STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G190	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	120 AVENUE C GRIFFITH, IN 46319

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for a pre-determined full recertification and state licensure survey. Dates of Survey: June 17, 18, 19, 20, 21, and 26, 2013 Surveyors: Tim Shebel, LSW-Team Leader Paula Chika, QIDP Facility number: 000722 Provider number: 15G190 AIM number: 100234570 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/2/13 by Ruth Shackelford, QIDP.	W000000		

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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W000136	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. Based on interview and record review for 1 additional client (#4), the facility failed to encourage and/or allow client #4 to go to church in the community. Findings include: During the 6/17/13 observation period between 4:10 PM and 6:55 PM, at the group home, client #4 walked up to the surveyor and stated "I want to go to church. They won't let me." Interview with client #4 on 6/17/13 at 5:22 PM indicated she wanted to go to church. Client #4's record was reviewed on 6/18/13 at 1:30 PM. Client #4's 8/21/12 Individual Support Plan (ISP) did not indicate the client should not be allowed to attend church in the community. Interview with the Director of Behavioral Health and Service Coordinator (SC) #1 indicated client #4 was allowed to go to church if the client wanted to go. SC #1 indicated she was not aware client #4 wanted to go to church.	W000136	The Idt will meet to modify Cl #4 ISP to reflect her desire to attend church by 7/26/13. In addition weekend plans will be developed to ensure that Cl #4 and other clients interested in attending Church do so. The Service coordinator will review weekend plans ensure that Cl #4 attends the Church of her choosing weekly for 4 weeks then biweekly for 2 months and randomly thereafter. The Service coordinator will randomly visit the home unannounced over the weekend to ensure that clients are out of the home when they are to be in church.7-22-13 Each week the residents and staff on duty will develop a schedule of activity. The area manager will monitor the home to ensure staff take the clients on scheduled outings on a weekly basis. When applicable clients will be encourage to bring brochures or take pictures of themselves at these outings. These items will be used to monitor compliance with outings.	07/26/2013

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	9-3-2(a)			

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W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 2 of 3 sampled clients (#1 and #2) and for 2 additional clients (#4 and #5), the facility failed to implement its policy and procedures to prevent potential neglect of client #4 in regard to a seizure. The facility also failed to implement its policy and procedures to conduct thorough investigations of an allegation of abuse and/or in regard to injuries of an unknown source for clients #1, #2 and #5. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 6/18/13 at 6:30 AM and at 9:59 AM. The facility's 4/2/13 reportable incident report indicated "[Client #4] was sitting in the chair and made a loud noise. [Client #4] went to the side of her chair and then slid out of her chair to the ground. [Client #4] was having a seizure. The health tech was page (sic) to the workshop. The health tech called 911. The health safety tech took [client #4's] vitals, the temperature-100, pulse-60, respiration 18, blood pressure-140/90. The seizure lasted two minutes, The	W000149	CI #4 team met on 4/2/13 Staff were interviewed for statements, but the facility failed to document this meeting or interviews. No neglect or intentional malice was found at the time. An additional IDT team meeting will be held to document and investigate the incidents regarding clients #4 seizure activity and follow up by 7/26/13. In the event unplanned and abnormal hospitalizations occur an investigation to ensure that the agency was not neglectful will be conducted. To monitor that this measure stays in place the Director of Health and Safety will review all incident report referring to incidents that lead to hospitalizations to ensure that investigations occurred where necessary. Investigators, the Behavior Health Director, and the Quality Assurance Director were trained on the requirements of a thorough investigation and reporting requirements on 6/19/13. In the future investigators will have a better understanding of this requirement and the Behavior Health and Quality Assurance Director (whom review all investigations) will have the ability to review all investigations in light of	07/26/2013

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	ambulance arrive (sic) and transported [client #4] to [name of hospital]." The reportable incident report indicated client #4 had the seizure at 11:22 AM. The facility's 4/2/13 Incident/Accident Report (IAR) indicated the health and safety tech called LPN #1 at 11:33 AM. The IAR indicated client #4 had the seizure at the workshop/day program which was owned by the facility. The facility's 4/2/13 IAR indicated at 6:45 AM, in the client #4's bedroom, "I (staff #1) went up stairs to help consumer when I hear (sic) [client #4] grunting as if she was stretching. When I looked in (sic) [client #4] was having a seizure, she was laying on her back. It lasted 1 1/2 minutes. She laid in bed for/until 7:19 AM. No known injuries at this time." The 4/2/13 IAR indicated "...Cause of this Incident/Accident I don't know. She is not known to have seizures...." The 4/2/13 IAR indicated staff #1 notified the nurse (no time documented on form). The IAR Part B Incident/Accident Follow-Up Report indicated "...Action Taken (treatment, intervention, referrals, etc.) Describe briefly [Client #4] was sent to the workshop and had another seizure in which the ambulance was called. [Client #4] was taken to the hospital and was kept overnight." The 4/2/13 IAR		the requirements. In addition all service coordinators, nurses and area managers will view the training tape by 7/26/13	

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	indicated in the comments section of the form "...did not have a seizure risk plan in place." The 4/2/13 IAR failed to indicate the specific time the nurse was notified and/or which nurse was notified of client #4's 6:45 AM seizure. The 4/2/13 IAR also failed to indicate the nurse assessed client #4 after the initial seizure at the group home, made recommendations, and/or gave specific instructions to staff as client #4 was not known to have seizures. The facility's 4/2/13 reportable incident report failed to include information in regard to client #4's initial seizure at the group home. The facility's 4/2/13 IARs and/or reportable incident report failed to indicate the facility initiated an investigation for possible neglect due to the lack of response/care after the initial seizure. The facility's Residential Services Pager Review (on-call log) was reviewed on 6/18/13 at 2:35 PM. The facility's on call log indicated RN #1 was called by facility staff at 7 AM on 4/2/13. The 4/2/13 log indicated "[Client #4] 6:45 Seizure 1.5 min (minutes) in bed...had one- 3 mos (months) ago MRI (unreadable word)." Client #4's record was reviewed on 6/18/13 at 1:30 PM. Client #4's Cumulative Medical Record indicated the following nurse entries (not all inclusive):			

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	-3/28/13 "CT scan results of head faxed to [name of doctor's] office. No new orders rec'd (received)." -4/2/13 "6:45 a Grand MAL seizure reported by staff. Seizure lasted 1/1/2 minutes while client was still in bed. Staff reported the incident to the on-call nurse." The 4/2/13 note was written by LPN #1. -4/2/13 "[Name of doctor's] office notified. MD (medical doctor) out of town. Sending client to [name of hospital] ER (emergency room) for evaluation." The 4/2/13 note was written by LPN #1. -4/2/13 "Seizure activity noted at the workshop lasting 2 minutes. Transferred to [name of hospital] per ambulance. T (temperature)-100.1 P (pulse)-60 R (respirations) 18 BP (blood pressure) 140/90 [Name of hospital] on bypass." The 4/2/13 note was written by LPN #1. -4/8/13 "Discharged from [name of hospital]. New Dx (diagnosis) of seizures." The above mentioned nurse notes did not indicate the facility assessed the client and/or immediately sought medical care			

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	for client #4 after the initial seizure at the group home. Client #4's 3/1/13 Annual Physical Examination did not indicate client #4 had a history and/or seizure diagnosis. Client #4's 8/21/12 Individual Support Plan indicated client #4 did not have a seizure diagnosis and/or demonstrate seizures. Client #4's 8/20/12 Medical Review Worksheet did not indicate client #4 had a history and/or seizure diagnosis. Interview with LPN #1 on 6/18/13 at 2:10 PM indicated she was the nurse for the group home. When asked if she was notified of client #4's initial seizure, LPN #1 stated "Probably on-call nursing took call." LPN #1 indicated she was notified of client #4's seizure. LPN #1 indicated she instructed staff to send client #4 out to be evaluated after the seizure at the workshop occurred. LPN #1 indicated she did not assess the client after the initial seizure at the group home. LPN #1 indicated client #4 was not assessed until the second seizure occurred. LPN #1 indicated client #4 had a seizure in November 2012 but had not had any seizures since then. LPN #1 indicated facility staff should have been given			

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	instructions on what to do after the initial seizure at the group home. LPN #1 indicated she would have sent client #4 to the hospital for an evaluation. When asked who was the nurse on call on 4/2/13, LPN #1 looked at the on-call log and stated "[RN #1] was on-call." LPN #1 indicated client #4 did not have a seizure diagnosis prior to 4/2/13. During an interview with the Director of Behavioral Health on 6/19/13 at 10:12 AM., when asked if the facility conducted an investigation in regard to possible neglect/care for client #4 due to the 4/2/13 seizures, the director indicated no investigation had been conducted for possible neglect. Interview with RN #1 on 6/19/13 at 10:42 AM indicated facility staff called her 15 minutes after client #4 had a seizure at the group home on 4/2/13. RN #1 indicated client #4 had a seizure 3 months ago. RN #1 indicated an MRI was ordered which did not show any problems. RN #1 indicated facility staff told her client #4 was laying in bed when the client had the seizure. When asked why client #4 was sent to the workshop after the seizure at the group home, RN #1 indicated facility staff told her client #4 did fine after the seizure. RN #1 stated she told the staff to monitor client #4 and if the client was			

