to be repaired. 9-3-1(a)			
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policies and procedures to prevent client to client abuse, conduct thorough investigations of client to client abuse, falls and injuries of unknown origin and ensure corrective action was taken to address client #2 and #4's falls.	W 0122	The Residential Director and QIDP met and reviewed the agency policies and procedures related to Client Protections. It was determined that although informal investigations were occurring via text and phone conversations with individuals present during an incident that evidence of such was not clearly identified in the Incident Reports. In the future the QIDP will utilize a “Follow-up on Incident and Investigations” forms to provide a paper trail for all incidents of client to client aggression, falls, injuries of unknown origin, neglect	01/22/2016

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	Findings include: 1) Please refer to W149. For 26 of 88 incident reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility neglected to implement its policies and procedures to prevent client to client abuse, conduct thorough investigations of client to client abuse, falls and injuries of unknown origin and ensure corrective action was taken to address client #2 and #4's falls. 2) Please refer to W154. For 26 of 88 incident reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility failed to conduct thorough investigations of client to client abuse and conduct thorough investigations of falls. 3) Please refer to W157. For 2 of 88 incident reports reviewed affecting clients #2 and #4, the facility failed to ensure corrective action was implemented to address the clients' falls. 9-3-2(a)		and exploitation. Furthermore, Residential Director and Executive Director determined that until a new QA Director could be hired and trained that investigations will be completed by a Department Head or Coordinator from a program outside of the group homes. Training was provided to those staff on Thursday, January 21, 2016. The QIDP is responsible ensuring thorough investigations are completed. In his absence the Residential Director will work with Designee assigned to complete the investigation to ensure a thorough investigation is conducted in a timely manner. Upon review of all 6 clients risk plans updates were made to five of them. Two of them were to clarify transfer protocol, two plans were to address falls and one was to clarify walker usage. Staff has been re-trained on all six client risk plans with emphasis on those that had updates. Although Risk Plans are available to staff in the home it was decided that placing them in the skills tracking books would allow for greater accessibility. (see attached Risk Management Plans for clients 2-6 with signature pages, and staff meeting agenda and signature page,Follow-up on Incidents and Investigations, Body Mechanics for Safe Lifting and Transferring).	
W 0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS			

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Bldg. 00	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 26 of 88 incident reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility neglected to implement its policies and procedures to prevent client to client abuse, conduct thorough investigations of client to client abuse, falls and injuries of unknown origin and ensure corrective action was taken to address client #2 and #4's falls. Findings include: On 1/5/16 at 1:13 PM, a review of the facility's incident reports was conducted and indicated the following: 1) On 1/24/15 at 5:30 PM, client #5 flipped backward in her wheelchair and hit her head on the floor. Client #5 was taken to the emergency room. Client #5 had a CAT (computerized axial tomography) scan and the results were normal. The 1/25/15 BDDS (Bureau of Developmental Disabilities Services) report indicated, "Prior to the incident, [client #5] was exhibiting no signs of anxiety/agitation. It is believed that the incident was attention seeking in nature... PCCS (Putnam County Comprehensive Services) staff will continue to monitor	W 0149	Residential Director met with QIDP and House Managers to review agency policies and procedures related to client protections. It was determined that although informal investigations were occurring via text and phone conversations with individuals present during an incident that evidence of such was not clearly identified in the Incident Reports. In the future the QIDP will utilize an “Follow-upon Incidents and Investigations” form (see attached) to provide a paper trail for all incidents of client to client aggression, falls, injuries of unknown origin, neglect and exploitation. This form will indicate safeguards that have been put into place and a summary of the investigation. Results will be submitted to the Executive Director within five days for all investigations involving suspected abuse, neglect, exploitation or injuries of unknown origin. Residential Director and Executive Director determined that until a new QA Director could be hired and trained that investigations will be completed by a Department Head or Coordinator from a program outside of the group homes. Risk plans for client #2 and 4 have been updated and staff has been trained. All Staff from the group home and adult services were	01/22/2016

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	[client #5] for any signs of a concussion...." There was no documentation the facility conducted an investigation. 2) On 1/28/15 at 1:20 PM, client #5 was walking with staff assistance using a gait belt at the facility-operated day program. The 1/29/15 BDDS report indicated, "[Client #5] currently needs staff's assistance walking to and from places per physical therapist from a previous incident. [Staff name] was walking with [client #5] from the restroom to the classroom, holding on to [client #5's] gait belt as they were walking...." Client #5 asked staff if she could do a craft activity. When client #5 was told she could not do the craft activity, she fell to the carpeted floor onto her knees and then laid flat on her stomach. Client #5 sustained two red spots on her left knee (one dime size and the other nickel size). There was no documentation the facility conducted an investigation to determine if the staff utilized client #5's gait belt in an appropriate manner to prevent her from falling. 3) On 2/5/15 at 8:55 AM, client #2 entered the facility-operated day program. Client #2 slipped on the concrete floor and fell onto her stomach. There was no documentation the facility conducted an		retrained on policy regarding abuse, neglect, exploitation and injuries of unknown origin. Training was provided to Adult Services staff on Thursday,January 21, 2016 while group home staff was trained on Friday January 22, 2016.(see attached Risk plans, staff meeting agenda and signature page, preventing falls, post fall assessment, fall tracking).	

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	investigation to ensure the staff implemented her plan as written for falls. On 1/6/16 at 11:14 AM, a review of client #2's record was conducted. Client #2's 10/8/15 Health Related Incident Management Plan indicated, in a section titled Physical Therapy, "On October 23, 2009, [client #2] experienced a mild stroke which resulted in partial paralysis on the right side of her body. She has limited mobility of her arm and leg. It was recommended by her cardiologist, [name], as well as her Neurologist, [name], that she receive physical therapy to help her regain mobility. While it is not expected that physical therapy will give her full use of her limbs, it is expected to improve her range of motion. Plan of Action: [Client #2] will continue to receive physical therapy as recommended by her physical therapist until it is no longer deemed necessary. Staff will verbally prompt as well as provide physical assistance when needed to ensure that she completes her physical therapy 5 times daily for approximately 10 minutes per session. [Client #2] also requires verbal prompting from staff to ensure that she is lifting her right leg up properly when walking and not allowing it to drag on the floor, creating a fall hazard."			

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	4) On 3/13/15 at 7:09 PM, client #4 was attempting to put her shower caddie on top of her dresser when she lost her balance and fell backward onto her buttocks. Client #4 was not injured. There was no documentation the facility conducted an investigation to ensure client #4 was using her walker at the time of the incident. On 1/6/16 at 11:53 AM, a review of client #4's record was conducted. Client #4's 11/5/15 Health Related Incident Management Plan indicated, "Due to extreme difficulties with walking, [client #4] was prescribed the use of a walker on July 9, 2010. It is the hope of her medical and residential staff that the ability to use a walker will not only provide assistance with walking, but it will also aid in correcting her back posture. Since implementing the use of a walker, [client #4's] ability to move about freely has improved dramatically. Although she still occasionally requires assistance from staff with walking, rarely does she require physical assistance. Plan of Action: [Client #4], staff, and PCCS are aware of [client #4's] difficulties with walking and are working hard to keep her on a healthy diet and fitness routine. [Client #4] will be expected to follow her exercise guidelines as recommended by her			

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	general physician, [name]. It is recommended that she walk for at least 30 minutes a day. Since implementation of the walker, [client #4] is better able to walk with occasional verbal prompting from staff, but she still requires physical assistance from staff when utilizing the stairs, entering or exiting a transportation vehicle, and from time to time with basic walking." 5) On 3/17/15 at 7:15 PM, client #5 was physically aggressive toward client #3. The 3/18/15 BDDS report indicated client #5 threw a pan at staff #4, hitting her in the leg. Client #5 threw the pan again but missed hitting staff #4. Client #5 picked up client #3's squirt bottle and squirted the contents all over client #3. Client #5 indicated she did this due to client #3 hitting her. The BDDS report indicated, "...she did not hit her and was on the other side of the counter." There was no documentation the facility conducted an investigation. 6) On 4/8/15 at 6:00 PM, client #4 was walking through the group home with her walker. Client #4 left her walker in the kitchen and started to walk toward the dining room when she fell down and hit her head on the wall between the kitchen and dining room. Client #4's right eye was bruised, her right cheek was scraped			

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	and bruised and she had a red scrape on her forehead. Client #4's right knee was swollen and slightly red. The BDDS report indicated, "[Staff #11] spoke with [client #4] following the incident, and [client #4] could not identify why she had fallen and stated that she did not know why she was not using her walker and that she must have just forgot about it... QIDP (Qualified Intellectual Disabilities Professional) spoke with [staff #11] while on the phone and reminded her that [client #4] needs to be utilizing her walker at all times, no matter how far she is walking - [staff #11] stated that she understood and stated what she would speak with [client #4]...." There was no documentation the facility conducted an investigation into client #4's fall with injury. 7) On 4/22/15 at 7:23 AM, client #5 tripped over a housemate's walker and fell to the floor. Client #5 was in the kitchen getting silverware. When she turned around to walk she tripped over her housemate's walker. The housemate was sitting on the walker at the time. Client #5 was not injured. The 4/22/15 BDDS report indicated, "[Client #5] has a fall risk plan that staff implemented correctly - [client #5] was just not paying attention at the time of the fall." There was no documentation the facility			

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	conducted an investigation to ensure client #5's risk plan for falls was implemented as written. On 1/6/16 at 10:33 AM, a focused review of client #5's record was conducted. Client #5's 10/8/15 Health Related Incident Management Plan indicated, "[Client #5] has had a few falls over the past year, mostly isolated to specific events, including, but not limited to, medication changes, carrying a blanket, and falling out of bed. Plan of Action: Staff will ensure to watch [client #5] following any medication changes and will assist her as needed with her walking. Staff will also ensure that [client #5] is not carrying anything that could cause her to trip and fall." 8) On 5/21/15 at 12:55 AM, client #5 was allegedly physically aggressive to client #1. The 5/21/15 BDDS report indicated, "[Staff #6] reports that [client #5] was in her bed after having just taken a shower due to nocturnal enuresis when at 12:55 AM, [staff #6] heard [client #1] yell for [staff #6]. [Staff #6] went back to her bedroom and [client #1] gestured to [staff #6] that [client #5] had put her hand on her chest while she was in bed - [staff #6] did not witness any physical aggression and [client #5] did not deny [client #1's] story...." The BDDS report			

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	indicated, "While completing [client #5's] shower prior to any incident, [staff #6] noted that [client #5] had a bruise on the left side of her stomach and on her left forearm approximately the size of 1.2 cm (centimeters) each - it is not known how she acquired the bruised areas, but [client #5] did drop to the floor and crawl on the floor several times the evening prior...." There was no documentation the facility conducted an investigation of the alleged client to client aggression. There was no documentation the facility conducted an investigation of client #5's injuries of unknown origin. 9) On 5/23/15 at 4:50 PM, client #5 was physically aggressive toward staff #5. Client #5 was restrained in an interim control position for 5 minutes and received a PRN (as needed) medication. After receiving the PRN, client #5 attempted to grab staff #2's arm. Client #5 was restrained in a single person baskethold for one minute. Following de-escalation, client #5 was checked for injuries. A one centimeter brownish color bruise was noted on the outside of her right wrist. The 5/26/15 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "When [client #5] was asked about if she knew how it occurred she stated that she did not know. It should be noted that [client			

