

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G797	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/24/2015
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 9029 S AMERICA RD LA FONTAINE, IN 46940
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W 000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 4/14, 4/15, 4/16, 4/17, and 4/24/15.</p> <p>Facility Number: 0012563 Provider Number: 15G797 AIM Number: 201018540</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 000		
W 125 Bldg. 00	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review, and interview, for 2 of 2 sampled clients (clients #1 and #2) and 2 additional clients (clients #3 and #4), the facility failed to ensure clients #1, #2, #3, and #4 had unimpeded access to secured coffee for clients #1, #2, #3, and #4 and failed to ensure the coffee restriction had been assessed.</p>	W 125	<p>W 125 Protection of Client Rights – Coffee restricted Corrective action for resident(s) found to have been affected The clients in this home enjoy coffee and drink caffeine free coffee with non-dairy creamer. All Direct Support Professionals (DSPs) will receive training on what is restricted (e.g., sharps) and what is not, such as coffee. This</p>	05/24/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>Findings include:</p> <p>On 4/14/15 from 1:25pm until 5:48pm, and on 4/15/15 from 6:20am until 8:20am, clients #1, #2, #3, and #4 were at the group home with GHS (Group Home Staff) #1 GHS #2, GHS #3, GHS #4, GHS #5, GHS #6, and GHS #7.</p> <p>On 4/14/15 from 1:25pm until 5:48pm, the facility's instant decaffeinated coffee was kept secured inside a locked cabinet and on top of the kitchen cabinets. From 1:25pm until 1:50pm, client #4 verbally requested coffee from GHS #4 and GHS #4 redirected client #4 that coffee was to be given after chores. At 1:50pm, GHS #4 unlocked and opened the secured kitchen cabinet and an eight (8) ounce (oz.) container of instant coffee was inside. GHS #4 indicated the coffee should not have been locked inside the kitchen cabinet. At 1:50pm, GHS #4 who indicated he was six feet six inches tall, held the container of instant coffee in his hand, extended his arm over his head, stood on his toes to place the container of instant coffee atop the kitchen cabinets and pushed the container back against the wall. GHS #4 stated client #4 "would drink it all" if client #4 had access to the coffee. From 1:50pm until 1:55pm, client #4 finished cleaning her room,</p>		<p>training will focus not only on the list of restrictions, but also on the importance of not restricting those things that the team – with HRC approval – has not determined need to be restricted.</p> <p>How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence Training staff on list of restrictions and importance of not restricting other things, including coffee. How corrective actions will be monitored to ensure no recurrence Managers supervise and train Direct Support Professional (DSP) staff members. The managers are supervised by the director who meets with them regularly. The director will ensure that the training takes place.</p>	

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	<p>bathroom, and wiped off door handles in the group home. At 1:55pm, client #4 returned to the dining room and requested coffee multiple times from GHS #4. Client #4 looked throughout the kitchen, opening/closing cabinets, and looked for the instant coffee. At 1:55pm, client #4 looked upward, pointed to the instant coffee container atop the kitchen cabinets, and indicated she wanted coffee. From 1:55pm until 2:10pm, GHS #4 prepared client #4's instant coffee in an individual coffee tumbler with a lid. GHS #4 replaced the instant coffee container back atop the kitchen cabinets. From 2:10pm until 5:48pm, client #4 drank her coffee from her cup. At 2:50pm, the staff at the group home changed and GHS #6 and GHS #7 were present with client #4. At 2:50pm, client #4 requested a cup of coffee. GHS #6 and GHS #7 checked the locked storage cabinet and no coffee was inside. Client #4 pointed to on top of the kitchen cabinets and indicated where the coffee was stored. At 2:50pm, GHS #6 and GHS #7 retrieved a dining room chair, stood on top of the chair, and reached the coffee. From 2:55pm until 5:48pm, client #4 drank coffee from her cup. The instant coffee was replaced atop the kitchen cabinets. At 2:55pm, client #4 indicated she could not reach to access the instant coffee independently.</p>			