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	"lethargic or had a seizure to call back." RN #1 indicated she did not document instructions given to staff. RN #1 indicated she told client #4's nurse after the nurse came in. RN #1 indicated client #4's cumulative medical notes indicated LPN #1 called the client's doctor after the initial seizure and assessed the client. The facility's policy and procedure was reviewed on 6/18/13 at 9:58 AM. The facility's 2/15/12 policy entitled Policy For Handling Cases Of Neglect And Abuse indicated "...I. The Arc Northwest Indiana prohibits all abuse, neglect and exploitation of our clients. II. Staff will immediately report any allegations of abuse, neglect or exploitation of our clients per agency reporting procedure. The Arc Northwest Indiana will meet current regulatory requirements for reporting all incidents. III. All allegations of abuse, neglect, humiliation or exploitation will be investigated per the Arc Northwest Indiana's investigation process while protecting the individual...." The facility's 2/15/12 policy indicated "Neglect- is defined as failure to consider and provide for the safety or care of the client and anticipate and remedy the placing of a client in a situation that poses a threat to his/her health and well-being. Examples include, but are not limited to depriving a client of ...or medical			

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	care/treatment...." 2. The facility's policy and procedure was reviewed on 6/18/13 at 9:58 AM. The facility's 2/15/12 policy entitled Policy For Handling Cases Of Neglect And Abuse indicated "...I. The Arc Northwest Indiana prohibits all abuse, neglect and exploitation of our clients. II. Staff will immediately report any allegations of abuse, neglect or exploitation of our clients per agency reporting procedure. The Arc Northwest Indiana will meet current regulatory requirements for reporting all incidents. III. All allegations of abuse, neglect, humiliation or exploitation will be investigated per the Arc Northwest Indiana's investigation process while protecting the individual...." The facility's 2/15/12 policy indicated "Neglect- is defined as failure to consider and provide for the safety or care of the client and anticipate and remedy the placing of a client in a situation that poses a threat to his/her health and well-being. Examples include, but are not limited to depriving a client of ...or medical care/treatment...." The facility's policy defined "Verbal Abuse/Humiliation-is defined as the willful infliction of emotional pain through any spoken or written communication, or faces or gestures that are derogatory, humiliating, or ridiculing			

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	the individual or holding the individual up to public shame. Examples include, but are not limited to...calling names, threatening gestures, etc...." The facility failed to report all allegations of abuse, neglect and/or injuries of unknown source immediately to the administrator, and/or to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for clients #1, #2 and #5. Please see W153. The facility failed to conduct a thorough investigation in regard to the alleged allegations and/or injuries of unknown source for clients #1 and #4. Please see W154. 9-3-2(a)			

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W000153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on observation, interview and record review for 3 of 4 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to report all allegations of abuse, neglect and/or injuries of unknown source immediately to the administrator and/or to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for clients #1, #2 and #4. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 6/18/13 at 6:30 AM and at 9:59 AM. The facility's 4/2/13 reportable incident report indicated "[Client #4] was sitting in the chair and made a loud noise. [Client #4] went to the side of her chair and then slid out of her chair to the ground. [Client #4] was having a seizure. The health tech was page (sic) to the workshop. The health tech called 911.	W000153	Investigators, the Behavior Health Director, and the Quality Assurance Director were trained on the requirements of a thorough investigation and reporting requirements on 6/19/13. In the future investigators will have a better understanding of this requirement and the Behavior Health and Quality Assurance Director (whom review all investigations) will have the ability to review all investigations in light of the requirements. In addition all service coordinators, nurses and area managers will view the training tape by 7/26/137-22-13To ensure future compliance, posters explaining client rights and reporting requirements were distributed to all group homes and the day program so that staff and clients become more aware of the requirements on an ongoing basis. Additionally all staff will be trained on reporting and investigation requirements for Abuse Neglect, and Exploitation at least annually unless changes occur or need requires this to be done more frequently. 7/30/13 In addition to the above corrections the internal incident report system	07/26/2013

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	The health safety tech took [client #4's] vitals, the temperature-100, pulse-60, respiration 18, blood pressure-140/90. The seizure lasted two minutes, The ambulance arrive (sic) and transported [client #4] to [name of hospital]." The reportable incident report indicated client #4 had the seizure at 11:22 AM. The facility's 4/2/13 Incident/Accident Report (IAR) indicated the health and safety tech called LPN #1 at 11:33 AM. The IAR indicated client #4 had the seizure at the workshop/day program which was owned by the facility. The facility's 4/2/13 IAR indicated at 6:45 AM, in the client #4's bedroom, "I (staff #1) went up stairs to help consumer when I hear (sic) [client #4] grunting as if she was stretching. When I looked in (sic) [client #4] was having a seizure, she was laying on her back. It lasted 1 1/2 minutes. She laid in bed for/until 7:19 AM. No known injuries at this time." The 4/2/13 IAR indicated "...Cause of this Incident/Accident I don't know. She is not known to have seizures...." The 4/2/13 IAR indicated staff #1 notified the nurse (no time documented on form). The IAR Part B Incident/Accident Follow-Up Report indicated "...Action Taken (treatment, intervention, referrals, etc.) Describe briefly [Client #4] was sent		has been modified. Direct care staff were trained on this system which has resulted in a significant increase in incident reporting. The administrator is informed on all incident report which contain mistreatment, Abuse, neglect and injury of unknown origin. Part of this incident report is documentation that the administrator and state officials is notified of reportable incidents. Additionally, on cite supervision had been occurring, the Service Coordinator and other professionals will visit the home Daily. This monitoring will fade to three times per week, weekly and then Bi weekly to ensure continued compliance with reporting requirements.	

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	to the workshop and had another seizure in which the ambulance was called. [Client #4] was taken to the hospital and was kept overnight." The 4/2/13 IAR indicated in the comments section of the form "...did not have a seizure risk plan in place." The 4/2/13 IAR failed to indicate the specific time the nurse was notified and/or which nurse was notified of client #4's 6:45 AM seizure. The 4/2/13 IAR also failed to indicate the nurse assessed client #4 after the initial seizure at the group home, made recommendations, and/or gave specific instructions to staff as client #4 was not known to have seizures. The facility's 4/2/13 reportable report failed to include information in regard to client #4's initial seizure at the group home, and/or to report possible neglect due to the lack of response/care after the initial seizure. Interview with the Director of Behavioral Health on 6/19/13 at 10:12 AM indicated the workshop staff reported client #4's seizure at the workshop. The director indicated the facility did not look at the incident as possible neglect. 2. The facility's reportable incident reports and/or investigations were reviewed on 6/18/13 at 6:30 AM and at 9:59 AM. The facility's 3/27/13 IAR indicated "Staff was having a			

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	conversation concerning events that bother [client #1]. She eventually told staff she was scared to open up about things concerning our lead [staff #1]. Staff asked who does she feel comfortable talking to & (and) she said [Service Coordinator #2] or [staff #5]. Eventually she stated she was scared because she didn't want to be jumped on. Tried to get client to open up by making her feel comfortable to talk. She also stated some remarks that was (sic) made to her that seem as if it was (sic) racial remarks (my point of view)...Not sure what caused the incident towards the client...." The 3/27/13 IAR indicated "Service Coordinator spoke w/ (with) [client #1]. [Client #1] denied any fear towards her staff. No abuse or neglect reported." The IAR indicated facility staff notified the Director of Behavioral Health on 3/28/13 at 10:00 AM. The IAR and the facility's reportable incident reports indicated the facility did not report the allegation of verbal/mental abuse to the administrator immediately, BDDS and/or APS. Interview with the Director of Behavioral Health on 6/18/13 at 10:54 AM indicated the Service Coordinator interviewed client #1 and determined the allegation did not need to be reported.			

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	3. During the 6/17/13 observation period between 4:10 PM and 6:55 PM, at the group home, client #2 took a shower with staff assistance at the group home. When client #2 came out dressed, client #2 walked past staff #6. Staff #6 stated "What happened to your neck?" Client #2 kept walking and staff #6 followed the client to try and look at her neck. Staff #6 then asked staff #7 how client #2 injured her neck. At 6:24 PM, client #2 came back upstairs with a Band-Aid to the back of her neck. Staff #6 then sat down and started filling out an IAR. Interview with staff #6 on 6/17/13 at 6:30 PM stated it looked like client #2 had a "small gash on her neck." Staff #6 tried to remove the Band-Aid to show the surveyor but the staff was not able to get the Band-Aid off. Client #2 also had three small scabbed puncture like marks below the bandaged area. Staff #6 indicated she did not know how the client was injured. The facility's reportable incident reports and/or investigations were reviewed on 6/18/13 at 6:30 AM and at 9:59 AM. The facility's reportable incident reports did not indicate the facility staff reported the injury of unknown origin immediately to the administrator and/or to BDDS.			

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	Interview with the Director of Behavioral Health and Service Coordinator (SC) #1 on 6/19/13 at 10:12 AM indicated as of 6/19/13, they had not been made aware of client #2's 6/17/13 injury to her neck. 9-3-2(a)			

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W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 2 of 4 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct a thorough investigation in regard to the allegations and/or injuries of unknown source for clients #1 and #4. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 6/18/13 at 6:30 AM and at 9:59 AM. The facility's 3/27/13 IAR indicated "Staff was having a conversation concerning events that bother [client #1]. She eventually told staff she was scared to open up about things concerning our lead [staff #1]. Staff asked who do (sic) she feel comfortable talking to & (and) she said [Service Coordinator #2] or [staff #5]. Eventually she stated she was scared because she didn't want to be jumped on. Tried to get client to open up by making her feel comfortable to talk. She also stated some remarks that was (sic) made to her that seem as if it was (sic) racial remarks (my point of view)...Not sure what caused the incident towards the	W000154	Investigators, the Behavior Health Director, and the Quality Assurance Director were trained on the requirements of a thorough investigation and reporting requirements on 6/19/13. In the future investigators will have a better understanding of this requirement and the Behavior Health and Quality Assurance Director (whom review all investigations) will have the ability to review all investigations in light of the requirements. In addition all service coordinators, nurses and area managers will view the training tape by 7/26/13	07/26/2013

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	client...." The 3/27/13 IAR indicated "Service Coordinator spoke w/ (with) [client #1]. [Client #1] denied any fear towards her staff. No abuse or neglect reported." The IAR indicated facility staff notified the Director of Behavioral Health on 3/28/13 at 10:00 AM. The IAR and the facility's reportable incident reports indicated the facility did not conduct an investigation in regard to client #1's allegation of verbal and/or mental abuse. Interview with the Director of Behavioral Health on 6/18/13 at 10:54 AM indicated the Service Coordinator interviewed client #1. The director indicated the allegations made by client #1 were not thoroughly investigated. 2. The facility's reportable incident reports and/or investigations were reviewed on 6/18/13 at 6:30 AM and at 9:59 AM. The facility's 7/2/12 reportable incident report indicated "[Client #1] reported to the Service Coordinator on 7/2/12 that she was assisting her roommate in finding her earrings. She said that staff saw her in her roommate's drawer looking for her earrings when staff yelled at her. [Client #1] stated that staff told her 'Get out of the room you're pissing me off.' [Client #1] stated the staff who yelled at her was [staff #1]....			