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	#5] has a history of bruising very easily and has exhibited bruises by bumping into table on accident." There was no documentation the facility conducted an investigation for client #5's bruise. 10) On 5/27/15 at 10:50 AM, client #2 was joking with a peer at the facility operated workshop. Client #2 slapped the peer knocking his glasses to the floor. The peer was not injured. The 5/27/15 BDDS report indicated, "Staff [name] does not believe there was intent to harm...." The 5/27/15 Narrative/Behavior Report indicated, "[Client #2] slapped [peer's initials] open-handed. Was playing around - no intent." There was no documentation the facility conducted an investigation. 11) On 5/28/15 at 12:23 AM, client #5 ran toward the bedrooms after being prompted by staff #6 to lower her voice due to her roommate being asleep. Client #5 was redirected. Client #5 "charged" at staff #6. Staff #6 used a single person basket hold. Staff #6 received approval to administer a PRN to client #5. Client #5, after receiving the PRN, continued to be physically aggressive toward staff #6. After client #5 calmed down, a small dime size bruise was noted on client #5's left breast. The 5/28/15 Incident Follow-Up Report indicated, "The			

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	individual was restrained for 38 minutes. [Client #5's] plan addressed the single person basket hold and specifically states with the BSP (behavior support plan): 'Maintain restraint until de-escalation is observed including return to normal breathing and evidence of relaxation.'" The follow up report indicated, "It is unknown what caused the injury. However, [client #5] does have a history of bruising very easily...." There was no documentation the facility conducted an investigation to determine to origin of the bruise or ascertain if the bruise was caused by the restraint. 12) On 6/3/15 at 4:00 PM, client #4 got out of her chair and tripped on her shoelace. Client #4 hit the right side of her head, just above her ear, on a kitchen chair. Client #4 had a small knot approximately the size of a nickel just above her right ear. There was no documentation the facility conducted an investigation to ensure client #4's plan was implemented as written at the time of her fall. On 1/6/16 at 11:53 AM, a review of client #4's record was conducted. Client #4's 11/5/15 Health Related Incident Management Plan indicated, "Due to extreme difficulties with walking, [client #4] was prescribed the use of a walker on			

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	July 9, 2010. It is the hope of her medical and residential staff that the ability to use a walker will not only provide assistance with walking, but it will also aid in correcting her back posture. Since implementing the use of a walker, [client #4's] ability to move about freely has improved dramatically. Although she still occasionally requires assistance from staff with walking, rarely does she require physical assistance. Plan of Action: [Client #4], staff, and PCCS are aware of [client #4's] difficulties with walking and are working hard to keep her on a healthy diet and fitness routine. [Client #4] will be expected to follow her exercise guidelines as recommended by her general physician, [name]. It is recommended that she walk for at least 30 minutes a day. Since implementation of the walker, [client #4] is better able to walk with occasional verbal prompting from staff, but she still requires physical assistance from staff when utilizing the stairs, entering or exiting a transportation vehicle, and from time to time with basic walking." 13) On 6/4/15 at 7:47 AM, client #2 was cleaning off the dining room table following breakfast. Staff #6 walked into the kitchen to check on another client when she heard a bang. Staff #6 returned			

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	to the dining room and found client #2 sitting on the floor. Client #2 indicated she pulled out a chair and fell. Client #2 had a 2 centimeter bruise on her right buttock and a 3 centimeter bruise on her left buttock. There was no documentation the facility conducted an investigation or implemented corrective action to ensure client #2 did not fall again. On 1/6/16 at 11:14 AM, a review of client #2's record was conducted. Client #2's 10/8/15 Health Related Incident Management Plan indicated, in a section titled Physical Therapy, "On October 23, 2009, [client #2] experienced a mild stroke which resulted in partial paralysis on the right side of her body. She has limited mobility of her arm and leg. It was recommended by her cardiologist, [name], as well as her Neurologist, [name], that she receive physical therapy to help her regain mobility. While it is not expected that physical therapy will give her full use of her limbs, it is expected to improve her range of motion. Plan of Action: [Client #2] will continue to receive physical therapy as recommended by her physical therapist until it is no longer deemed necessary. Staff will verbally prompt as well as provide physical assistance when needed to ensure that she completes her physical			

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	therapy 5 times daily for approximately 10 minutes per session. [Client #2] also requires verbal prompting from staff to ensure that she is lifting her right leg up properly when walking and not allowing it to drag on the floor, creating a fall hazard." On 1/8/16 at 11:11 AM, the QIDP indicated it was an oversight on his part for not indicating the corrective action taken in the BDDS report. The QIDP indicated since she was pulling out a chair the plan addressed walking backward. The QIDP indicated he did not indicate the corrective action taken in the BDDS report which was the plan addressed walking backward. 14) On 6/18/15 at 8:30 AM, client #2 was in her bedroom getting ready for the morning while watching television. Staff #3 reported client #2 was walking backward and tripped over her own feet and fell onto the floor hitting her buttocks. Client #2 was not injured. There was no documentation the facility conducted an investigation into client #2's fall. On 1/6/16 at 11:14 AM, a review of client #2's record was conducted. Client #2's 10/8/15 Health Related Incident Management Plan indicated, in a section			

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	titled Physical Therapy, "On October 23, 2009, [client #2] experienced a mild stroke which resulted in partial paralysis on the right side of her body. She has limited mobility of her arm and leg. It was recommended by her cardiologist, [name], as well as her Neurologist, [name], that she receive physical therapy to help her regain mobility. While it is not expected that physical therapy will give her full use of her limbs, it is expected to improve her range of motion. Plan of Action: [Client #2] will continue to receive physical therapy as recommended by her physical therapist until it is no longer deemed necessary. Staff will verbally prompt as well as provide physical assistance when needed to ensure that she completes her physical therapy 5 times daily for approximately 10 minutes per session. [Client #2] also requires verbal prompting from staff to ensure that she is lifting her right leg up properly when walking and not allowing it to drag on the floor, creating a fall hazard." 15) On 6/19/15 at 7:55 AM, client #4 was kneeling on the floor gathering items to put in her bag. As she started to stand up she lost her balance and fell onto her right knee. The 6/19/15 BDDS report indicated, "...there was some redness approximately the size of a post it note on			

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	her right knee cap...." The BDDS report indicated, "[Client #4's] Risk Management Plan (RMP) addresses vertigo and falls - staff correctly followed [client #4's] RMP during this accident." There was no documentation the facility conducted an investigation. 16) On 6/24/15 at 6:34 AM, client #6 fell out of her wheelchair. Staff #3 indicated while a fire drill was being conducted, staff #3 was assisting client #6 in her manual wheelchair to exit the home. Staff #3 was pushing the wheelchair. When the wheelchair went from the concrete to the grass, client #6 fell forward into the grass. The 6/24/15 BDDS report indicated, "Upon going from the concrete to the grass, [client #6] fell forward into the grass - she remained in her wheelchair as there is a gait belt that is tied around her waist and the wheelchair." Client #6 was not injured. There was no documentation the facility conducted an investigation. 17) On 7/11/15 at 5:23 PM, client #5 lunged toward client #2 and grabbed client #2 with both hands around her neck. Staff #9 released client #5's hands from client #2's neck. Client #5 lunged toward client #2's body causing both clients to fall to the floor. Client #2 had a 3.5 inch long scratch on her right neck			

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	and shoulder area. There was no documentation the facility conducted an investigation. 18) On 7/30/15 at 3:45 AM, client #5 fell and hit her head on the closet door. Staff #6 indicated she was putting away cleaning supplies and went into client #5's bedroom and saw her sitting on the floor. Client #5 told staff #6 she got up to make her bed. Client #5 told staff #6 she fell and hit her head on the closet door. Client #5 was not injured. The 7/30/15 BDDS report indicated, "[Client #5] has a Fall Risk Management Plan and staff correctly followed the plan as she has been trained...." There was no documentation the facility conducted an investigation. On 1/6/16 at 1:33 PM, a review of client #5's 10/8/15 Health Related Incident Management Plan indicated she had a plan for falls. The plan indicated, "History/Current Status: [Client #5] has had a few falls over the past year, mostly isolated to specific events, including, but not limited to, medication changes, carrying a blanket, and falling out of bed. Plan of Action: Staff will ensure to watch [client #5] following any medication changes and will assist her as needed with her walking. Staff will also ensure that [client #5] is not carrying anything			

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	that could cause her to trip and fall." 19) On 8/24/15 at 8:00 AM, client #4 fell while attempting to sit on her walker seat. Staff #12 indicated client #4 walked into the living room and attempted to sit on her walker. Client #4 did not apply her brakes on the walker. Client #4 fell onto her buttocks. Client #4 was not injured. There was no documentation the facility conducted an investigation. On 1/6/16 at 11:53 AM, a review of client #4's record was conducted. Client #4's 11/5/15 Health Related Incident Management Plan indicated, "Due to extreme difficulties with walking, [client #4] was prescribed the use of a walker on July 9, 2010. It is the hope of her medical and residential staff that the ability to use a walker will not only provide assistance with walking, but it will also aid in correcting her back posture. Since implementing the use of a walker, [client #4's] ability to move about freely has improved dramatically. Although she still occasionally requires assistance from staff with walking, rarely does she require physical assistance. Plan of Action: [Client #4], staff, and PCCS are aware of [client #4's] difficulties with walking and are working hard to keep her on a healthy diet and fitness routine. [Client #4] will be			

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	expected to follow her exercise guidelines as recommended by her general physician, [name]. It is recommended that she walk for at least 30 minutes a day. Since implementation of the walker, [client #4] is better able to walk with occasional verbal prompting from staff, but she still requires physical assistance from staff when utilizing the stairs, entering or exiting a transportation vehicle, and from time to time with basic walking." 20) On 9/11/15 at 3:59 PM, client #4 fell while she was attempting to sit on the chair of her walker while at the bank. Staff #5 indicated client #4 was in line at the bank with staff and her peers when she attempted to sit on her walker. The walker moved backward and client #4 fell to the floor. The 9/12/15 BDDS report indicated, "[Client #4] did not lock the brake prior to attempting to sit down in the chair... [Client #4] was reminded of the importance of locking the wheels prior to sitting in the chair... Locking of the brake is addressed in [client #4's] Risk Management Plan... As a result of the incident, a wheel on the walker broke and [client #4] is unable to use the wheeled walker at this time... A formal goal will be created for [client #4] to lock the brake on her walker prior to sitting in the chair and will begin once [client #4]			