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	<p>On 4/15/15 from 6:20am until 7:00am, client #4 and GHS #2 searched each cabinet in the kitchen, closets, and the instant coffee container could not be located at the group home by client #4. At 7:00am, GHS #2 and client #4 requested assistance of GHS #8 to locate the instant coffee. At 7:00am, GHS #8 and client #4 opened the kitchen cabinet, moved boxes of mixes and bottles of unopened salad dressings, and reached to the back of the cabinet to retrieve the opened instant coffee container. At 7:00am, client #4 independently made her own coffee. At 7:00am, GHS #8 stated client #4 drank "lots" of coffee and indicated the coffee was kept behind the other items to ensure the facility did not run out of coffee.</p> <p>On 4/16/15 at 8:50am, an interview with the Agency Registered Nurse (RN) was conducted. The RN indicated client #4 had no medical reason to restrict her coffee. The RN indicated too much coffee was not good for a person.</p> <p>On 4/24/15 at 9:10am, an interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) was conducted. The QIDPD indicated client #4 would drink coffee all day if staff did not try to redirect her from drinking too</p>			

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	<p>much coffee. The QIDPD indicated the instant coffee should not have been kept secured and out of reach of clients #1, #2, #3, and #4. The QIDPD indicated clients #1, #2, #3, and #4 did not have unimpeded access to the secured coffee and did not have goals or a plan to decrease the restrictions of the coffee. The QIDPD indicated clients #1, #2, #3, and #4 had not given consent for the coffee to be secured. The QIDPD indicated no assessments were completed for clients #1, #2, #3, and #4 for secured coffee.</p> <p>On 4/15/15 at 10:30am, client #1's record was reviewed. Client #1's 4/21/14 ISP (Individual Support Plan) updated 1/2015, 4/2014 BSP (Behavior Support Plan), and 4/2014 FA (Functional Assessment) did not indicate an identified need to secure coffee. Client #1's record did not indicate consent for secured coffee.</p> <p>On 4/15/15 at 9:15am, client #2's record was reviewed. Client #2's 5/29/14 ISP updated 1/2015, 3/30/15 BSP, and 4/2014 FA did not indicate an identified need to secure coffee. Client #2's record did not indicate consent for secured coffee.</p> <p>On 4/15/15 at 11:00am, client #4's record was reviewed. Client #4's 4/21/14 ISP</p>			

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W 137 Bldg. 00	<p>and 4/2014 BSP did not indicate an identified need to secure coffee. Client #4's record did not indicate consent for secured coffee.</p> <p>9-3-2(a)</p> <p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation and interview, for 2 additional clients (clients #3 and #4), the facility failed to ensure clients #3 and #4's clothing fit to client #3 and #4's body type to protect their personal privacy.</p> <p>Findings include:</p> <p>1. On 4/14/15 from 1:25pm until 5:48pm, on 4/15/15 from 6:20am until 8:20am, and on 4/15/15 at 11:20am, at the Day Services Site, client #3 wore oversized blue jeans. On 4/14/15 from 1:25pm until 5:48pm, client #3 wore oversized blue jeans without a belt. From 1:25pm until 1:55pm, client #3 wore blue jeans and slept in her bed at the group home. From 1:55pm until 5:48pm, client #3 wore the same oversized blue jeans without a belt, her pants sagged downward when she</p>	W 137	<p>W 137 Protection of Client Rights – Clothing & Personal Privacy Corrective action for resident(s) found to have been affected DSPs will receive training to be observant of clothing covering each resident's body appropriately and to intervene with verbal prompting if privacy issues emerge. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Staff training on recognizing privacy issues with clothing and providing verbal prompts as needed to maintain appropriate covering. How corrective actions will be monitored to ensure no</p>	05/24/2015