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	The reportable incident report indicated staff #1 was suspended pending an investigation. The facility's 11/6/12 follow-up report indicated "...The outcome of the investigation is as follows: The allegation was not substantiated. Staff was redirecting consumer prior to understanding the situation prior to redirecting. No intent for verbal abuse. It appears that [client #1] was embarrassed at being redirected by staff and labeled the redirection as yelling. In regards to corrective action from the Service Coordinator will mediate between the consumer and staff to clear any hurt feelings and establish a good relationship between staff and consumer. Staff returned to schedule. As of this date this communication has been established and they have a good relationship with no concerns from [client #1] per Service Coordinator." The facility's 11/7/12 follow-up report indicated BDDS wanted to know what "...led the team to determine that the staff member did not say this to [client #1]? What will the agency do to monitor this staff member to ensure that [client #1] is free from abuse and/or to prevent future false allegations? Answer: The statement was never said by staff. The staff asked			

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	the consumer [client #1] if she could go sit downstairs until she calmed [client #1's] roommate down. This was the non verbal housemate whose drawer [client #1] was looking through who appeared to be upset. Based on 2 consumers and 1 staff statements they did not witness any statement or yelling by staff towards [client #1]. The Service Coordinator meets randomly with consumer to see if she has any concerns about staff to ensure [client #1] is free from abuse...The allegation was clearly not substantiated...." The facility's 7/21/12 investigation report indicated "Conclusion: It appears that it is staff's word versus consumer's word. Based on the client's story she stayed consistent with her allegation that staff yelled at her. The client was questioned two consecutive days. Per Service Coordinator [client #1] does not have a history of telling untruths." The investigation indicated the investigator made the above statement/conclusion on 7/3/12. The 7/21/12 typed investigation indicated "Recommendations: It appears that [client #1] was embarrassed at being redirected. Staff did not take time to fully understand the situation prior to redirecting client. No intent of verbal abuse. Staff [staff #1] apologized to Client. Service Coordinator to mediate a			

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	meeting between client and staff to clear the air of hurt feelings and establish a good relationship between client and staff." The recommendations were written by administrative staff #2. The facility's 7/3/12 hand written Investigation Fact Sheet Summary and Conclusion indicated the investigator interviewed client #1 on 7/2 and 7/3/12. The hand written sheet indicated client #1 "Stayed consistent both days." The fact sheet indicated the Service Coordinator indicated "...that [staff #1] has gotten upset with Service Coor (coordinator) and [staff #1's] tone was off. The Service Coor was refencing (sic) that she (staff #1) tends to have a tone." The 7/3/12 fact sheet indicated "More probable (sic) true because [client #1] stayed consistent with her story. Based on history she does not have a history of lying (sic)-Per Service Coor...." An undated typed sheet entitled Recommendations on investigation of Incident 17729 indicated "It is clear that [client #1] was redirected out of [client #3's] room by [staff #1]. [Client #1] states that she was looking for lost earrings. However, [staff #1] does not indicate that she knew why [client #1] was in [client #3's] room or looking in [client #3's] drawers. [Staff #1] indicates			

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	that she redirected [client #1] from looking in [client #3's] drawers and educated [client #1] on not going into other people's drawers. It would appear that [client #1] did not like being redirected therefore labeled it as yelling despite no other resident or staff ever having known [staff #1] to have yelled at a consumer. Recommend returning [staff #1] to the schedule and facilitating a conversation between [client #1] and [staff #1] so that [client #1] understands [staff #1's] responsibility to each of the clients at the home and that being redirected from a task is different from being yelled at." The facility's 7/21/12 investigation report indicated the Service Coordinator, 2 staff and 4 clients were interviewed. The facility's 7/21/12 investigation did not interview all staff in regard to staff verbal abuse of clients. The facility's investigation also failed to specifically indicate how they determined client #1 was "embarrassed and did not know the difference between redirection and yelling." Interview with the Director of Behavioral Health on 6/18/13 at 10:54 AM indicated the staff who worked with client #2 at the time of the incident were the only staff interviewed. The director indicated 2			

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	staff were at the group home on 7/2/12. The director indicated no additional staff were interviewed. The director stated "She (client #1) was "embarrassed by it" (being redirected). When asked how the facility determined client #1 was embarrassed when she did not change her story, the director did not answer the question. 3. The facility's reportable incident reports and/or investigations were reviewed on 6/18/13 at 6:30 AM and at 9:59 AM. The facility's 4/2/13 reportable incident report indicated "[Client #4] was sitting in the chair and made a loud noise. [Client #4] went to the side of her chair and then slid out of her chair to the ground. [Client #4] was having a seizure. The health tech was page (sic) to the workshop. The health tech called 911. The health safety tech took [client #4's] vitals, the temperature-100, pulse-60, respiration 18, blood pressure-140/90. The seizure lasted two minutes, The ambulance arrive (sic) and transported [client #4] to [name of hospital]." The reportable incident report indicated client #4 had the seizure at 11:22 AM. The facility's 4/2/13 Incident/Accident Report (IAR) indicated the health and safety tech called LPN #1 at 11:33 AM. The IAR indicated client #4 had the			

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	seizure at the workshop/day program which was owned by the facility. The facility's 4/2/13 IAR indicated at 6:45 AM, in the client #4's bedroom, "I (staff #1) went up stairs to help consumer when I hear (sic) [client #4] grunting as if she was stretching. When I looked in (sic) [client #4] was having a seizure, she was laying on her back. It lasted 1 1/2 minutes. She laid in bed for/until 7:19 AM. No known injuries at this time." The 4/2/13 IAR indicated "...Cause of this Incident/Accident I don't know. She is not known to have seizures...." The 4/2/13 IAR indicated staff #1 notified the nurse (no time documented on form). The IAR Part B Incident/Accident Follow-Up Report indicated "...Action Taken (treatment, intervention, referrals, etc.) Describe briefly [Client #4] was sent to the workshop and had another seizure in which the ambulance was called. [Client #4] was taken to the hospital and was kept overnight." The 4/2/13 IAR indicated in the comments section of the form "...did not have a seizure risk plan in place." The 4/2/13 IAR failed to indicate the specific time the nurse was notified and/or which nurse was notified of client #4's 6:45 AM seizure. The 4/2/13 IAR also failed to indicate the nurse assessed client #4 after the initial seizure at the group home, made recommendations,			

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	and/or gave specific instructions to staff as client #4 was not known to have seizures. The facility's 4/2/13 reportable incident report failed to include information in regard to client #4's initial seizure at the group home, and/or an investigation in regard to possible neglect due to the lack of response/care after the initial seizure. Interview with the Director of Behavioral Health on 6/19/13 at 10:12 AM indicated the workshop staff reported client #4's seizure at the workshop. The director indicated the facility did not conduct an investigation as the facility did not look at the incident as possible neglect. 9-3-2(a)			

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W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 1 of 4 allegations of abuse/neglect reviewed, the facility failed to take appropriate corrective action in regard to an allegation of verbal abuse involving client #1. Findings include: The facility's reportable incident reports and/or investigations were reviewed on 6/18/13 at 6:30 AM and at 9:59 AM. The facility's 7/2/12 reportable incident report indicated "[Client #1] reported to the Service Coordinator on 7/2/12 that she was assisting her roommate in finding her earrings. She said that staff saw her in her roommate's drawer looking for her earrings when staff yelled at her. [Client #1] stated that staff told her 'Get out of the room you're pissing me off.' [Client #1] stated the staff who yelled at her was [staff #1]...." The reportable incident report indicated staff #1 was suspended pending an investigation. The facility's 11/6/12 follow-up report indicated "...The outcome of the investigation is as follows: The allegation was not substantiated. Staff was redirecting consumer prior to	W000157	Staff #1 was trained on interactions with client #1. She will be retrained with more thorough documentation on respecting client's, tone of voice, non-verbal interactions, and reporting concerns with clients by 7/26/13. Client #1 will be enrolled in the self advocates group through day program, and her IDT will evaluate the need to add assertiveness training to her ISP by 7/26/13. Investigators, the Behavior Health Director, and the Quality Assurance Director were trained on the requirements of a thorough investigation and reporting requirements and protecting clients on 6/19/13. In the future investigators will have a better understanding of this requirement and the Behavior Health and Quality Assurance Director (whom review all investigations) will have the ability to review all investigations in light of the requirements. In addition all service coordinators, nurses and area managers will view the training tape by 7/26/13	07/26/2013