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	has another walker that has wheels and a chair - she is currently using a traditional walker without wheels or a chair...." Client #4 was not injured. There was no documentation the facility conducted an investigation. On 1/6/16 at 11:53 AM, a review of client #4's record was conducted. Client #4's 11/5/15 Health Related Incident Management Plan indicated, "Due to extreme difficulties with walking, [client #4] was prescribed the use of a walker on July 9, 2010. It is the hope of her medical and residential staff that the ability to use a walker will not only provide assistance with walking, but it will also aid in correcting her back posture. Since implementing the use of a walker, [client #4's] ability to move about freely has improved dramatically. Although she still occasionally requires assistance from staff with walking, rarely does she require physical assistance. Plan of Action: [Client #4], staff, and PCCS are aware of [client #4's] difficulties with walking and are working hard to keep her on a healthy diet and fitness routine. [Client #4] will be expected to follow her exercise guidelines as recommended by her general physician, [name]. It is recommended that she walk for at least 30 minutes a day. Since implementation			

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	of the walker, [client #4] is better able to walk with occasional verbal prompting from staff, but she still requires physical assistance from staff when utilizing the stairs, entering or exiting a transportation vehicle, and from time to time with basic walking." There was no documentation in client #4's Risk Management Plan indicating client #4 needed to lock the brake on her walker. Client #4's 11/5/15 Individual Support Plan did not include a formal goal for client #4 to lock the brakes on her walker prior to sitting in the chair. On 1/8/16 at 11:11 AM, the QIDP indicated there was no goal in place for client #4 to lock the brakes on her walker prior to sitting in the chair. The QIDP stated, "A goal was not created but it should have been. I should have created a goal." 21) On 9/13/15 at 1:38 AM, client #5 was physically aggressive toward client #1. The 9/13/15 BDDS report indicated, "[Staff #9] reports that [client #5] had just gotten up and used the restroom for the fifth time in 15 minutes and was in bed talking to herself when [client #1] told her to go to sleep. [Client #5] then got out of bed and went over to [client #1] and grabbed her left shoulder.			

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	Roommate yelled and came out of bedroom to get staff...." Client #1 was not injured. There was no documentation the facility conducted an investigation. 22) On 10/29/15 at 6:10 AM, client #5 fell out of her shower chair while taking a shower. Staff #6 indicated client #5 moved the seat too close to the faucet and while staff #6 was adjusting the seat back, the rubber cover on the foot came off and caused client #5 to fall backward onto her buttocks. Client #5 was not injured. There was no documentation the facility conducted an investigation. 23) On 11/10/15 at 2:30 AM, client #4 fell on her right knee while going to the restroom. Staff #6 indicated client #4 was walking with her walker down the hall to go to the restroom when her legs gave out. Client #4 had a scrape and a dime size bruise on her right knee. The 11/10/15 BDDS report indicated, "[Client #4] has a Risk Management Plan (RMP) that addresses falls/instability while walking and staff correctly followed the RMP at the time of the incident, as it was indicated that [client #4] was utilizing her prescribed walker at the time...." There was no documentation the facility conducted an investigation. 24) On 11/17/15 at 8:30 AM, client #2			

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	smacked client #5 on the shoulder and told her to get up when the group home van arrived at the day program. Client #5 was not injured. There was no documentation the facility conducted an investigation. 25) On 12/14/15 at 8:25 AM, client #4 was asked to wait prior to exiting the van. Client #4 did not wait and fell on her buttocks onto the top step. Client #4 was not injured. The 12/14/15 BDDS report indicated, "[Client #4] has a Risk Management Plan that addresses falls and staff correctly followed the plan...." There was no documentation the facility conducted an investigation. 26) On 12/19/15 at 10:12 AM, client #4 was sitting on the seat of her walker when she tipped backward and fell onto the floor. Staff #4 indicated client #4 was sitting on her walker looking out the window when she tipped backward and fell onto the floor. Client #4 was not injured. Staff #4 indicated at the time of the incident, client #4's brakes were not locked. The BDDS report indicated, "[Client #4] was counseled on the importance of locking her wheels if she is going to sit in the walker chair...." There was no documentation the facility conducted an investigation.			

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	On 1/6/16 at 9:28 AM, the Group Home Director (GHD) indicated client to client aggression was not considered abuse by the facility. The GHD indicated she attended the Surveyor Supervisor's training on conducting investigations and did not recall being trained client to client aggression was abuse and should be investigated. The GHD indicated the facility did not conduct investigations of client to client aggression. The GHD indicated the facility should prevent abuse of the clients. The GHD indicated the facility had a policy and procedure prohibiting abuse of the clients. On 1/6/16 at 9:37 AM, the GHD indicated the facility reviewed all the falls during the past 12 months. The GHD indicated the staff write an incident report, the QIDP follows up with the staff and notified the GHD. The GHD indicated the information compiled by the QIDP was included in the BDDS reports. The GHD indicated there was not a separate investigation conducted. On 1/6/16 at 9:44 AM, the GHD indicated injuries of unknown origin require full investigations. On 1/5/16 at 2:19 PM, the QIDP indicated for client to client aggression, the staff document the incident on an incident report and from their report, he submitted a BDDS report. The QIDP			

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	stated the facility conducted an "informal investigation." The QIDP indicated the facility did not conduct a formal investigation. The QIDP stated the facility, "Don't necessarily treat client to client as abuse." The QIDP stated, "Don't believe they mean to do harm. No intent to harm." The QIDP indicated the staff documenting the incident on an incident report was an investigation. The QIDP indicated the facility had not conducted any investigations of abuse, neglect and exploitation in the past 12 months. On 1/6/16 at 12:40 PM, the QIDP indicated there was no documentation he conducted an investigation of falls. The QIDP indicated there was no documentation of his interviews with staff after falls. The QIDP indicated after a fall, staff complete an incident report. The QIDP indicated the staff contacted him, he asked questions, informed the staff to complete an incident report, asked additional questions, notified his peers and superiors and then completed the BDDS reports. On 1/6/16 at 12:58 PM, the QIDP indicated one of client #5's injuries of unknown origin was attributed to a restraint the previous day. The QIDP indicated client #5 bruised easily. The QIDP indicated there was no documentation of formal investigations being conducted of client #5's injuries of unknown origin.			

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	On 1/5/16 at 1:12 PM, a review was conducted of the facility's January 2006 Individual Abuse and Neglect/Mistreatment Policy. The policy indicated the following, "PCCS shall prohibit any form of mistreatment, neglect or abuse, including physical, verbal, mental or sexual abuse. Any form of abuse, including but not limited to humiliation, harassment and threats of punishment or deprivation will not be tolerated." The policy indicated, "Any reports of such mistreatments, abuse or neglect shall be thoroughly investigated by the Investigation Committee, reviewed by the Executive Director and reported to the Human Rights Committee." The policy indicated, "Physical abuse includes, but not limited to, any physical motion or action, i.e., slapping, punching, kicking, pinching, by which intentional bodily harm or trauma occurs. It include the use of corporal punishment as well as the use of any restrictive, intrusive procedure to control challenging behaviors for purpose of punishment. Physical abuse also occurs when too much intentional force is used during restraint procedures." The January 2006 Abuse and Neglect policy indicated, "To insure that battery, neglect or exploitation of clients by staff members, other clientele or others will not be tolerated,			

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	15G274		01/11/2016

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	all alleged incidents will be immediately and thoroughly investigated...." 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 26 of 88 incident reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility failed to conduct thorough investigations of client to client abuse, injuries of unknown origin and falls. Findings include: On 1/5/16 at 1:13 PM, a review of the facility's incident reports was conducted and indicated the following: 1) On 1/24/15 at 5:30 PM, client #5 flipped backward in her wheelchair and hit her head on the floor. Client #5 was taken to the emergency room. Client #5 had a CAT (computerized axial tomography) scan and the results were normal. The 1/25/15 BDDS (Bureau of Developmental Disabilities Services) report indicated, "Prior to the incident, [client #5] was exhibiting no signs of	W 0154	Residential Director met with QIDP and House Managers to review agency policies and procedures related to client protections. It was determined that although informal investigations were occurring via text and phone conversations with individuals present during an incident that evidence of such was not clearly identified in the Incident Reports. In the future the QIDP and any other staff completing an investigation or follow-up on an incident will utilize a “Follow-up on Incidents and Investigations” form (see attached) to provide a paper trail for all incidents of client to client aggression, falls, injuries of unknown origin, neglect and exploitation. This form will indicate safeguards that have been put into place and a summary of the investigation. Results will be submitted to the Executive Director within five days for all investigations involving suspected	01/22/2016

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	anxiety/agitation. It is believed that the incident was attention seeking in nature... PCCS (Putnam County Comprehensive Services) staff will continue to monitor [client #5] for any signs of a concussion...." There was no documentation the facility conducted an investigation. 2) On 1/28/15 at 1:20 PM, client #5 was walking with staff assistance using a gait belt at the facility-operated day program. The 1/29/15 BDDS report indicated, "[Client #5] currently needs staff's assistance walking to and from places per physical therapist from a previous incident. [Staff name] was walking with [client #5] from the restroom to the classroom, holding on to [client #5's] gait belt as they were walking...." Client #5 asked staff if she could do a craft activity. When client #5 was told she could not do the craft activity, she fell to the carpeted floor onto her knees and then laid flat on her stomach. Client #5 sustained two red spots on her left knee (one dime size and the other nickel size). There was no documentation the facility conducted an investigation to determine if the staff utilized client #5's gait belt in an appropriate manner to prevent her from falling. 3) On 2/5/15 at 8:55 AM, client #2		abuse,neglect, exploitation or injuries of unknown origin. Residential Director and Executive Director determined that until a new QA Director could be hired and trained that investigations will be completed by a Department Head or Coordinator from a program outside of the group homes. Training was provided to those staff on Thursday, January 21, 2016. (see attached agenda).	