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	<p>moved, and client #3 held up her pants by holding the waist edges up with her left hand. From 1:55pm until 2:55pm, male GHS (Group Home Staff) #4 prompted client #3 to pull up her pants twice when female client #3's pants sagged below her knees. At 2:10pm, GHS #4 stated client #3's pants were "oversized" and did not fit client #3. At 2:10pm, client #3 and GHS #4 showed client #3's bedroom and closet. Both indicated client #3's clothing inside the bedroom closet was in larger sizes than her body type. From 3:00pm until 5:48pm, client #3's pants sagged below her waist and hips four (4) additional times. Client #3 was not prompted or encouraged to change clothing or to wear a belt.</p> <p>On 4/15/15 from 6:20am until 8:20am, client #3 was observed at the group home. At 6:20am, client #3 woke up dressed in the same oversized jeans which she wore on 4/14/15. At 6:55am, client #3 indicated she wore the same oversized jeans as on 4/14/15 and did not wear a belt. From 6:20am until 7:10am, client #3 wore the same oversized blue jeans and held onto her pants with her left hand. At 7:10am, client #3 indicated she was holding up her pants. At 7:10am, client #3 and GHS (Group Home Staff) #3 and GHS #8 went into client #3's bedroom and client #3 exited her</p>		<p>recurrence Managers supervise and train Direct Support Professional (DSP) staff members. The managers are supervised by the director who meets with them regularly. The director will ensure that the training takes place.</p>	

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	<p>bedroom wearing the same blue jeans with a black belt.</p> <p>2. On 4/14/15 from 1:25pm until 5:48pm, and on 4/15/15 from 6:20am until 8:20am, client #4 wore a pink striped top with a low neckline to expose a dark red colored bra. From 1:25pm until 2:55pm, male GHS (Group Home Staff) #4 sat at the dining room table talking. Client #4 leaned forward multiple times onto the table while she was speaking with GHS #4 and her left breast covered with the red bra was exposed from the "V" neck of her striped pink top. When client #4 leaned backward into her chair each time after this occurred and client #4 shrugged her shoulders to shift her breast back into her shirt. No redirection was observed.</p> <p>On 4/24/15 at 9:10am, an interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) was conducted. The QIDPD indicated client #3 had oversized clothes and client #3 should wear clean clothing daily. The QIDPD indicated client #3 should wear a belt if her pants sagged to prevent client #3's pants from falling down to expose her body parts. The QIDPD indicated client #3 dressed in the current style of oversized clothing. The QIDPD indicated the group home had male staff</p>			

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W 227 Bldg. 00	<p>and female clients living and working there. The QIDPD indicated clients #3 and #4 should have been redirected during formal and informal opportunities to teach and encourage clients to wear clothing which fit their body types.</p> <p>9-3-2(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview, for 1 of 2 sampled clients (client #2), the facility failed to develop a program to address client #2's identified communication need.</p> <p>Findings include:</p> <p>On 4/14/15 from 1:25pm until 5:48pm, and on 4/15/15 from 6:20am until 8:20am, client #2 was assisted by the facility staff. During both observation periods GHS #1, GHS #2, GHS #8, and GHS #9 obtained client #2's drinks into a sippy cup without client #2 indicating she wanted a drink, selected client #2's activity of sorting plastic discs into baskets, and selected client #2's music on her radio located beside client #2. On</p>	W 227	<p>W 227 Individual Program Plan – Develop a Communication Goal Corrective action for resident(s) found to have been affected There is a communication goal already in place for the individual (client #2), which consists of using a sign to indicate wanting a drink. This goal will be reviewed with staff members to ensure that it is being implemented appropriately. In addition, a communication goal will be added to the ISP for time spent at the day program. How facility will identify other residents potentially affected & what measures taken This citation and its correction really only apply to one resident with significant deficits in speech. Measures or systemic changes facility put in place to ensure</p>	05/24/2015