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	understanding the situation prior to redirecting. No intent for verbal abuse. It appears that [client #1] was embarrassed at being redirected by staff and labeled the redirection as yelling. In regards to corrective action from the Service Coordinator will mediate between the consumer and staff to clear any hurt feelings and establish a good relationship between staff and consumer. Staff returned to schedule. As of this date this communication has been established and they have a good relationship with no concerns from [client #1] per Service Coordinator." The facility's 11/7/12 follow-up report indicated BDDS wanted to know what "...led the team to determine that the staff member did not say this to [client #1]? What will the agency do to monitor this staff member to ensure that [client #1] is free from abuse and/or to prevent future false allegations? Answer: The statement was never said by staff. The staff asked the consumer [client #1] if she could go sit downstairs until she calmed [client #1's] roommate down. This was the non verbal housemate whose drawer [client #1] was looking through who appeared to be upset. Based on 2 consumers and 1 staff statements they did not witness any statement or yelling by staff towards [client #1]. The Service Coordinator			

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	meets randomly with consumer to see if she has any concerns about staff to ensure [client #1] is free from abuse...The allegation was clearly not substantiated...." The facility's 7/21/12 investigation report indicated "Conclusion: It appears that it is staff's word versus consumer's word. Based on the client's story she stayed consistent with her allegation that staff yelled at her. The client was questioned two consecutive days. Per Service Coordinator [client #1] does not have a history of telling untruths." The investigation indicated the investigator made the above statement/conclusion on 7/3/12. The 7/21/12 typed investigation indicated "Recommendations: It appears that [client #1] was embarrassed at being redirected. Staff did not take time to fully understand the situation prior to redirecting client. No intent of verbal abuse. Staff [staff #1] apologized to Client. Service Coordinator to mediate a meeting between client and staff to clear the air of hurt feelings and establish a good relationship between client and staff." The recommendations were written by administrative staff #2. The facility's 7/3/12 hand written Investigation Fact Sheet Summary and Conclusion indicated the investigator			

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	interviewed client #1 on 7/2 and 7/3/12. The hand written sheet indicated client #1 "Stayed consistent both days." The fact sheet indicated the Service Coordinator indicated "...that [staff #1] has gotten upset with Service Coor (coordinator) and [staff #1's] tone was off. The Service Coor was refencing (sic) that she (staff #1) tends to have a tone." The 7/3/12 fact sheet indicated "More probable (sic) true because [client #1] stayed consistent with her story. Based on history she does not have a history of lying (sic)-Per Service Coor...." An undated typed sheet entitled Recommendations on investigation of Incident 17729 indicated "It is clear that [client #1] was redirected out of [client #3's] room by [staff #1]. [Client #1] states that she was looking for lost earrings. However, [staff #1] does not indicate that she knew why [client #1] was in [client #3's] room or looking in [client #3's] drawers. [Staff #1] indicates that she redirected [client #1] from looking in [client #3's] drawers and educated [client #1] on not going into other people's drawers. It would appear that [client #1] did not like being redirected therefore labeled it as yelling despite no other resident or staff ever having known [staff #1] to have yelled at a consumer. Recommend returning [staff			

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	#1] to the schedule and facilitating a conversation between [client #1] and [staff #1] so that [client #1] understands [staff #1's] responsibility to each of the clients at the home and that being redirected from a task is different from being yelled at." The facility's Staff Development Individual Training/Group Training Reports were reviewed on 6/18/13 at 11:15 AM. The facility's 7/5/12 training record indicated "I (staff #1) spoke to [client #1] and explained to her not to touch others belongings without asking first. [Client #1] said ok and I told her I'm sorry, she said she would not do it anymore (sic)." The facility's 7/5/12 training record and/or 7/21/12 investigation indicated the facility failed to retrain staff #1 in regard to clients' rights, abuse, neglect and/or appropriate interactions with clients to ensure staff #1 understood the difference between redirecting a client and abuse. Interview with the Director of Behavioral Health on 6/18/13 at 10:54 AM indicated the facility met with staff #1 after the incident occurred. The director indicated staff #1 apologized to client #1. The director indicated staff #1's training record should indicate the specific			

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	training staff #1 received. 9-3-2(a)			

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W000159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review, and interview, the facility's Service Coordinator (Qualified Intellectual Disabilities Professional) failed to: 1. Assure training objectives for 3 of 3 sampled clients (clients #1, #2, and #3), and 2 additional clients (clients #4 and #5) specified methods to be used in their implementation; 2. Assure group home staff had a copy of 1 of 3 sampled client's (client #2's) day program training objective for purchasing an item from a vending machine; 3. Assure training programs were reviewed to determine if the clients successfully completed the objectives, regressed or lost skills, failed to progress toward their objectives, and/or were to be considered for new training objectives for 2 of 3 sampled clients (clients #2, and #3), and 2 additional clients (clients #4 and #5). Findings include: 1. Client #1's record was reviewed on 6/18/13 at 11:17 A.M.. A review of the client's 10/24/12 IPP (Individual Program Plan) indicated, in part, the following training objectives: 1. Add value of	W000159	The Service Coordinator will be trained by the Staff Development Director on PPSEE, our electronic Data and Programming by July 16, 2013. The Service Coordinator will also be trained on assessing a client's ability to participate in a program, sensor-motor assessments, communication skills, implementing physical therapy recommendations, informal training opportunities, monitoring objectives, monitoring for progress/ regression, by the Behavior Health Director by July 16, 2013. To ensure the Service Coordinator implement these measures, the Behavior Health Director will meet with the Service Coordinator daily until these measures are completed and then weekly until proficiency in implementation is acquired and then fade to bi weekly meetings. 7-22-13 The QMRP observes the clients at the day program at least weekly.	07/26/2013

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	money presented up to $10.00. 2. Learn six rights of medication. Further review of client #1's training objectives failed to identify the training methods to be used for the implementation of the aforementioned training objectives. Client #2's record was reviewed on 6/18/13 at 12:26 P.M.. A review of the client's 10/17/12 IPP (Individual Program Plan) indicated, in part, the following training objectives: 1. Prepare a food item. 2. Recognize the numbers and the reasons for calling 911. 3. When prompted, client #2 will let staff assist her in shaving her face within ten minutes of being asked to shave. 4. Client #2 will purchase an item from a vending machine. Further review of client #2's training objectives failed to identify the training methods to be used for the implementation of the aforementioned training objectives. Client #3's record was reviewed on 6/18/13 at 1:12 P.M.. A review of the client's 10/15/12 IPP (Individual Program Plan) indicated, in part, the following training objectives: 1. Will continue to identify the value of a penny and nickel by pointing, gesturing, or saying. 2. Client #3 will learn to repeat a word with verbal prompts for staff. Further review of client #3's training objectives failed to			

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	identify the training methods to be used for the implementation of the aforementioned training objectives. Client #4's record was reviewed on 6/18/13 at 2:08 P.M.. A review of the client's 8/21/12 IPP (Individual Program Plan) indicated, in part, the following training objectives: 1. Client #4 will improve functional academics by learning to add double digits to 25. 2. Client #4 will improve her simple meal preparation skills. 3. Client #4 will improve her knowledge of her over the counter medications. 4. Client #4 will improve her personal hygiene skills. 5. Client #4 will help plan and participate in community outing for peers and staff once a month. Further review of client #4's training objectives failed to identify the training methods to be used for the implementation of the aforementioned training objectives. Client #5's record was reviewed on 6/18/13 at 2:33 P.M.. A review of the client's 10/22/12 IPP (Individual Program Plan) indicated, in part, the following training objectives: 1. Client #5 will continue to learn her medication by stating the purpose and side effects and will administer own medication with 100% independence. 2. Client #5 will insert hearing aid, turning it on and			

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	adjusting the volume. 3. During mealtime, client #5 will eat slowly. 4. Client #5 will continue to learn her phone number. 5. Client #5 will count ten items. Further review of client #5's training objectives failed to identify the training methods to be used for the implementation of the aforementioned training objectives. Service Coordinator #1 (Qualified Intellectual Disabilities Professional) was interviewed on 6/19/13 at 9:56 A.M.. Service Coordinator #1 indicated client #1, #2, #3, #4, and #5's training objectives will be reviewed and corrected to indicate criteria and methods to be used in their implementation. 2. Client #2 was observed at her day program assignment on 6/17/13 from 1:02 P.M. to 2:21 P.M.. During the observation period, client #2 identified assorted pictures and played bingo. Day program staff were not observed to assist or prompt client #2 to purchase an item from a vending machine. Client #2's record was reviewed on 6/17/13 at 2:22 P.M.. The review of the client's day program objectives indicated the client had an objective to "purchase an item from a vending machine." Review			

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	of data collection sheet for the implementation of the objective from 6/1/13 to 6/18/13 indicated the objective had not been implemented. Day program staff #1 was interviewed on 6/17/13 at 2:27 P.M.. Day program staff #1 stated, "We haven't been implementing this objective because house staff don't send any money for [client #2] to use in the vending machine." Direct care staff #1 was interviewed on 6/18/13 at 8:23 A.M.. Direct care staff #1 stated, "That's an old goal (purchase an item from a vending machine). It's not in the book so we don't implement that any more." Client #2's record was reviewed on 6/18/13 at 12:26 P.M.. A review of the client's 10/17/12 IPP (Individual Program Plan) indicated, in part, the following training objective: "[Client #2] will purchase an item from a vending machine." Service Coordinator #1 (Qualified Intellectual Disabilities Professional) was interviewed on 6/19/13 at 9:56 A.M.. Service Coordinator #1 indicated client #2's objective for purchasing an item from a vending machine is a current objective and staff at the group home should have a			

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	copy of the objective so they can send money to the workshop for its implementation. 3. Client #2's record was reviewed on 6/18/13 at 12:26 P.M.. A review of the client's 10/17/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 10/17/12. Client #3's record was reviewed on 6/18/13 at 1:12 P.M.. A review of the client's 10/15/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 10/15/12. Client #4's record was reviewed on 6/18/13 at 2:08 P.M.. A review of the client's 8/21/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 8/21/12. Client #5's record was reviewed on 6/18/13 at 2:33 P.M.. A review of the client's 10/22/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 10/22/12. Program Director #1 was interviewed on 6/19/13 at 9:56 A.M.. Program Director			