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	entered the facility-operated day program. Client #2 slipped on the concrete floor and fell onto her stomach. There was no documentation the facility conducted an investigation to ensure the staff implemented her plan as written for falls. On 1/6/16 at 11:14 AM, a review of client #2's record was conducted. Client #2's 10/8/15 Health Related Incident Management Plan indicated, in a section titled Physical Therapy, "On October 23, 2009, [client #2] experienced a mild stroke which resulted in partial paralysis on the right side of her body. She has limited mobility of her arm and leg. It was recommended by her cardiologist, [name], as well as her Neurologist, [name], that she receive physical therapy to help her regain mobility. While it is not expected that physical therapy will give her full use of her limbs, it is expected to improve her range of motion. **Plan of Action:** [Client #2] will continue to receive physical therapy as recommended by her physical therapist until it is no longer deemed necessary. Staff will verbally prompt as well as provide physical assistance when needed to ensure that she completes her physical therapy 5 times daily for approximately 10 minutes per session. [Client #2] also requires verbal prompting from staff to ensure that she is lifting her right leg up			

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	properly when walking and not allowing it to drag on the floor, creating a fall hazard." 4) On 3/13/15 at 7:09 PM, client #4 was attempting to put her shower caddie on top of her dresser when she lost her balance and fell backward onto her buttocks. Client #4 was not injured. There was no documentation the facility conducted an investigation to ensure client #4 was using her walker at the time of the incident. On 1/6/16 at 11:53 AM, a review of client #4's record was conducted. Client #4's 11/5/15 Health Related Incident Management Plan indicated, "Due to extreme difficulties with walking, [client #4] was prescribed the use of a walker on July 9, 2010. It is the hope of her medical and residential staff that the ability to use a walker will not only provide assistance with walking, but it will also aid in correcting her back posture. Since implementing the use of a walker, [client #4's] ability to move about freely has improved dramatically. Although she still occasionally requires assistance from staff with walking, rarely does she require physical assistance. Plan of Action: [Client #4], staff, and PCCS are aware of [client #4's] difficulties with walking and are working			

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	hard to keep her on a healthy diet and fitness routine. [Client #4] will be expected to follow her exercise guidelines as recommended by her general physician, [name]. It is recommended that she walk for at least 30 minutes a day. Since implementation of the walker, [client #4] is better able to walk with occasional verbal prompting from staff, but she still requires physical assistance from staff when utilizing the stairs, entering or exiting a transportation vehicle, and from time to time with basic walking." 5) On 3/17/15 at 7:15 PM, client #5 was physically aggressive toward client #3. The 3/18/15 BDDS report indicated client #5 threw a pan at staff #4, hitting her in the leg. Client #5 threw the pan again but missed hitting staff #4. Client #5 picked up client #3's squirt bottle and squirted the contents all over client #3. Client #5 indicated she did this due to client #3 hitting her. The BDDS report indicated, "...she did not hit her and was on the other side of the counter." There was no documentation the facility conducted an investigation. 6) On 4/8/15 at 6:00 PM, client #4 was walking through the group home with her walker. Client #4 left her walker in the kitchen and started to walk toward the			

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	dining room when she fell down and hit her head on the wall between the kitchen and dining room. Client #4's right eye was bruised, her right cheek was scraped and bruised and she had a red scrape on her forehead. Client #4's right knee was swollen and slightly red. The BDDS report indicated, "[Staff #11] spoke with [client #4] following the incident, and [client #4] could not identify why she had fallen and stated that she did not know why she was not using her walker and that she must have just forgot about it... QIDP (Qualified Intellectual Disabilities Professional) spoke with [staff #11] while on the phone and reminded her that [client #4] needs to be utilizing her walker at all times, no matter how far she is walking - [staff #11] stated that she understood and stated what she would speak with [client #4]...." There was no documentation the facility conducted an investigation into client #4's fall with injury. 7) On 4/22/15 at 7:23 AM, client #5 tripped over a housemate's walker and fell to the floor. Client #5 was in the kitchen getting silverware. When she turned around to walk she tripped over her housemate's walker. The housemate was sitting on the walker at the time. Client #5 was not injured. The 4/22/15 BDDS report indicated, "[Client #5] has a			

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	fall risk plan that staff implemented correctly - [client #5] was just not paying attention at the time of the fall." There was no documentation the facility conducted an investigation to ensure client #5's risk plan for falls was implemented as written. 8) On 5/21/15 at 12:55 AM, client #5 was allegedly physically aggressive to client #1. The 5/21/15 BDDS report indicated, "[Staff #6] reports that [client #5] was in her bed after having just taken a shower due to nocturnal enuresis when at 12:55 AM, [staff #6] heard [client #1] yell for [staff #6]. [Staff #6] went back to her bedroom and [client #1] gestured to [staff #6] that [client #5] had put her hand on her chest while she was in bed - [staff #6] did not witness any physical aggression and [client #5] did not deny [client #1's] story...." The BDDS report indicated, "While completing [client #5's] shower prior to any incident, [staff #6] noted that [client #5] had a bruise on the left side of her stomach and on her left forearm approximately the size of 1.2 cm (centimeters) each - it is not known how she acquired the bruised areas, but [client #5] did drop to the floor and crawl on the floor several times the evening prior...." There was no documentation the facility conducted an investigation of the alleged client to client aggression. There was no			

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	documentation the facility conducted an investigation of client #5's injuries of unknown origin. 9) On 5/23/15 at 4:50 PM, client #5 was physically aggressive toward staff #5. Client #5 was restrained in an interim control position for 5 minutes and received a PRN (as needed) medication. After receiving the PRN, client #5 attempted to grab staff #2's arm. Client #5 was restrained in a single person baskethold for one minute. Following de-escalation, client #5 was checked for injuries. A one centimeter brownish color bruise was noted on the outside of her right wrist. The 5/26/15 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "When [client #5] was asked about if she knew how it occurred she stated that she did not know. It should be noted that [client #5] has a history of bruising very easily and has exhibited bruises by bumping into table on accident." There was no documentation the facility conducted an investigation for client #5's bruise. 10) On 5/27/15 at 10:50 AM, client #2 was joking with a peer at the facility operated workshop. Client #2 slapped the peer knocking his glasses to the floor. The peer was not injured. The 5/27/15 BDDS report indicated, "Staff [name]			

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	does not believe there was intent to harm...." The 5/27/15 Narrative/Behavior Report indicated, "[Client #2] slapped [peer's initials] open-handed. Was playing around - no intent." There was no documentation the facility conducted an investigation. 11) On 5/28/15 at 12:23 AM, client #5 ran toward the bedrooms after being prompted by staff #6 to lower her voice due to her roommate being asleep. Client #5 was redirected. Client #5 "charged" at staff #6. Staff #6 used a single person basket hold. Staff #6 received approval to administer a PRN to client #5. Client #5, after receiving the PRN, continued to be physically aggressive toward staff #6. After client #5 calmed down, a small dime size bruise was noted on client #5's left breast. The 5/28/15 Incident Follow-Up Report indicated, "The individual was restrained for 38 minutes. [Client #5's] plan addressed the single person basket hold and specifically states with the BSP (behavior support plan): 'Maintain restraint until de-escalation is observed including return to normal breathing and evidence of relaxation.'" The follow up report indicated, "It is unknown what caused the injury. However, [client #5] does have a history of bruising very easily...." There was no documentation the facility conducted an			

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	investigation to determine to origin of the bruise or ascertain if the bruise was caused by the restraint. 12) On 6/3/15 at 4:00 PM, client #4 got out of her chair and tripped on her shoelace. Client #4 hit the right side of her head, just above her ear, on a kitchen chair. Client #4 had a small knot approximately the size of a nickel just above her right ear. There was no documentation the facility conducted an investigation to ensure client #4's plan was implemented as written at the time of her fall. On 1/6/16 at 11:53 AM, a review of client #4's record was conducted. Client #4's 11/5/15 Health Related Incident Management Plan indicated, "Due to extreme difficulties with walking, [client #4] was prescribed the use of a walker on July 9, 2010. It is the hope of her medical and residential staff that the ability to use a walker will not only provide assistance with walking, but it will also aid in correcting her back posture. Since implementing the use of a walker, [client #4's] ability to move about freely has improved dramatically. Although she still occasionally requires assistance from staff with walking, rarely does she require physical assistance. Plan of Action: [Client #4], staff, and			

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	PCCS are aware of [client #4's] difficulties with walking and are working hard to keep her on a healthy diet and fitness routine. [Client #4] will be expected to follow her exercise guidelines as recommended by her general physician, [name]. It is recommended that she walk for at least 30 minutes a day. Since implementation of the walker, [client #4] is better able to walk with occasional verbal prompting from staff, but she still requires physical assistance from staff when utilizing the stairs, entering or exiting a transportation vehicle, and from time to time with basic walking." 13) On 6/4/15 at 7:47 AM, client #2 was cleaning off the dining room table following breakfast. Staff #6 walked into the kitchen to check on another client when she heard a bang. Staff #6 returned to the dining room and found client #2 sitting on the floor. Client #2 indicated she pulled out a chair and fell. Client #2 had a 2 centimeter bruise on her right buttock and a 3 centimeter bruise on her left buttock. There was no documentation the facility conducted an investigation. 14) On 6/18/15 at 8:30 AM, client #2 was in her bedroom getting ready for the morning while watching television. Staff			

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	#3 reported client #2 was walking backward and tripped over her own feet and fell onto the floor hitting her buttocks. Client #2 was not injured. There was no documentation the facility conducted an investigation into client #2's fall. 15) On 6/19/15 at 7:55 AM, client #4 was kneeling on the floor gathering items to put in her bag. As she started to stand up she lost her balance and fell onto her right knee. The 6/19/15 BDDS report indicated, "...there was some redness approximately the size of a post it note on her right knee cap...." The BDDS report indicated, "[Client #4's] Risk Management Plan (RMP) addresses vertigo and falls - staff correctly followed [client #4's] RMP during this accident." There was no documentation the facility conducted an investigation. 16) On 6/24/15 at 6:34 AM, client #6 fell out of her wheelchair. Staff #3 indicated while a fire drill was being conducted, staff #3 was assisting client #6 in her manual wheelchair to exit the home. Staff #3 was pushing the wheelchair. When the wheelchair went from the concrete to the grass, client #6 fell forward into the grass. The 6/24/15 BDDS report indicated, "Upon going from the concrete to the grass, [client #6]			

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	fell forward into the grass - she remained in her wheelchair as there is a gait belt that is tied around her waist and the wheelchair." Client #6 was not injured. There was no documentation the facility conducted an investigation. 17) On 7/11/15 at 5:23 PM, client #5 lunged toward client #2 and grabbed client #2 with both hands around her neck. Staff #9 released client #5's hands from client #2's neck. Client #5 lunged toward client #2's body causing both clients to fall to the floor. Client #2 had a 3.5 inch long scratch on her right neck and shoulder area. There was no documentation the facility conducted an investigation. 18) On 7/30/15 at 3:45 AM, client #5 fell and hit her head on the closet door. Staff #6 indicated she was putting away cleaning supplies and went into client #5's bedroom and saw her sitting on the floor. Client #5 told staff #6 she got up to make her bed. Client #5 told staff #6 she fell and hit her head on the closet door. Client #5 was not injured. The 7/30/15 BDDS report indicated, "[Client #5] has a Fall Risk Management Plan and staff correctly followed the plan as she has been trained...." There was no documentation the facility conducted an investigation.			

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	On 1/6/16 at 1:33 PM, a review of client #5's 10/8/15 Health Related Incident Management Plan indicated she had a plan for falls. The plan indicated, "History/Current Status: [Client #5] has had a few falls over the past year, mostly isolated to specific events, including, but not limited to, medication changes, carrying a blanket, and falling out of bed. Plan of Action: Staff will ensure to watch [client #5] following any medication changes and will assist her as needed with her walking. Staff will also ensure that [client #5] is not carrying anything that could cause her to trip and fall." 19) On 8/24/15 at 8:00 AM, client #4 fell while attempting to sit on her walker seat. Staff #12 indicated client #4 walked into the living room and attempted to sit on her walker. Client #4 did not apply her brakes on the walker. Client #4 fell onto her buttocks. Client #4 was not injured. There was no documentation the facility conducted an investigation. 20) On 9/11/15 at 3:59 PM, client #4 fell while she was attempting to sit on the chair of her walker while at the bank. Staff #5 indicated client #4 was in line at the bank with staff and her peers when she attempted to sit on her walker. The walker moved backward and client #4			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUTNAM COUNTY COMPREHENSIVE SERVICES INC	1222 BLOOMINGTON GREENCASTLE, IN 46135

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	fell to the floor. The 9/12/15 BDDS report indicated, "[Client #4] did not lock the brake prior to attempting to sit down in the chair... [Client #4] was reminded of the importance of locking the wheels prior to sitting in the chair... Locking of the brake is addressed in [client #4's] Risk Management Plan... As a result of the incident, a wheel on the walker broke and [client #4] is unable to use the wheeled walker at this time... A formal goal will be created for [client #4] to lock the brake on her walker prior to sitting in the chair and will begin once [client #4] has another walker that has wheels and a chair - she is currently using a traditional walker without wheels or a chair...." Client #4 was not injured. There was no documentation the facility conducted an investigation. On 1/6/16 at 11:53 AM, a review of client #4's record was conducted. Client #4's 11/5/15 Health Related Incident Management Plan indicated, "Due to extreme difficulties with walking, [client #4] was prescribed the use of a walker on July 9, 2010. It is the hope of her medical and residential staff that the ability to use a walker will not only provide assistance with walking, but it will also aid in correcting her back posture. Since implementing the use of a walker, [client #4's] ability to move about			

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	freely has improved dramatically. Although she still occasionally requires assistance from staff with walking, rarely does she require physical assistance. Plan of Action: [Client #4], staff, and PCCS are aware of [client #4's] difficulties with walking and are working hard to keep her on a healthy diet and fitness routine. [Client #4] will be expected to follow her exercise guidelines as recommended by her general physician, [name]. It is recommended that she walk for at least 30 minutes a day. Since implementation of the walker, [client #4] is better able to walk with occasional verbal prompting from staff, but she still requires physical assistance from staff when utilizing the stairs, entering or exiting a transportation vehicle, and from time to time with basic walking." There was no documentation in client #4's Risk Management Plan indicating client #4 needed to lock the brake on her walker. Client #4's 11/5/15 Individual Support Plan did not include a formal goal for client #4 to lock the brakes on her walker prior to sitting in the chair. 21) On 9/13/15 at 1:38 AM, client #5 was physically aggressive toward client #1. The 9/13/15 BDDS report indicated, "[Staff #9] reports that [client #5] had			

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	just gotten up and used the restroom for the fifth time in 15 minutes and was in bed talking to herself when [client #1] told her to go to sleep. [Client #5] then got out of bed and went over to [client #1] and grabbed her left shoulder. Roommate yelled and came out of bedroom to get staff...." Client #1 was not injured. There was no documentation the facility conducted an investigation. 22) On 10/29/15 at 6:10 AM, client #5 fell out of her shower chair while taking a shower. Staff #6 indicated client #5 moved the seat too close to the faucet and while staff #6 was adjusting the seat back, the rubber cover on the foot came off and caused client #5 to fall backward onto her buttocks. Client #5 was not injured. There was no documentation the facility conducted an investigation. 23) On 11/10/15 at 2:30 AM, client #4 fell on her right knee while going to the restroom. Staff #6 indicated client #4 was walking with her walker down the hall to go to the restroom when her legs gave out. Client #4 had a scrape and a dime size bruise on her right knee. The 11/10/15 BDDS report indicated, "[Client #4] has a Risk Management Plan (RMP) that addresses falls/instability while walking and staff correctly followed the RMP at the time of the incident, as it was			

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	indicated that [client #4] was utilizing her prescribed walker at the time...." There was no documentation the facility conducted an investigation. 24) On 11/17/15 at 8:30 AM, client #2 smacked client #5 on the shoulder and told her to get up when the group home van arrived at the day program. Client #5 was not injured. There was no documentation the facility conducted an investigation. 25) On 12/14/15 at 8:25 AM, client #4 was asked to wait prior to exiting the van. Client #4 did not wait and fell on her buttocks onto the top step. Client #4 was not injured. The 12/14/15 BDDS report indicated, "[Client #4] has a Risk Management Plan that addresses falls and staff correctly followed the plan...." There was no documentation the facility conducted an investigation. 26) On 12/19/15 at 10:12 AM, client #4 was sitting on the seat of her walker when she tipped backward and fell onto the floor. Staff #4 indicated client #4 was sitting on her walker looking out the window when she tipped backward and fell onto the floor. Client #4 was not injured. Staff #4 indicated at the time of the incident, client #4's brakes were not locked. The BDDS report indicated,			

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	"[Client #4] was counseled on the importance of locking her wheels if she is going to sit in the walker chair...." There was no documentation the facility conducted an investigation. On 1/6/16 at 9:28 AM, the Group Home Director (GHD) indicated she attended the Surveyor Supervisor's training on conducting investigations and did not recall being trained client to client aggression was abuse and should be investigated. The GHD indicated the facility did not conduct investigations of client to client aggression. On 1/6/16 at 9:37 AM, the GHD indicated the facility reviewed all the falls during the past 12 months. The GHD indicated the staff write an incident report, the QIDP follows up with the staff and notified the GHD. The GHD indicated the information compiled by the QIDP was included in the BDDS reports. The GHD indicated there was not a separate investigation conducted. On 1/6/16 at 9:44 AM, the GHD indicated injuries of unknown origin require full investigations. On 1/5/16 at 2:19 PM, the QIDP indicated for client to client aggression, the staff document the incident on an incident report and from their report, he submitted a BDDS report. The QIDP			

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	stated the facility conducted an "informal investigation." The QIDP indicated the facility did not conduct a formal investigation. The QIDP stated the facility, "Don't necessarily treat client to client as abuse." The QIDP stated, "Don't believe they mean to do harm. No intent to harm." The QIDP indicated the staff documenting the incident on an incident report was an investigation. The QIDP indicated the facility had not conducted any investigations of abuse, neglect and exploitation in the past 12 months. On 1/6/16 at 12:40 PM, the QIDP indicated there was no documentation he conducted an investigation of falls. The QIDP indicated there was no documentation of his interviews with staff after falls. The QIDP indicated after a fall, staff complete an incident report. The QIDP indicated the staff contacted him, he asked questions, informed the staff to complete an incident report, asked additional questions, notified his peers and superiors and then completed the BDDS reports. On 1/6/16 at 12:58 PM, the QIDP indicated one of client #5's injuries of unknown origin was attributed to a restraint the previous day. The QIDP indicated client #5 bruised easily. The QIDP indicated there was no documentation of formal investigations being conducted of client #5's injuries of unknown origin.			

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	9-3-2(a)			
W 0157 Bldg. 00	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 2 of 88 incident reports reviewed affecting clients #2 and #4, the facility failed to ensure corrective action was implemented to address the clients' falls. Findings include: On 1/5/16 at 1:13 PM, a review of the facility's incident reports was conducted and indicated the following: 1) On 6/4/15 at 7:47 AM, client #2 was cleaning off the dining room table following breakfast. Staff #6 walked into the kitchen to check on another client when she heard a bang. Staff #6 returned to the dining room and found client #2 sitting on the floor. Client #2 indicated she pulled out a chair and fell. Client #2 had a 2 centimeter bruise on her right buttock and a 3 centimeter bruise on her left buttock. There was no documentation the facility implemented corrective action to ensure client #2 did	W 0157	Residential Director met with QIDP and House Managers to review agency policies and procedures related to client protections. It was determined that although informal investigations were occurring via text and phone conversations with individuals present during an incident that evidence of such was not clearly identified in the Incident Reports. In the future the QIDP and any other staff completing an investigation or follow-up on an incident will utilize a“Follow-up on Incidents and Investigations” form (see attached) to provide a paper trail for all incidents of client to client aggression, falls, injuries of unknown origin, neglect and exploitation. This form will indicate safeguards that have been put into place and a summary of the investigation. Results will be submitted to the Executive Director within five days for all investigations involving suspected abuse, neglect, exploitation or injuries of unknown origin. Residential	01/22/2016

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	not fall again. On 1/6/16 at 11:14 AM, a review of client #2's record was conducted. Client #2's 10/8/15 Health Related Incident Management Plan indicated, in a section titled Physical Therapy, "On October 23, 2009, [client #2] experienced a mild stroke which resulted in partial paralysis on the right side of her body. She has limited mobility of her arm and leg. It was recommended by her cardiologist, [name], as well as her Neurologist, [name], that she receive physical therapy to help her regain mobility. While it is not expected that physical therapy will give her full use of her limbs, it is expected to improve her range of motion. Plan of Action: [Client #2] will continue to receive physical therapy as recommended by her physical therapist until it is no longer deemed necessary. Staff will verbally prompt as well as provide physical assistance when needed to ensure that she completes her physical therapy 5 times daily for approximately 10 minutes per session. [Client #2] also requires verbal prompting from staff to ensure that she is lifting her right leg up properly when walking and not allowing it to drag on the floor, creating a fall hazard." On 1/8/16 at 11:11 AM, the QIDP		Director and Executive Director determined that until a new QA Director could be hired and trained that investigations will be completed by a Department Head or Coordinator from a program outside of the group homes. Training was provided to those staff on Thursday, January 21, 2016. (see attached agenda). In order to ensure that the identified corrective action has been put into place evidence of the correction i.e. revisions to plans, new goals, staff disciplinary action or termination etc. is to be attached to the Investigation results when submitted to Executive Director. In this particular case the Risk Plans were updated, fall prevention training was provided, fall tracking was implemented, post fall assessment form implemented. All staff trained on the revised Risk Plans, fall tracking and post fall assessment. (see attached revised Risk Plans, fall prevention, fall tracking, post fall assessment, Staff meeting Agenda and signature page)	

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	indicated it was an oversight on his part for not indicating the corrective action taken in the BDDS report. The QIDP indicated since she was pulling out a chair the plan addressed walking backward. The QIDP indicated he did not indicate the corrective action taken in the BDDS report which was the plan addressed walking backward. 2) On 9/11/15 at 3:59 PM, client #4 fell while she was attempting to sit on the chair of her walker while at the bank. Staff #5 indicated client #4 was in line at the bank with staff and her peers when she attempted to sit on her walker. The walker moved backward and client #4 fell to the floor. The 9/12/15 BDDS report indicated, "[Client #4] did not lock the brake prior to attempting to sit down in the chair... [Client #4] was reminded of the importance of locking the wheels prior to sitting in the chair... Locking of the brake is addressed in [client #4's] Risk Management Plan... As a result of the incident, a wheel on the walker broke and [client #4] is unable to use the wheeled walker at this time... A formal goal will be created for [client #4] to lock the brake on her walker prior to sitting in the chair and will begin once [client #4] has another walker that has wheels and a chair - she is currently using a traditional walker without wheels or a chair...."			