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	#1 indicated client #2, #3, #4, and #5's Individual Program Plans had not been routinely reviewed by the Service Coordinator. Program director #1 stated, "Client completion of objectives could not be determined due to the past Service Coordinator not analyzing (reviewing) the clients' data." Program director #1 further indicated client regression or losing of skills could not be determined, clients who were failing to progress toward their objectives could not be determined, and clients who should be considered for new training objectives could not be determined due to the past Service Coordinator not analyzing and reviewing the clients' IPP and data. 9-3-3(a)			

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W000210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, interview and record review for 1 additional client (#4), the interdisciplinary team failed to re-assess the client's hearing as needed. Findings include: During the 6/17/13 observation period at the facility's owned day program between 1:05 PM and 2:00 PM, when asked a question, client #4 leaned toward the surveyor as if the client was not able to hear. Client #4 would then say "Huh." During the 6/17/13 observation period between 4:10 PM and 6:55 PM, at the group home, client #4 appeared to have difficulty hearing. The TV was on in the group home in the living room. A movie was playing on the TV. Client #4 sat on a couch across the room. Client #4 would lean her body forward to attempt to hear the TV. At one point, staff #6 asked client #4 if she could hear the TV. Client #4 stated "No." Staff #6 got up and turned the TV's volume up. Also during the same observation period, client #4 would lean in toward the surveyor when	W000210	Client #4 had an appointment with the audiologist to assess her hearing on July 12, 2013. The community service nurse will review the client for assessment needs monthly and will then fade to quarterly assessment and will refer to the Health care manager for any new assessments that are required. The Service coordinator will audit the file weekly until all current assessments are obtained and will then fade to monthly and quarterly assessments.7-22-13 The Community service nurse will review all other client charts to ensure hearing evaluations and hearing aid care is completed.	07/26/2013

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	talking. Client #4 appeared to have difficulty hearing as the client would say "Huh." Client #4 was observed at the group home on 6/18/13 from 5:31 A.M. until 8:29 A.M.. During medication administration, client continually said, "Huh?" At the end of the medication administration client #4 said, "My ears are messed up." Client #4's record was reviewed on 6/18/13 at 1:30 PM. Review of the 3/1/13 Annual Physical Examination indicated client #4 had an audiological examination completed on 2/28/12. Client #4's 2/28/12 audiological exam indicated the client's hearing in right and left ears was within normal limits. Client #4's Cumulative Medical Record indicated on 5/17/13 client #4 saw her doctor. The 5/17/13 note indicated client #4 ears were impacted with cerumen (ear wax). The note indicated Debrox drops (ear wax removal) was ordered to be used 2 times a day in each ear for 10 days. The note indicated client #4 was to return to the doctor in 2 weeks. Client #4's record and/or 5/13 Cumulative Medical record did not indicate client #4's hearing had been re-assessed.			

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	Interview with LPN #1 on 6/18/13 at 2:10 PM indicated she was not aware client #4 had a problem with hearing. LPN #1 indicated client #4 had complained of an earache in the past and was seen by an Ear/Nose/Throat (ENT) doctor. LPN #1 stated client #4 had a "build up of ear wax." LPN #1 indicated client #4's hearing was last tested in 2/12. LPN #1 indicated client #4 was to return to the ENT for a follow-up in 2 weeks, but the follow-up appointment did not get done as client #4 went to camp. Interview with the Director of Behavioral Health and Service Coordinator (SC) #1 on 6/19/13 at 10:08 AM indicated they were not aware client #4 had a problem hearing. SC #1 indicated client #4's hearing would need to be re-assessed. 9-3-4(a)			

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W000234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. Based on record review and interview, the facility failed to assure training objectives for 3 of 3 sampled clients (clients #1, #2, and #3), and 2 additional clients (clients #4 and #5) specified methods to be used in their implementation. Findings include: Client #1's record was reviewed on 6/18/13 at 11:17 A.M.. A review of the client's 10/24/12 IPP (Individual Program Plan) indicated, in part, the following training objectives: 1. Add value of money presented up to $10.00. 2. Learn six rights of medication. Further review of client #1's training objectives failed to identify the training methods to be used for the implementation of the aforementioned training objectives. Client #2's record was reviewed on 6/18/13 at 12:26 P.M.. A review of the client's 10/17/12 IPP (Individual Program Plan) indicated, in part, the following training objectives: 1. Prepare a food item. 2. Recognize the numbers and the reasons for calling 911. 3. When prompted, client #2 will let staff assist her	W000234	Once trained, the Service Coordinator will train the direct care staff on the client's new IPP and Programming needs. They will also be trained on active treatment and providing training at naturally occurring opportunities. Directly following this training, the Service Coordinator and other professionals will visit the home Daily to ensure that staff are providing these services. This monitoring will continue until staff have show proficiency in programming and will then fade to three times per week, weekly and then Bi weekly to ensure continued implementation.7-22-13The Service Coordinator will be trained by the Staff Development Director on PPSEE, our electronic Data and Programming by July 16, 2013. The Service Coordinator will also be trained on developing training methods for objectives, by the Behavior Health Director by July 16, 2013. To ensure the Service Coordinator implement these measures, the Behavior Health Director will meet with the Service Coordinator daily until these measures are completed and then weekly until proficiency in implementation is	07/26/2013

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	in shaving her face within ten minutes of being asked to shave. 4. Client #2 will purchase an item from a vending machine. Further review of client #2's training objectives failed to identify the training methods to be used for the implementation of the aforementioned training objectives. Client #3's record was reviewed on 6/18/13 at 1:12 P.M.. A review of the client's 10/15/12 IPP (Individual Program Plan) indicated, in part, the following training objectives: 1. Will continue to identify the value of a penny and nickel by pointing, gesturing, or saying. 2. Client #3 will learn to repeat a word with verbal prompts for staff. Further review of client #3's training objectives failed to identify the training methods to be used for the implementation of the aforementioned training objectives. Client #4's record was reviewed on 6/18/13 at 2:08 P.M.. A review of the client's 8/21/12 IPP (Individual Program Plan) indicated, in part, the following training objectives: 1. Client #4 will improve functional academics by learning to add double digits to 25. 2. Client #4 will improve her simple meal preparation skills. 3. Client #4 will improve her knowledge of her over the counter medications. 4. Client #4 will improve		acquired and then fade to bi weekly meetings7/30/13The objectives at this home for all clients were reviewed and were applicable the method of training was modified. The remainder of the above plan of correction serves as monitoring for continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G190	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/26/2013
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 120 AVENUE C GRIFFITH, IN 46319	

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	her personal hygiene skills. 5. Client #4 will help plan and participate in community outing for peers and staff once a month. Further review of client #4's training objectives failed to identify the training methods to be used for the implementation of the aforementioned training objectives. Client #5's record was reviewed on 6/18/13 at 2:33 P.M.. A review of the client's 10/22/12 IPP (Individual Program Plan) indicated, in part, the following training objectives: 1. Client #5 will continue to learn her medication by stating the purpose and side effects and will administer own medication with 100% independence. 2. Client #5 will insert hearing aid, turning it on and adjusting the volume. 3. During mealtime, client #5 will eat slowly. 4. Client #5 will continue to learn her phone number. 5. Client #5 will count ten items. Further review of client #5's training objectives failed to identify the training methods to be used for the implementation of the aforementioned training objectives. Service Coordinator #1 (Qualified Intellectual Disabilities Professional) was interviewed on 6/19/13 at 9:56 A.M.. Service Coordinator #1 indicated client #1, #2, #3, #4, and #5's training objectives			

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	will be reviewed and corrected to indicate criteria and methods to be used in their implementation. 9-3-4(a)			

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W000248	483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on observation, record review, and interview, the facility failed to assure group home staff had a copy of 1 of 3 sampled client's (client #2's) complete Individual Program Plan which included the day program training objective for purchasing an item from a vending machine. Findings include: Client #2 was observed at her day program assignment on 6/17/13 from 1:02 P.M. to 2:21 P.M.. During the observation period, client #2 identified assorted pictures and played bingo. Day program staff were not observed to assist or prompt client #2 to purchase an item from a vending machine. Client #2's record was reviewed on 6/17/13 at 2:22 P.M.. The review of the client's day program objectives indicated the client had an objective to "purchase an item from a vending machine." Review of data collection sheet for the implementation of the objective from 6/1/13 to 6/18/13 indicated the objective	W000248	The group home will be provided with copies of all IPPS the Service Coordinator will train the direct care staff on the client's new IPP and Programming needs. They will also be trained on active treatment and providing training at naturally occurring opportunities. Directly following this training, the Service Coordinator and other professionals will visit the home Daily to ensure that staff are providing these services and the documentation remains in place. This monitoring will continue until staff have show proficiency in programming and will then fade to three times per week, weekly and then Bi weekly to ensure continued implementation.	07/26/2013

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	had not been implemented. Day program staff #1 was interviewed on 6/17/13 at 2:27 P.M.. Day program staff #1 stated, "We haven't been implementing this objective because house staff don't send any money for [client #2] to use in the vending machine." Direct care staff #1 was interviewed on 6/18/13 at 8:23 A.M.. Direct care staff #1 stated, "That's an old goal (purchase an item from a vending machine). It's not in the book (client #2's Individual Program Plan binder) so we don't implement that any more." Client #2's record was reviewed on 6/18/13 at 12:26 P.M.. A review of the client's 10/17/12 IPP (Individual Program Plan) indicated, in part, the following training objective: "[Client #2] will purchase an item from a vending machine." Service Coordinator #1 (Qualified Intellectual Disabilities Professional) was interviewed on 6/19/13 at 9:56 A.M.. Service Coordinator #1 indicated client #2's objective for purchasing an item from a vending machine is a current objective and staff at the group home should have a copy of the client's complete Individual Program Plan which included the vending			