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	Client #4 was not injured. On 1/6/16 at 11:53 AM, a review of client #4's record was conducted. Client #4's 11/5/15 Health Related Incident Management Plan indicated, "Due to extreme difficulties with walking, [client #4] was prescribed the use of a walker on July 9, 2010. It is the hope of her medical and residential staff that the ability to use a walker will not only provide assistance with walking, but it will also aid in correcting her back posture. Since implementing the use of a walker, [client #4's] ability to move about freely has improved dramatically. Although she still occasionally requires assistance from staff with walking, rarely does she require physical assistance. Plan of Action: [Client #4], staff, and PCCS are aware of [client #4's] difficulties with walking and are working hard to keep her on a healthy diet and fitness routine. [Client #4] will be expected to follow her exercise guidelines as recommended by her general physician, [name]. It is recommended that she walk for at least 30 minutes a day. Since implementation of the walker, [client #4] is better able to walk with occasional verbal prompting from staff, but she still requires physical assistance from staff when utilizing the stairs, entering or exiting a transportation			

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	vehicle, and from time to time with basic walking." There was no documentation in client #4's Risk Management Plan indicating client #4 needed to lock the brake on her walker. Client #4's 11/5/15 Individual Support Plan did not include a formal goal for client #4 to lock the brakes on her walker prior to sitting in the chair. On 1/8/16 at 11:11 AM, the QIDP indicated there was no goal in place for client #4 to lock the brakes on her walker prior to sitting in the chair. The QIDP stated, "A goal was not created but it should have been. I should have created a goal." 9-3-2(a)			
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 of 3 clients in the sample (#4), the facility failed to ensure client #4's Individual Support Plan included a formal goal to lock her brakes prior to sitting on her walker.	W 0227	Residential Director met with QIDP and House Managers to review agency policies and procedures related to client protections specifically corrective action to prevent reoccurrence. Although informal investigations	01/22/2016

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	Findings include: On 1/6/16 from 6:19 AM to 8:21 AM, an observation was conducted at the group home. At 7:13 AM, client #4 was coughing during breakfast. Client #4 got up and walked from the dining room to the restroom without the use of her walker. Staff #3, #6 and #7 were sitting at the dining room table and did not prompt client #4 to use her walker. Client #4's walker was in the living room. Client #4 returned to the table a minute later and walked from the restroom to the dining room table without using her walker. Staff #3, #6 and #7 did not prompt client #4 to use her walker. On 1/5/16 at 1:13 PM, a review of the facility's incident reports was conducted and indicated the following: 1) On 8/24/15 at 8:00 AM, client #4 fell while attempting to sit on her walker seat. Staff #12 indicated client #4 walked into the living room and attempted to sit on her walker. Client #4 did not apply her brakes on the walker. Client #4 fell onto her buttocks. Client #4 was not injured. The 8/24/15 Bureau of Developmental Disabilities Services (BDDS) Incident Report indicated, "The team believes that this is an isolated incident and that no		and corrective actions were identified there was not a mechanism to ensure the corrective action was completed. In the future the QIDP and any other staff completing an investigation or follow-up on an incident will utilize a “Follow-up on Incidents and Investigations” form (see attached) to provide a paper trail for all incidents requiring an investigation. In order to ensure that the identified corrective action has been put into place evidence of the correction i.e. revisions to plans, new goals, staff disciplinary action or termination etc. is to be attached to the Investigation results when submitted to Executive Director. Training was provided to staff responsible for completing investigations January 21, 2016. A review of all six clients program plans was conducted including, Risk Management Plans, IPPs and ISP as well as Quarterly Case Conference Notes to address all areas of client’s needs. Updates were completed for five of six clients Risk Management Plans. Client #4’s Risk Management Plan has been revised to address use of the walker, as well as specifically addressing the use of the brakes. In addition two formal goals were developed to address use of the brakes when walker is not in use and another goal to address locking the brakes on the walker prior to sitting in the walker chair.	

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	changes need to be made to [client #4's] Risk Management Plan as a result of the fall." 2) On 9/11/15 at 3:59 PM, client #4 fell while she was attempting to sit on the chair of her walker while at the bank. Staff #5 indicated client #4 was in line at the bank with staff and her peers when she attempted to sit on her walker. The walker moved backward and client #4 fell to the floor. The 9/12/15 BDDS report indicated, "[Client #4] did not lock the brake prior to attempting to sit down in the chair... [Client #4] was reminded of the importance of locking the wheels prior to sitting in the chair... Locking of the brake is addressed in [client #4's] Risk Management Plan... As a result of the incident, a wheel on the walker broke and [client #4] is unable to use the wheeled walker at this time... A formal goal will be created for [client #4] to lock the brake on her walker prior to sitting in the chair and will begin once [client #4] has another walker that has wheels and a chair - she is currently using a traditional walker without wheels or a chair...." Client #4 was not injured. 3) On 12/19/15 at 10:12 AM, client #4 was sitting on the seat of her walker when she tipped backward and fell onto the floor. Staff #4 indicated client #4		The continuation, revision,advancement, completion, or termination of this goal will be discussed at client #4's quarterly meeting and an analysis of the goal will be conducted monthly in the Q-Notes. Staff was provided training at the staff meeting on Friday, January 22, 2016. In the future QIDP will develop and implement training objectives for any type of new equipment prescribed for a consumer as the IDT deems necessary or as concerns are identified. (see attached goals for client #4 and staff meeting agenda).	

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	was sitting on her walker looking out the window when she tipped backward and fell onto the floor. Client #4 was not injured. The 12/19/15 BDDS report indicated, "...Looking further into what had happened, [staff #4] noticed that the wheels on her walker were not locked which caused the fall. [Client #4] was counseled on the importance of locking her wheels if she is going to sit in the walker chair...." On 1/6/16 at 11:53 AM, a review of client #4's record was conducted. Client #4's 11/5/15 Health Related Incident Management Plan indicated, "History/Current Status: Due to extreme difficulties with walking, [client #4] was prescribed the use of a walker on July 9, 2010. It is the hope of her medical and residential staff that the ability to use a walker will not only provide assistance with walking, but it will also aid in correcting her back posture. Since implementing the use of a walker, [client #4's] ability to move about freely has improved dramatically. Although she still occasionally requires assistance from staff with walking, rarely does she require physical assistance. Plan of Action: [Client #4], staff, and PCCS (Putnam County Comprehensive Services) are aware of [client #4's] difficulties with walking and are working			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2016

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PUTNAM COUNTY COMPREHENSIVE SERVICES INC	1222 BLOOMINGTON GREENCASTLE, IN 46135

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	hard to keep her on a healthy diet and fitness routine. [Client #4] will be expected to follow her exercise guidelines as recommended by her general physician, [name of physician]. It is recommended that she walk for at least 30 minutes a day. Since implementation of the walker, [client #4] is better able to walk with occasional verbal prompting from staff, but she still requires physical assistance from staff when utilizing the stairs, entering or exiting a transportation vehicle, and from time to time with basic walking." There was no documentation in client #4's Risk Management Plan indicating client #4 needed to lock the brake on her walker. Client #4's 11/5/15 Individual Support Plan did not include a formal goal for client #4 to lock the brakes on her walker prior to sitting in the chair. The Health Related Incident Management Plan did not indicate if client #4 was to use the walker at all times. The plan did not indicate client #4 was to be redirected and encouraged to use her walker at all times. The plan did not indicate whether or not it was acceptable for client #4 to walk without the use of her walker. The plan did not indicate client #4's walker's brakes should be locked when the walker was not in use.			

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	On 1/6/16 at 12:40 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #4 was supposed to use her walker at all times. The QIDP indicated client #4 should have the walker with her and the staff should encourage the use of her walker. The QIDP indicated client #4 had several falls over the past 12 months. The QIDP indicated some of the falls were due to the brakes not being locked on the walker and when she tried to use it, the walker moved. The QIDP indicated the staff remind her to lock the brakes. The QIDP stated, "presents a safety danger when she doesn't lock (the brakes)." The QIDP indicated the plan did not include staff should encourage the use of the walker and locking the walker's brakes. On 1/8/16 at 11:11 AM, the QIDP indicated there was no goal in place for client #4 to lock the brakes on her walker prior to sitting in the chair. The QIDP stated, "A goal was not created but it should have been. I should have created a goal." On 1/8/16 at 1:27 PM, the QIDP indicated he previously indicated client #4 needed to use her walker at all times. The QIDP indicated after reviewing the plan and her orders, the walker was needed PRN (as needed). The QIDP indicated client #4's plan should indicate the use of the walker was PRN. The QIDP indicated it was			

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	client #4's choice to use the walker or not. The QIDP indicated client #4 ambulated better with the walker. On 1/8/16 at 1:29 PM, the Group Home Director (GHD) indicated there was no medical order for client #4 to use her walker at all times. The GHD stated, "It's her choice." 9-3-4(a)			
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 1 of 3 sampled clients (#4) and one additional client (#3), the facility failed to ensure: 1) client #4's plan indicated when client #4 was to use her walker, if client #4 was to be redirected and encouraged to use her walker at all times, whether or not it was acceptable for client #4 to walk without the use of her walker, and client #4's walker's brakes should be locked when the walker was not in use and 2) client #3's plan indicated the transfer method staff was to use to assist her during transfers. Findings include:	W 0240	Although client files included information regarding relevant interventions to support the individual toward independence that information was not consistently carried over into the Individual Program Plan of which the Risk Management Plan is a component of. The Residential Director and QIDP met and discussed the importance of pulling all pertinent information into a single location and at times providing clarification so as to assist staff with providing the appropriate level of care. In order to accomplish that goal all consumer files have been reviewed and the IPP's have been updated where necessary.	01/22/2016

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	1) On 1/5/16 at 3:14 PM, a review of the facility's evacuation drills was conducted and indicated the following: On 11/22/15 at 6:05 AM, the evacuation drill was conducted with one staff. The Evacuation Drill Roster indicated client #3 was in bed asleep at the start of the drill. The form indicated, "...carried [client #3] out of house...." On 1/6/16 at 10:33 AM, a focused review of client #3's record was conducted. Client #3's 11/5/15 Individual Support Plan indicated in her goal to use a walker, "Staff will assist [client #3] in getting into her walker... Staff will assist [client #3] in transferring back to her chair." Client #3's 11/5/15 Individual Program Plan indicated, "[Client #3] is non-ambulatory. She cannot raise herself to a sitting position and remain unsupported for any length of time. She cannot crawl across the floor on hands and knees without her stomach touching the floor. She is able to provide some assistance to staff with dressing and repositioning by moving her body accordingly, but she cannot complete these tasks on her own. She cannot transfer herself from her chair to another area without assistance. [Client #3] does utilize a Power Wheelchair to get from place to place... [Client #3] needs		Specifically,Client #4's Risk Management Plan and IPP has been updated to include when she is to use her walker, when staff are to encourage use of the walker, whether she can walk without the use of her walker, and when the walker brakes need to be utilized. Client's #3 & 6 Risk Management Plan and IPP has been updated to include acceptable transfer methods that staff may utilize when completing transfers. Clients 2, 4 and 5 have had updates to their Risk Management Plans to provide clarification in regards to falls. In addition the fire evacuation plan has been updated to include special provisions regarding evacuation of Client 3. (See attached IPPS and Risk Management Plans for clients 2,3,4,5, and 6, and revised Fire Evacuation Plan with updated special provisions.) All existing staff will be trained on Friday January 22,2016 new hires will be trained prior to assuming their job duties.	

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	assistance when transferring from her chair... She cannot transfer into a tub or stand in a shower without assistance... Staff will transfer [client #3] into the shower chair... She completely requires the assistance of staff to transfer from her chair to the toilet chair...." Client #3's 11/5/15 Health Related Incident Management Plan indicated, in part, "[Client #3] was diagnosed with spasmodic quadriplegic cerebral palsy at approximately 6 months of age. As a result of [client #3's] cerebral palsy, she is unable to walk and has limited control over her movements. She must rely on staff for physical assistance to complete all of her daily living skills. She has a power wheelchair to assist in her mobility and a communication device to communicate her wants and needs. Plan of Action: [Client #3] will continue to receive the assistance she needs from staff to support her healthcare needs in regards to her Cerebral Palsy, which includes physical assistance in all repositioning throughout the day, bathing, grooming, dressing, toileting, ROM (range of motion) exercises, eating, and all aspects of transportation... As a result of [client #3's] cerebral palsy, she is unable to walk and has limited control over her movements. She must rely on staff for physical assistance to complete all of her daily living skills."			

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	There was no documentation in client #3's record indicating the number of staff required to assist her during transfers. On 1/8/16 at 11:11 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #3's Individual Program Plan addressed the need for a two person transfer. The QIDP stated, "All staff informed that [client #3] is a two man transfer." The QIDP indicated client #3's plan should indicate she was a two person transfer. The QIDP stated, "She is to require two people when transferring." On 1/8/16 at 1:27 PM, the QIDP indicated there was no plan for a two person transfer. The QIDP indicated the use of a one person or two person transfer was at the discretion of the staff. The QIDP indicated it was best practice for two staff to assist client #3 during transfers but not necessary. The QIDP indicated the plan needed to include this information. On 1/8/16 at 1:29 PM, the Group Home Director (GHD) indicated the best practice was a two person transfer. The GHD indicated there was no medical order or directive for the use of a two person transfer. The GHD indicated a two person transfer was best practice but not a requirement. The GHD indicated			

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	the plan needed to indicate the use of a one or two person transfer. 2) On 1/6/16 from 6:19 AM to 8:21 AM, an observation was conducted at the group home. At 7:13 AM, client #4 was coughing during breakfast. Client #4 got up and walked from the dining room to the restroom without the use of her walker. Staff #3, #6 and #7 were sitting at the dining room table and did not prompt client #4 to use her walker. Client #4's walker was in the living room. Client #4 returned to the table a minute later and walked from the restroom to the dining room table without using her walker. Staff #3, #6 and #7 did not prompt client #4 to use her walker. On 1/5/16 at 1:13 PM, a review of the facility's incident reports was conducted and indicated the following: a) On 8/24/15 at 8:00 AM, client #4 fell while attempting to sit on her walker seat. Staff #12 indicated client #4 walked into the living room and attempted to sit on her walker. Client #4 did not apply her brakes on the walker. Client #4 fell onto her buttocks. Client #4 was not injured. The 8/24/15 Bureau of Developmental Disabilities Services (BDDS) Incident Report indicated, "The team believes that this is an isolated incident and that no			

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	changes need to be made to [client #4's] Risk Management Plan as a result of the fall." b) On 9/11/15 at 3:59 PM, client #4 fell while she was attempting to sit on the chair of her walker while at the bank. Staff #5 indicated client #4 was in line at the bank with staff and her peers when she attempted to sit on her walker. The walker moved backward and client #4 fell to the floor. The 9/12/15 BDDS report indicated, "[Client #4] did not lock the brake prior to attempting to sit down in the chair... [Client #4] was reminded of the importance of locking the wheels prior to sitting in the chair... Locking of the brake is addressed in [client #4's] Risk Management Plan... As a result of the incident, a wheel on the walker broke and [client #4] is unable to use the wheeled walker at this time... A formal goal will be created for [client #4] to lock the brake on her walker prior to sitting in the chair and will begin once [client #4] has another walker that has wheels and a chair - she is currently using a traditional walker without wheels or a chair...." Client #4 was not injured. c) On 12/19/15 at 10:12 AM, client #4 was sitting on the seat of her walker when she tipped backward and fell onto the floor. Staff #4 indicated client #4			

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	was sitting on her walker looking out the window when she tipped backward and fell onto the floor. Client #4 was not injured. The 12/19/15 BDDS report indicated, "...Looking further into what had happened, [staff #4] noticed that the wheels on her walker were not locked which caused the fall. [Client #4] was counseled on the importance of locking her wheels if she is going to sit in the walker chair...." On 1/6/16 at 11:53 AM, a review of client #4's record was conducted. Client #4's 11/5/15 Health Related Incident Management Plan indicated, "History/Current Status: Due to extreme difficulties with walking, [client #4] was prescribed the use of a walker on July 9, 2010. It is the hope of her medical and residential staff that the ability to use a walker will not only provide assistance with walking, but it will also aid in correcting her back posture. Since implementing the use of a walker, [client #4's] ability to move about freely has improved dramatically. Although she still occasionally requires assistance from staff with walking, rarely does she require physical assistance. Plan of Action: [Client #4], staff, and PCCS (Putnam County Comprehensive Services) are aware of [client #4's] difficulties with walking and are working			

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	hard to keep her on a healthy diet and fitness routine. [Client #4] will be expected to follow her exercise guidelines as recommended by her general physician, [name of physician]. It is recommended that she walk for at least 30 minutes a day. Since implementation of the walker, [client #4] is better able to walk with occasional verbal prompting from staff, but she still requires physical assistance from staff when utilizing the stairs, entering or exiting a transportation vehicle, and from time to time with basic walking." There was no documentation in client #4's Risk Management Plan indicating client #4 needed to lock the brake on her walker. The Health Related Incident Management Plan did not indicate if client #4 was to use the walker at all times. The plan did not indicate client #4 was to be redirected and encouraged to use her walker at all times. The plan did not indicate whether or not it was acceptable for client #4 to walk without the use of her walker. The plan did not indicate client #4's walker's brakes should be locked when the walker was not in use. On 1/6/16 at 12:40 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #4 was supposed to use her walker at all times. The QIDP			

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	indicated client #4 should have the walker with her and the staff should encourage the use of her walker. The QIDP indicated client #4 had several falls over the past 12 months. The QIDP indicated some of the falls were due to the brakes not being locked on the walker and when she tried to use it, the walker moved. The QIDP indicated the staff remind her to lock the brakes. The QIDP stated, "presents a safety danger when she doesn't lock (the brakes)." The QIDP indicated the plan did not include staff should encourage the use of the walker and locking the walker's brakes. On 1/8/16 at 1:27 PM, the QIDP indicated he previously indicated client #4 needed to use her walker at all times. The QIDP indicated after reviewing the plan and her orders, the walker was needed PRN (as needed). The QIDP indicated client #4's plan should indicate the use of the walker was PRN. The QIDP indicated it was client #4's choice to use the walker or not. The QIDP indicated client #4 ambulated better with the walker. On 1/8/16 at 1:29 PM, the Group Home Director (GHD) indicated there was no medical order for client #4 to use her walker at all times. The GHD stated, "It's her choice." 9-3-4(a)			

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W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 5 of 6 clients (#1, #2, #4, #5 and #6) living in the group home, the facility failed to administer the clients' medications as prescribed. Findings include: On 1/5/16 at 1:13 PM, a review of the facility's incident reports was conducted and indicated the following medication errors as reported to the Bureau of Developmental Disabilities Services (BDDS): 1) On 2/7/15 at 8:00 PM, client #6 received Clonazepam (anxiety). It was prescribed to be administered at 8:00 AM. The 2/8/15 BDDS report indicated, "[Nurse] reports that staff member [staff #5] reported to her that [client #6] received her medication at both 8:00 AM and 8:00 PM due to his error...." 2) On 3/18/15 at 12:00 PM, client #6 did not receive ProAir inhaler. The 3/18/15	W 0368	Residential Director, QIDP and Consultant RN met to discuss the concerns of medication errors within the group home. All agreed that administration of medications as prescribed is a top priority to ensure quality client care. In order to further enhance the likelihood of error free med passes the following is being implemented; 1. The RN is presenting medication administration procedures training at the next staff meeting. 2. The medication cart has been arranged so that administering staff are not relying on color coordination between the medication card and the MAR when completing medication passes. 3. RN, House Manager or QIDP will observe a random unannounced medication pass for all staff that administers medications to group home clients at least one time per year. A tracking sheet has been developed and will be utilized to identify the staff completing the medication pass and any findings identified through the observation (see attached Medication Pass Observation Log). In the event negative findings are identified	01/22/2016

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	BDDS report indicated, "[Staff #1] reports that when she picked up [client #6] from the sheltered workshop, she forgot about the inhaler and did not realize the error until it was too late for [client #6] to receive the medication...." 3) On 3/21/15 at 8:00 AM, client #6 did not receive her 8:00 AM dosage of Clonazepam (anxiety) 0.5mg (milligrams) earlier that morning. Staff member, [staff #11] was completing her evening medication passes and when she went to count the medications, she noticed that [client #6's] dosage of clonazepam 0.5mg had not been giving that morning...." 4) On 5/17/15 at 10:00 AM, client #1 did not receive her antibiotic doxycycline (the purpose of the antibiotic was not indicated in the 5/18/15 BDDS report). 5) On 6/12/15 at 8:00 AM, client #5 did not receive Effexor (anxiety). The 6/13/15 BDDS report indicated, "...[client #5] did not receive her 8:00 AM dosage of Effexor 75mg due to an error by staff member, [staff #9]." 6) On 7/7/15 at 6:00 AM, client #4 did not receive Synthroid (thyroid). 7) On 8/3/15 at 4:00 PM, client #4 was		staff will be referred for retraining.4. Medication Administration Procedure will be reviewed at each staff meeting. 5. Any staff with a medication error will automatically be required to participate in retraining either via I-train, one on one RN training or retaking of Core A. 6. Any staff receiving a written employee warning will forfeit the opportunity to participate in the agency incentive program. PCCS is committed to the health and safety of all of its clientele. (see attached simplified Medication Administration Procedure)	

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	not administered her Os-Cal + D for osteoporosis. 8) On 9/14/15 at 8:00 PM, client #5 did not receive Macrobid (urinary tract infection). The 9/15/15 BDDS report indicated, "[Staff #1] reports that the medication error was found by staff member, [staff #6], while she was administering [client #5's] 8:00 AM medications...." 9) On 12/16/15 at 12:00 PM, client #4 did not receive Tobramycin Ophthalmic Solution 5 ml (milliliters) for conjunctivitis. 10) On 12/18/15 at 2:20 PM, client #2 did not receive an antibiotic as prescribed. The 12/18/15 BDDS report indicated, "[Client #2] started an antibiotic (unsure of name) 500mg (every 4 hours) the evening of 12-17-15. On December 18th, 2015 at 2:20 PM [staff #13] pulled the girls (sic) home communication book to write in and put their checks in there. When [staff #13] opened the communication book she noticed there was an antibiotic (unsure of name) 500mg for [client #2] in there. The staff that dropped [client #2] off to the workshop did not let workshop staff know there was a new antibiotic medication...."			