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	machine objective so group home staff can send money to the workshop for its implementation. 9-3-4(a)			

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W000249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and interview, the facility failed to assure a day program training objective was implemented for 1 of 3 sampled clients (client #2). Findings include: Client #2 was observed at her day program assignment on 6/17/13 from 1:02 P.M. to 2:21 P.M.. During the observation period, client #2 identified assorted pictures and played bingo. Day program staff were not observed to assist or prompt client #2 to purchase an item from a vending machine. Client #2's record was reviewed on 6/17/13 at 2:22 P.M.. The review of the client's day program objectives indicated the client had an objective to "purchase an item from a vending machine." Review of data collection sheet for the implementation of the objective from 6/1/13 to 6/18/13 indicated the objective had not been implemented.	W000249	The group home will be provided with copies of all IPPS the Service Coordinator will train the direct care staff on the client's new IPP and Programming needs. They will also be trained on active treatment and providing training at naturally occurring opportunities. Directly following this training, the Service Coordinator and other professionals will visit the home Daily to ensure that staff are providing these services and the documentation remains in place. This monitoring will continue until staff have show proficiency in programming and will then fade to three times per week, weekly and then Bi weekly to ensure continued implementation.	07/26/2013

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	Day program staff #1 was interviewed on 6/17/13 at 2:27 P.M.. Day program staff #1 stated, "We haven't been implementing this objective because house staff don't send any money for [client #2] to use in the vending machine." Group home staff #1 was interviewed on 6/18/13 at 8:23 A.M.. Group home staff #1 stated, "That's an old goal (purchase an item from a vending machine). It's not in the book so we don't implement that any more." Client #2's record was reviewed on 6/18/13 at 12:26 P.M.. A review of the client's 10/17/12 IPP (Individual Program Plan) indicated, in part, the following training objective: "[Client #2] will purchase an item from a vending machine." Service Coordinator #1 (Qualified Intellectual Disabilities Professional) was interviewed on 6/19/13 at 9:56 A.M.. Service Coordinator #1 indicated client #2's objective for purchasing an item from a vending machine is a current objective and staff at the group home should be sending money to the workshop for its implementation. 9-3-4(a)			

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W000255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. Based on record review and interview, the facility failed to assure training programs for 2 of 3 sampled clients (clients #2 and #3), and 2 additional clients (clients #4 and #5) were reviewed by the Service Coordinator (Qualified Intellectual Disabilities Professional) to determine if the clients successfully completed the objectives. Findings include: Client #2's record was reviewed on 6/18/13 at 12:26 P.M.. A review of the client's 10/17/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 10/17/12. Client #3's record was reviewed on 6/18/13 at 1:12 P.M.. A review of the client's 10/15/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 10/15/12.	W000255	The group home will be provided with copies of all IPPS the Service Coordinator will train the direct care staff on the client's new IPP and Programming needs. They will also be trained on active treatment and providing training at naturally occurring opportunities. Directly following this training, the Service Coordinator and other professionals will visit the home Daily to ensure that staff are providing these services and the documentation remains in place. This monitoring will continue until staff have show proficiency in programming and will then fade to three times per week, weekly and then Bi weekly to ensure continued implementation.	07/26/2013

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	Client #4's record was reviewed on 6/18/13 at 2:08 P.M.. A review of the client's 8/21/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 8/21/12. Client #5's record was reviewed on 6/18/13 at 2:33 P.M.. A review of the client's 10/22/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 10/22/12. Program Director #1 was interviewed on 6/19/13 at 9:56 A.M.. Program Director #1 indicated client #2, #3, #4, and #5's Individual Program Plans had not been routinely reviewed by the Service Coordinator. Program Director #1 stated, "Client completion of objectives could not be determined due to the past Service Coordinator not analyzing (reviewing) the clients' data." 9-3-4(a)			

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W000256	483.440(f)(1)(ii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is regressing or losing skills already gained. Based on record review and interview, the facility failed to assure training programs for 2 of 3 sampled clients (clients #2 and #3), and 2 additional clients (clients #4 and #5) were reviewed by the Service Coordinator (Qualified Intellectual Disabilities Professional) to determine if the clients were regressing or losing skills. Findings include: Client #2's record was reviewed on 6/18/13 at 12:26 P.M.. A review of the client's 10/17/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 10/17/12. Client #3's record was reviewed on 6/18/13 at 1:12 P.M.. A review of the client's 10/15/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 10/15/12. Client #4's record was reviewed on 6/18/13 at 2:08 P.M.. A review of the	W000256	The service coordinator will be trained by the Staff Development Director on PPSEE, our electronic Data and programming program, by 7/7/13. The service coordinator will also be trained on monitoring for progress/regression, by the Behavior health director by 7/7/13. Once trained the service Coordinator will review all client goals for areas in which the client may be experiencing regression or lose of skills as necessary. To ensure the QIDP continues to implement these measures the Behavior Health Director will meet with the QIDP daily until these measures are completed and then weekly until proficiency in implementation is acquired and then will fade to bi-weekly meetings.	07/26/2013

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	client's 8/21/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 8/21/12. Client #5's record was reviewed on 6/18/13 at 2:33 P.M.. A review of the client's 10/22/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 10/22/12. Program Director #1 was interviewed on 6/19/13 at 9:56 A.M.. Program Director #1 indicated client #2, #3, #4, and #5's Individual Program Plans had not been routinely reviewed by the Service Coordinator. Program Director #1 further indicated client regression or losing of skills could not be determined due to the past Service Coordinator not analyzing and reviewing the clients' data. 9-3-4(a)			

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W000257	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. Based on record review and interview, the facility failed to assure training programs for 2 of 3 sampled clients (clients #2 and #3), and 2 additional clients (clients #4 and #5) were reviewed by the Service Coordinator (Qualified Intellectual Disabilities Professional) to determine if the clients were failing to progress toward their objectives. Findings include: Client #2's record was reviewed on 6/18/13 at 12:26 P.M.. A review of the client's 10/17/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 10/17/12. Client #3's record was reviewed on 6/18/13 at 1:12 P.M.. A review of the client's 10/15/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 10/15/12. Client #4's record was reviewed on	W000257	The service coordinator will be trained by the Staff Development Director on PPSEE, our electronic Data and programming program, by 7/7/13. The service coordinator will also be trained on monitoring for progress/regression, by the Behavior health director by 7/7/13. Once trained the service Coordinator will review all client goals for areas in which the client may have failed to progress toward identified objectives as necessary. To ensure the QIDP continues to implement these measures the Behavior Health Director will meet with the QIDP daily until these measures are completed and then weekly until proficiency in implementation is acquired and then will fade to bi-weekly meetings.	07/26/2013

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	6/18/13 at 2:08 P.M.. A review of the client's 8/21/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 8/21/12. Client #5's record was reviewed on 6/18/13 at 2:33 P.M.. A review of the client's 10/22/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 10/22/12. Program Director #1 was interviewed on 6/19/13 at 9:56 A.M.. Program Director #1 indicated client #2, #3, #4, and #5's Individual Program Plans had not been routinely reviewed by the Service Coordinator. Program Director #1 further indicated it could not be determined if clients were failing to progress toward their objectives due to the past Service Coordinator not analyzing and reviewing the clients' IPP and data. 9-3-4(a)			

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W000258	483.440(f)(1)(iv) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is being considered for training towards new objectives. Based on record review and interview, the facility failed to assure training programs for 2 of 3 sampled clients (clients #2 and #3), and 2 additional clients (clients #4 and #5) were reviewed by the Service Coordinator (Qualified Intellectual Disabilities Professional) to determine if the clients were to be considered for new training objectives. Findings include: Client #2's record was reviewed on 6/18/13 at 12:26 P.M.. A review of the client's 10/17/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 10/17/12. Client #3's record was reviewed on 6/18/13 at 1:12 P.M.. A review of the client's 10/15/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 10/15/12. Client #4's record was reviewed on	W000258	The service coordinator will be trained by the Staff Development Director on PPSEE, our electronic Data and programming program, by 7/7/13. The service coordinator will also be trained on monitoring for progress/regression, by the Behavior health director by 7/7/13. Once trained the service Coordinator will review all client goals for areas in which the client may require new objectives. To ensure the QIDP continues to implement these measures the Behavior Health Director will meet with the QIDP daily until these measures are completed and then weekly until proficiency in implementation is acquired and then will fade to bi-weekly meetings.	07/26/2013

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	6/18/13 at 2:08 P.M.. A review of the client's 8/21/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 8/21/12. Client #5's record was reviewed on 6/18/13 at 2:33 P.M.. A review of the client's 10/22/12 IPP (Individual Program Plan) indicated the client's IPP had not been reviewed by the Service Coordinator since 10/22/12. Program Director #1 was interviewed on 6/19/13 at 9:56 A.M.. Program Director #1 indicated client #2, #3, #4, and #5's Individual Program Plans had not been routinely reviewed by the Service Coordinator. Program Director #1 further indicated it could not be determined if clients should be considered for new training objectives due to the past Service Coordinator not analyzing and reviewing the clients' IPP and data. 9-3-4(a)			

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W000267	483.450(a)(1) CONDUCT TOWARD CLIENT The facility must develop and implement written policies and procedures for the management of conduct between staff and clients. Based on interview and record review for 1 of 3 sampled clients (client #1), the facility failed to develop a written policy and procedure which specifically addressed/outlined appropriate staff to client conduct and interactions. Findings include: The facility's reportable incident reports and/or investigations were reviewed on 6/18/13 at 6:30 AM and at 9:59 AM. The facility's 3/27/13 IAR (incident/accident reports) indicated "Staff was having a conversation concerning events that bother [client #1]. She eventually told staff she was scared to open up about things concerning our lead [staff #1]. Staff asked who (sic) do she feel comfortable talking to & (and) she said [Service Coordinator #2] or [staff #5]. Eventually she stated she was scared because she didn't want to be jumped on. Tried to get client to open up by making her feel comfortable to talk. She also stated some remarks that was (sic) made to her that seem as if it was (sic) racial remarks (my point of view)...Not sure what caused the incident towards the	W000267	The behavior health director will develop a consolidated policy for the management of conduct between staff and clients by 7/26/13, which will indicate the do and don'ts of staff to client conduct/interactions. Directly following the Director will train all of his service coordinators whom will distribute the information to direct care staff. This will be added to the annual training schedule under the abuse and neglect, respect and dignity topic. Training records are reviewed by management staff quarterly. 7-22-13 Interactions with staff and consumers will be monitored during home and workshop visits. To ensure staff are following these requirements professional staff will observe 3 times per week until staff have shown appropriate interactions. Once proficiency is obtained, observations will fade to one time per week for one month and the every other week thereafter.	07/26/2013

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	client...." The 3/27/13 IAR indicated "Service Coordinator spoke w/ (with) [client #1]. [Client #1] denied any fear towards her staff. No abuse or neglect reported." The facility's reportable incident reports and/or investigations were reviewed on 6/18/13 at 6:30 AM and at 9:59 AM. The facility's 7/2/12 reportable incident report indicated "[Client #1] reported to the Service Coordinator on 7/2/12 that she was assisting her roommate in finding her earrings. She said that staff saw her in her roommate drawer looking for her earrings when staff yelled at her. [Client #1] stated that staff told her 'Get out of the room you're pissing me off.' [Client #1] stated the staff who yelled at her was [staff #1]...." The facility's 11/6/12 follow-up report indicated "...The outcome of the investigation is as follows: The allegation was not substantiated. Staff was redirecting consumer prior to understanding the situation prior to redirecting. No intent for verbal abuse. It appears that [client #1] was embarrassed at being redirected by staff and labeled the redirection as yelling. In regards to corrective action from the Service Coordinator will mediate between the consumer and staff to clear any hurt			

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	feelings and establish a good relationship between staff and consumer...." The facility's 7/3/12 hand written Investigation Fact Sheet Summary and Conclusion indicated the investigator interviewed client #1 on 7/2 and 7/3/12. The hand written sheet indicated client #1 "Stayed consistent both days." The fact sheet indicated the Service Coordinator indicated "...that [staff #1] has gotten upset with Service Coor (coordinator) and [staff #1's] tone was off. The Service Coor was refencing (sic) that she (staff #1) tends to have a tone." The facility's policy and procedures were reviewed on 6/18/13 at 11:58 AM. The facility's 9/11 policy entitled Resident's Rights indicated a section entitled "Privacy." The section indicated Each Resident to be: "1. Treated with consideration, respect and full recognition of his dignity and individuality. 2. Given privacy during treatment and care of personal needs. 3. Protected by confidential treatment of all needs. 4. Protected from release if information from his record without his written consent to anyone not specified by law to receive it...."			

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	The facility's undated Corrective Action/Discipline policy indicated "When standards of conduct are violated, corrective action will be administered in accordance with the nature and severity of the offense at the sole discretion of The Arc Northwest Indiana...." The undated corrective action policy for staff and/or the facility's client rights policy did not specifically address and/or include a policy in regard to staff to client conduct and interactions as the policies did not specifically indicate the do and don'ts of staff to client conduct/interactions. Interview with administrative staff #1 on 6/18/13 at 11:58 AM indicated the undated Corrective Action Discipline Policy and the 9/11 Client Rights policy were the policies the facility utilized in regard to staff to client conduct and interactions. Interview with the Director of Behavioral Health on 6/19/13 at 10:12 AM indicated he did not know if the facility had a policy and procedure in regard to staff to client interactions/conduct. 9-3-5(a)			

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review for 1 additional client (#4), the facility's nursing services failed to meet the nursing needs of the client. The facility's nursing services failed to conduct and or seek medical treatment/evaluation of a client after the client had had a seizure at the group home. The facility's nursing services failed to give staff specific instructions and/or guidelines to follow after the client's initial seizure. The facility's nursing services failed to ensure client #4 returned to her doctor for a follow-up appointment in regard to the client's ear wax. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 6/18/13 at 6:30 AM and at 9:59 AM. The facility's 4/2/13 reportable incident report indicated "[Client #4] was sitting in the chair and made a loud noise. [Client #4] went to the side of her chair and then slid out of her chair to the ground. [Client #4] was having a seizure. The health tech was page (sic) to the workshop. The health tech called 911. The health safety tech took [client #4's] vitals, the temperature-100, pulse-60,	W000331	Cl #4 has been evaluated by a neurologist and had a follow up appointment on 4/24/13 her next appointment is in August. To prevent future episodes a copy of the risk plans is accompanying the on call nursing phone beginning 7/12/13. These risk plans will inform the nurse of exisiting conditions so that they are better able to identify emerging issues. Risk plans will be revised annually and as needed. These plans will be monitored by the Nursing services director or designee on a quarterly basis to ensure they are kept up to date. Cl #4 saw the audiologist on 6/21/13 was treated and had cerumen removed. A follow up appointment is to occur within 3 to 4 weeks. Once scheduled this appointment and its follow up appointments will be maintained in an annual schedule of required appointments by the Health Care Manager. The Community Services Nurse will audit the consumers file to ensue other required assessments are completed annually and will audit the file annually as needed following this initial audit.	07/26/2013

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	respiration 18, blood pressure-140/90. The seizure lasted two minutes, The ambulance arrive (sic) and transported [client #4] to [name of hospital]." The reportable incident report indicated client #4 had the seizure at 11:22 AM. The facility's 4/2/13 Incident/Accident Report (IAR) indicated the health and safety tech called LPN #1 at 11:33 AM. The IAR indicated client #4 had the seizure at the workshop/day program which was owned by the facility. The facility's 4/2/13 IAR indicated at 6:45 AM, in the client #4's bedroom, "I (staff #1) went up stairs to help consumer when I hear (sic) [client #4] grunting as if she was stretching. When I looked in (sic) [client #4] was having a seizure, she was laying on her back. It lasted 1 1/2 minutes. She laid in bed for/until 7:19 AM. No known injuries at this time." The 4/2/13 IAR indicated "...Cause of this Incident/Accident I don't know. She is not known to have seizures...." The 4/2/13 IAR indicated staff #1 notified the nurse (no time documented on form). The IAR Part B Incident/Accident Follow-Up Report indicated "...Action Taken (treatment, intervention, referrals, etc.) Describe briefly [Client #4] was sent to the workshop and had another seizure in which the ambulance was called.			

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	[Client #4] was taken to the hospital and was kept overnight." The 4/2/13 IAR indicated in the comments section of the form "...did not have a seizure risk plan in place." The 4/2/13 IAR failed to indicate the specific time the nurse was notified and/or which nurse was notified of client #4's 6:45 AM seizure. The 4/2/13 IAR also failed to indicate the nurse assessed client #4 after the initial seizure at the group home, made recommendations, and/or gave specific instructions to staff as client #4 was not known to have seizures. The facility's Residential Services Pager Review (on-call log) was reviewed on 6/18/13 at 2:35 PM. The facility's on call log indicated RN #1 was called by facility staff at 7 AM on 4/2/13. The 4/2/13 log indicated "[Client #4] 6:45 Seizure 1.5 min (minutes) in bed...had one- 3 mos (months) ago MRI (unreadable word)." Client #4's record was reviewed on 6/18/13 at 1:30 PM. Client #4's Cumulative Medical Record indicated the following nurse entries (not all inclusive): -3/28/13 "CT scan results of head faxed to [name of doctor's] office. No new orders rec'd (received)." -4/2/13 "6:45 a Grand MAL seizure			

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	reported by staff. Seizure lasted 1/1/2 minutes while client was still in bed. Staff reported the incident to the on-call nurse." The 4/2/13 note was written by LPN #1. -4/2/13 "[Name of doctor's] office notified. MD (medical doctor) out of town. Sending client to [name of hospital] ER (emergency room) for evaluation." The 4/2/13 note was written by LPN #1. -4/2/13 "Seizure activity noted at the workshop lasting 2 minutes. Transferred to [name of hospital] per ambulance. T (temperature)-100.1 P (pulse)-60 R (respirations) 18 BP (blood pressure) 140/90 [Name of hospital] on bypass." The 4/2/13 note was written by LPN #1. -4/8/13 "Discharged from [name of hospital]. New Dx (diagnosis) of seizures." The above mentioned nurse notes did not indicate the facility assessed the client and/or immediately sought medical evaluation/care for client #4 after the initial seizure at the group home. Client #4's 3/1/13 Annual Physical Examination did not indicate client #4 had a history and/or seizure diagnosis.			