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	11) On 12/26/15 at 8:00 AM, client #1 did not receive her antibiotic, Cefdinir, for an ear infection. On 1/6/16 at 9:32 AM, the Group Home Director (GHD) indicated the facility would not have medication errors if the staff followed and implemented the training they received. On 1/8/16 at 11:11 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the staff should administer the clients' medications as prescribed by their physicians. The QIDP indicated the staff should implement the training they were provided during Core A and B medication administration training. 9-3-6(a)			
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to conduct quarterly evacuation drills for each shift of personnel.	W 0440	The Residential Director met with the House Manager to discuss how and why we missed 2 drills during 2015. It was determine that a typo on the 2015 Master Drill Schedule caused one of the fire evacuation drills during the last quarter of the year to be	01/22/2016

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	Findings include: On 1/5/16 at 3:14 PM, a review of the facility's evacuation drills was conducted. During the evening shift (4:00 PM to 12:00 AM), there were no evacuation drills conducted from 9/26/15 to 1/5/16. During the night shift (12:00 AM to 8:00 AM), there were no evacuation drills conducted from 2/16/15 to 6/23/15. This affected clients #1, #2, #3, #4, #5 and #6. On 1/5/16 at 4:05 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the facility should conduct one evacuation drill per shift per quarter. On 1/6/16 at 9:23 AM, the Group Home Director indicated the facility should conduct one evacuation drill per shift per quarter. 9-3-7(a)		omitted. Mock Fire Evacuation drills are conducted at each monthly staff meeting. Although these do not typically include the clients they do help staff to sharpen their skills. A schedule of drills to be completed for each shift for each quarter for 2016 has been developed and reviewed for accuracy prior to being posted in the fire evacuation book. All staff members of the facility have been provided a copy of their own and have signed off on the master copy schedule. Additionally, fire drills will also be included on the staffing schedule when a drill falls during the time that a weekly schedule is submitted to all scheduled staff. Monitoring of fire drills will be completed by the House Manager and will also be reviewed quarterly by the Safety Committee to ensure compliance with dates and times of drills completed.Fire evacuation procedures will continue to be reviewed and practiced at each staff meeting. (see attached 2016 drill schedule)	
W 0441 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to hold evacuation drills under	W 0441	The facility continues to utilize 3 shifts for evacuations to be completed (12A –8A; 8A-4P; and 4P-12A). The Fire Drill Schedule 2016 has been developed to	01/22/2016

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	varied conditions. Findings include: On 1/5/16 at 3:14 PM, a review of the facility's evacuation drills was conducted. During the night shift (12:00 AM to 8:00 AM), the facility conducted evacuation drills on 2/15/15 at 7:15 AM, 6/24/15 at 6:00 AM, 8/20/15 at 6:20 AM, 8/22/15 at 7:30 AM and 11/22/15 at 6:05 AM. -On 2/15/15 at 7:15 AM, the evacuation drill was conducted with three staff present. The Evacuation Drill Roster indicated client #1 went to the safe area independently, client #2 was assisted to the safe area, client #3 was in bed and physically lifted to the safe area, client #4 went to the safe area independently, client #5 needed several verbal prompts to go to the safe area and client #6 was physically pushed in her wheelchair to the safe area. -On 6/24/15 at 6:00 AM, the evacuation drill was conducted with three staff present. The Evacuation Drill Roster indicated clients #1 and #4 went to the safe area independently. Client #2 "just stood there - do (sic) to grass being wet." Client #3 was "carried by staff." The form indicated client #5 "wouldn't get up - required assist to garage area." The		provide a greater variety of times the drills are to be conducted throughout the year for each shift. All staff members have been provided their own copy of the Fire Drill Schedule and have signed the schedule that is to be referred to within the house once a drill is completed. The varied time Fire Drill Schedule will be utilized when creating schedules for the future to ensure that evacuation drills are occurring at varied times throughout all shifts. We will continue to vary time, weather conditions and location of fire to ensure both staff and clients are aware how to evacuate under varied conditions. Monthly monitoring of fire drills will be completed by the House Manager and will also be reviewed quarterly by the Safety Committee to ensure compliance with dates and times of drills completed. (see attached drill schedule)	

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	form indicated client #6 "turne (sic) over in the grass... [QIDP - Qualified Intellectual Disabilities Professional] was called and notified and body check on [client #6] right." The form indicated, "QIDP said wheelchairs should be wheeled out backwards over thrushholds (sic)." -On 8/20/15 at 6:20 AM, the evacuation drill was conducted with three staff present. The Evacuation Drill Roster indicated, "[Client #5] was on couch and needed hands on assistance to get to the safety area. [Client #2] needed hands on assistance once out the door. [Client #3] was pushed to safety area by [staff #12]. All ladies had assistance from staff [#3] holding the door open...." -On 8/22/15 at 7:30 AM, the evacuation drill was conducted with three staff present. The Evacuation Drill Roster indicated clients #3, #4 and #5 were in bed asleep at the time of the drill. The form indicated, "Staff carried [client #3] out of house... [Clients #1 and #4] needed to be redirected to appropriate exit." -On 11/22/15 at 6:05 AM, the evacuation drill was conducted with one staff. The Evacuation Drill Roster indicated at the time of the drill starting client #4 was in			

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	the quiet room, client #6 was at the computer and client #2 was using the restroom. The form indicated clients #1, #3 and #5 were in bed asleep at the time of the drill. The form indicated, "Had to wake [client #5] & carried [client #3] out of house...." There were no evacuation drills conducted from 12:00 AM to 6:00 AM. There were no drills conducted with one staff during the night shift when all the clients were asleep. This affected clients #1, #2, #3, #4, #5 and #6. On 1/6/16 at 6:34 AM, staff #6 indicated she worked the night shift by herself regularly during the past 4 years. Staff #6 indicated there was one staff working at the group home from 12:00 AM to 6:00 AM. Staff #6 indicated the Group Home Director wanted the night shift drill conducted by two staff. Staff #6 stated, in regard to conducting evacuation drills during the night shift, "haven't done one for four years by myself." On 1/6/16 at 1:04 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated one evacuation drill was conducted with one staff while the clients were asleep. The QIDP indicated there were additional staff who worked during the night shift in addition to staff			

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	#6. On 1/6/16 at 9:24 AM, the Group Home Director (GHD) indicated the times staff conduct the evacuation drills was up to their discretion. The GHD indicated there should be a variety in the times the drills were conducted. The GHD stated "in the past" evacuation drills were conducted with one staff during the overnight shift in a sufficient amount of time when all the clients were asleep. The GHD indicated the facility needed to conduct evacuation drills with one staff present while the clients were asleep. 9-3-7(a)			
W 9999 Bldg. 00	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met: 460 IAC 9-3-1(a) Governing Body	W 9999	The Residential Director met with the QIDP to discuss the importance of filing incident reports in a timely manner. It is recognized that there may be times the QIDP is out of the area and without means of submitting a state reportable incident. To prevent this from occurring in the future the Residential Director and Executive Director met and	01/22/2016

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	(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 11. An emergency intervention for the individual resulting from: a. a physical symptom; b. a medical or psychiatric condition; c. any other event. 14. A significant injury to an individual that includes but is not limited to: g. any injury requiring more than first aid. 18. Use of any PRN (as needed) medication related to an individual's behavior. 19. Use of any physical or manual restraint regardless of: a. planning; b. human rights committee approval; c. informed consent. This state rule was not met as evidenced by: Based on record review and interview for 6 of 88 incident reports reviewed affecting clients #5 and #6, the facility failed to submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours in accordance with state law. Findings include: On 1/5/16 at 1:13 PM, a review of the facility's incident reports was conducted		determined in the absence of the QIDP and Residential Director the following positions would be responsible for completing all Incident Reports and needed Investigations; Director of Adult Services, Director of Community Living and Adult Services Coordinators. Staff has been provided training on the additional Administrative On-Call staff and their contact information. In the event QIDP receives a text regarding an incident but is unable to respond he will notify another staff from the Administrative On-Call list. If DSP attempt to reach QIDP and do not receive a response they have been trained to contact someone from the Administrative On-Call list. All staff listed on the Administrative On-Call List has been trained in filing Incident Reports and completing investigations. The Administrative On-Call Contact list is posted in the homes. (see Attached Administrative On-Call Incident reporting call list)	

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	and indicated the following: 1) On 2/15/15 at 6:14 AM (reported to BDDS on 2/17/15), client #5 was physically aggressive toward staff #11 while at the dinner table. Staff #11 prompted client #5 several times during the meal to slow down, take smaller bites and to take drinks in between bites. Client #5 ate at a faster rate. Client #5 poked staff #11 on the side several times. Staff #11 prompted client #5 to go to a quiet area to calm down. Client #5 was administered a PRN (as needed) medication due to physical aggression toward staff #11. 2) On 3/21/15 at 8:00 AM (reported to BDDS on 3/23/15), staff failed to administer client #6's 8:00 AM dose of clonazepam (anxiety). 3) On 3/21/15 at 4:00 PM (reported to BDDS on 3/23/15), client #5 physically aggressed toward staff #10 by grabbing her with both of her hands. Staff #10 attempted to restrain client #5 however client #5 dropped to the floor and the restraint was not successful. 4) On 5/23/15 at 8:53 AM (reported to BDDS on 5/26/15), client #5 received an as needed medication (PRN) due to physical aggression toward staff #2.			

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	Client #5 slammed a chair against staff #2's wrist while sitting at the breakfast table. 5) On 5/23/15 at 4:50 PM (reported to BDDS on 5/26/15), staff #5 used a restraint (interim control position) on client #5 after client #5 scratched his face causing him to bleed. Client #5 received an as needed medication (PRN) due to physical aggression toward staff #5. Client #5 was restrained (single person baskethold) after receiving her PRN medication due to attempting to grab staff #2. 6) On 8/7/15 at 8:00 PM (reported to BDDS on 8/10/15), client #6's thumb was swollen and red. On 8/7/15 as staff #4 assisted client #6 to bed, client #6 sat on her own thumb bending it backward. Staff #4 looked at the area and there was no redness or swelling. At 6:00 AM on 8/8/15, client #6 requested and received acetaminophen for right thumb pain. Client #6 did not complain the remainder of the day. Client #6 went on therapeutic leave on 8/8/15 for the afternoon and when she returned, her thumb was noticeably swollen. Client #6 was taken to the emergency room and diagnosed with hyperextension to her right thumb. On 1/5/16 at 1:58 PM, the Qualified			

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	Intellectual Disabilities Professional (QIDP) indicated BDDS reports were to be submitted within 24 hours. The QIDP indicated he was not sure why the reports were submitted late. The QIDP stated, "It should have been reported on time." On 1/6/16 at 9:28 AM, the Group Home Director (GHD) indicated BDDS reports should be submitted within 24 hours. 9-3-1(b)			