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	Client #4's 8/21/12 Individual Support Plan indicated client #4 did not have a seizure diagnosis and/or demonstrate seizures. Client #4's 8/20/12 Medical Review Worksheet did not indicate client #4 had a history and/or seizure diagnosis. Interview with LPN #1 on 6/18/13 at 2:10 PM indicated she was the nurse for the group home. When asked if she was notified of client #4's initial seizure, LPN #1 stated "Probably on-call nursing took call." LPN #1 indicated she was notified of client #4's seizure. LPN #1 indicated she instructed staff to send client #4 out to be evaluated after the seizure at the workshop occurred. LPN #1 indicated she did not assess the client after the initial seizure at the group home. LPN #1 indicated client #4 was not assessed until the second seizure occurred. LPN #1 indicated client #4 had a seizure in November 2012 but had not had any seizures since then. LPN #1 indicated facility staff should have been given instructions on what to do after the initial seizure at the group home. LPN #1 indicated she would have sent client #4 to the hospital for an evaluation. When asked who was the nurse on call on 4/2/13, LPN #1 looked at the on-call log			

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	and stated "[RN #1] was on-call." LPN #1 indicated client #4 did not have a seizure diagnosis prior to 4/2/13. Interview with RN #1 on 6/19/13 at 10:42 AM indicated facility staff called her 15 minutes after client #4 had a seizure at the group home on 4/2/13. RN #1 indicated client #4 had a seizure 3 months ago. RN #1 indicated an MRI was ordered which did not show any problems. RN #1 indicated facility staff told her client #4 was laying in bed when the client had the seizure. When asked why client #4 was sent to the workshop after the seizure at the group home, RN #1 indicated facility staff told her client #4 did fine after the seizure. RN #1 stated she told the staff to monitor client #4 and if the client was "lethargic or had a seizure to call back." RN #1 indicated she did not document instructions given to staff. RN #1 indicated she told client #4's nurse after the nurse came in. RN #1 indicated client #4's cumulative medical notes indicated LPN #1 called the client's doctor after the initial seizure and assessed the client. 2. During the 6/17/13 observation period at the facility's owned day program between 1:05 PM and 2:00 PM, when asked a question, client #4 leaned toward the surveyor as if the client was not able to hear. Client #4 would then say "Huh."			

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	During the 6/17/13 observation period between 4:10 PM and 6:55 PM, at the group home, client #4 appeared to have difficulty hearing. The TV was on in the group home in the living room. A movie was playing on the TV. Client #4 sat on a couch across the room. Client #4 would lean her body forward to attempt to hear the TV. At one point, staff #6 asked client #4 if she could hear the TV. Client #4 stated "No." Staff #6 got up and turned the TV's volume up. Also during the same observation period, client #4 would lean in toward the surveyor when talking. Client #4 appeared to have difficulty hearing as the client would say "Huh." Client #4's record was reviewed on 6/18/13 at 1:30 PM. The 3/1/13 Annual Physical Examination indicated client #4 had an audiological examination completed on 2/28/12. Client #4's 2/28/12 audiological exam indicated the client's hearing in right and left ears was within normal limits. Client #4's Cumulative Medical Record indicated on 5/17/13 client #4 saw her doctor. The 5/17/13 note indicated client #4 ears were impacted with cerumen (ear wax). The note indicated Debrox drops			

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	(ear wax removal) was ordered to be used 2 times a day in each ear for 10 days. The note indicated client #4 was to return to the doctor in 2 weeks. Client #4's medical records did not indicate client #4 returned to her doctor for a follow-up visit. Client #4's record and/or 5/13 Cumulative Medical record did not indicate client #4's hearing had been re-assessed. Interview with LPN #1 on 6/18/13 at 2:10 PM indicated she was not aware client #4 had a problem with hearing. LPN #1 indicated client #4 had complained of an earache in the past and was seen by an Ear/Nose/Throat (ENT) doctor. LPN #1 stated client #4 had a "build up of ear wax." LPN #1 indicated client #4's hearing was last tested in 2/12. LPN #1 indicated client #4 was to return to the ENT for a follow-up in 2 weeks, but the follow-up appointment did not get done as client #4 went to camp. LPN #1 indicated the appointment would need to be rescheduled. 9-3-6(a)			

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W000436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, the facility failed to assure 1 of 3 sampled clients (client #2) wore eyeglasses as prescribed. Findings include: Client #2 was observed at the group home on 6/18/13 from 5:31 A.M. until 8:29 A.M.. From 5:31 A.M. until 8:28 A.M., client #2 did not wear eyeglasses. Direct care staff #2 prompted client #2 to put her eyeglasses on at 8:28 A.M.. Client #2's record was reviewed on 6/18/13 at 12:26 P.M.. A review of the client's 6/6/13 physician orders indicated client #2 was to put on her eyeglasses upon rising in the morning. Nurse #1 was interviewed on 6/18/13 at 2:05 P.M.. Nurse #1 stated, "[Client #2] should have been wearing her glasses this morning." 9-3-7(a)	W000436	Client #2 will have a risk plan put in place in regards to her eyeglasses by 7/26/13 which will provide her with multiple prompts and documentation of these prompts throughout the day. This plan will be monitored by the service coordinator 2x a week until Cl #2 is consistently wearing her glasses. Monitoring will fade to weekly for a month and then biweekly thereafter. 7-22-13 A training objective has been developed for Cl #2 to wear her glasses	07/26/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G190	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/26/2013

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W000455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview, the facility failed to assure 2 of 3 sampled clients (clients #2 and #3) washed their hands after toileting at the day program. Findings include: Clients #2 and #3 were observed at their day program assignment on 6/17/13 from 1:02 P.M. to 2:21 P.M.. During the observation period, client #2 went to the bathroom at 1:03 P.M. and at 1:29 P.M. Upon exiting the bathroom, day program staff did not prompt or assist client #2 in washing her hands. Client #3 went to the bathroom at 1:31 P.M. and at 1:46 P.M.. Upon exiting the bathroom, day program staff did not prompt or assist client #3 in washing her hands. Service Coordinator #1 (Qualified Intellectual Disabilities Professional) was interviewed on 6/19/13 at 9:56 A.M.. Service Coordinator #1 indicated day program staff should have assisted or prompted clients #2 and #3 in washing their hands after using the bathroom. 9-3-7(a)	W000455	All staff will be trained to execute universal precautions and basic sanitization practices by 7/26/13 this includes prompting consumers to wash their hands. To ensure future compliance professional staff will audit the day program three times per week on a random schedule to ensure that all staff are practicing and prompting clients to practice universal precautions. Once routine is established monitoring will fade to the weekly visits and then biweekly visits.	07/26/2013

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W000484	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation, interview and record review for 3 of 3 sampled clients (#1, #2 and #3) and for 2 additional clients (#4 and #5), the facility failed to place/provide clients with a butter knife when eating their dinner meal. Findings include: During the 6/17/13 observation period between 4:10 PM and 6:55 PM, at the group home, the group home had lasagna, salad and mixed vegetables for dinner. Client #5 set the dining room table for the dinner meal. Client #5 placed a fork at each setting. No knife and/or spoon was placed on the table for clients #1, #2, #3, #4 and #5 to use. Once the dinner was finished staff #7 placed the lasagna on each client's plate in the kitchen. During the 6/17/13 observation period, staff #7 retrieved a butter knife from the kitchen and cut up client #3 and #5's lasagna. Client #2's lasagna was cut into a square with large noodles. Client #2 placed whole lasagna noodles into her mouth. Client #2 was not encouraged and/or offered a butter knife to cut up the lasagna noodles.	W000484	Staff will be trained on proper table settings for meals including a full set of dinning wear, beverages, condiments being present, prompting for appropriate rate and size of bites, and family style dinning by 7/26/13. To ensure staff are following these requirements professional staff will observe 3 meals per week until staff have shown proficiency in preparing and prompting clients at meal times. Once obtained, observations will fade to one time per week for one month and the every other week thereafter.	07/26/2013

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	Interview with Service Coordinator (SC) #1 on 6/19/13 at 10:12 AM indicated butter knives should have been placed on the table for clients #1, #2, #3, #4 and #5 to use. 9-3-8(a)			

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W000488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 3 of 3 sampled clients (#1, #2 and #3) and for 2 additional clients (#4 and #5), the facility failed to encourage the clients to eat family style at the dinner meal. The facility failed to encourage clients to slow down and/or to take smaller bites of food. Findings include: During the 6/17/13 observation period between 4:10 PM and 6:55 PM, at the group home, the group home had lasagna, salad and mixed vegetables for dinner. Staff #7 and client #5 prepared the dinner meal. Once the dinner was finished staff #7 placed the lasagna and mixed vegetables on each client's plate in the kitchen. Staff #7 assisted client #5 to place salad on each client's plate. Client #5 then carried client #1, #2, #3, #4 and #5's plates into the dining room and placed them on the table. Client #5 and staff #7 filled each client's glass with water from the faucet at the kitchen sink. No ice was placed in the cups/glasses. Clients #1, #2, #3, #4 and #5 were not encouraged to eat family style and/or to serve themselves as the clients had skills and capabilities to serve themselves.	W000488	Staff will be trained on proper table settings for meals including a full set of dinning wear, beverages, condiments being present, prompting for appropriate rate and size of bites, and family style dinning by 7/26/13. To ensure staff are following these requirements professional staff will observe 3 meals per week until staff have shown proficiency in preparing and prompting clients at meal times. Once obtained, observations will fade to one time per week for one month and the every other week thereafter. 7-22-13 After proficiency has been obtained professional staff will continue to monitor meals on at least a weekly basis.	07/26/2013

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	During the 6/17/13 dinner meal clients #1, #2, #3, #4 and #5 poured their own salad dressing onto their salads and/or with hand over hand assistance. During the 6/17/13 observation period, staff #7 cut up client #3 and #5's lasagna without teaching and/or encouraging the clients to assist. Also during the 6/17/13 dinner meal, clients #2 and #3 took large bites of food without redirection and/or prompts to take smaller bites. Interview with Service Coordinator (SC) #1 on 6/19/13 at 10:12 AM indicated clients #1, #2, #3, #4 and #5 should eat family style meals. SC #1 indicated clients should be allowed to serve themselves. 9-3-8(a)			