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	<p>4/15/15 at 7:00am, GHS #2, GHS #8, and GHS #9 indicated they did not know sign language. GHS #2 and #8 indicated client #2 would lead them to what she wanted. During both observation periods client #2 was non verbal and did not speak words to communicate her wants/needs. No sign language, pictures, communication tools, and verbal communication were taught or used to communicate with client #2.</p> <p>On 4/15/15 at 9:15am, client #2's record was reviewed. Client #2's 5/29/14 ISP updated 1/2015, and 3/30/15 BSP indicated an identified need to communicate. Client #2's record did not indicate a goal/objective to communicate. Client #2's ISP indicated client #2 "communicates via signs and uses one word phrases to express her wants and needs. [Client #2] is able to understand language spoken to her. Reports refusal to use any type of communication book." Client #2's ISP indicated client #2 "uses a few signs to express her wants and needs, she also will lead staff to what she desires." No goal/objective to teach client #2 to communicate her wants and needs was available for review.</p> <p>On 4/24/15 at 9:10am, an interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) was</p>		<p>no recurrence Current goal will be reviewed with staff, and a new communication goal will be added to address time at day program. Staff will also receive training on the connections between communication and frustration, which can lead to maladaptive behavior. Specifically, that the staff need to train client #2 to utilize communication skills so she does not become frustrated when staff do not understand her requests. How corrective actions will be monitored to ensure no recurrence Managers supervise and train Direct Support Professional (DSP) staff members. One of these managers is responsible for implementing ISP goals, including those at the day program. The managers are supervised by the director who meets with them regularly. The director will ensure that the new goal is implemented and that training takes place.</p>				

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W 268 Bldg. 00	<p>conducted. The QIDPD stated client #2 used "some sign" language to communicate and "some" one word responses. The QIDPD indicated client #2 did not have a goal/objective developed for communicating her wants and needs.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview, for 2 additional clients (clients #3 and #4), the facility failed to teach clients #3 and #4 regarding dignity and personal privacy.</p> <p>Findings include:</p> <p>1. On 4/14/15 from 1:25pm until 5:48pm, on 4/15/15 from 6:20am until 8:20am, and on 4/15/15 at 11:20am, at the Day Services Site, client #3 wore oversized blue jeans. On 4/14/15 from 1:25pm until 5:48pm, client #3 wore oversized blue jeans without a belt. From 1:25pm until 1:55pm, client #3 wore blue jeans and slept in her bed at the group home. From 1:55pm until 5:48pm, client #3 wore the same oversized blue jeans without a belt, her</p>	W 268	<p>W 268 Conduct Toward Client – Clothing, Dignity & Personal Privacy Corrective action for resident(s) found to have been affected DSPs will receive training to be observant of clothing covering each resident's body appropriately and to intervene with verbal prompting if privacy issues emerge. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Staff training on recognizing privacy issues with clothing and providing verbal prompts as needed to maintain appropriate covering. How</p>	05/24/2015

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	<p>pants sagged downward when she moved, and client #3 held up her pants by holding the waist edges up with her left hand. From 1:55pm until 2:55pm, male GHS (Group Home Staff) #4 prompted client #3 to pull up her pants twice when female client #3's pants sagged below her knees. At 2:10pm, GHS #4 stated client #3's pants were "oversized" and did not fit client #3. From 3:00pm until 5:48pm, client #3's pants sagged below her waist and hips four (4) additional times. Client #3 was not prompted or encouraged to change clothing or to wear a belt.</p> <p>On 4/15/15 from 6:20am until 8:20am, client #3 was observed at the group home. At 6:20am, client #3 woke up dressed in the same oversized jeans which she wore on 4/14/15. At 6:55am, client #3 indicated she wore the same oversized jeans as on 4/14/15 and did not wear a belt. From 6:20am until 7:10am, client #3 wore the same oversized blue jeans and held onto her pants with her left hand. At 7:10am, client #3 indicated she was holding up her pants. At 7:10am, client #3, GHS (Group Home Staff) #3, and GHS #8 went into client #3's bedroom and client #3 exited her bedroom wearing the same blue jeans with a black belt. At 7:10am, GHS #8 indicated client #3 put on a belt after the surveyor had asked regarding client #3's</p>		<p>corrective actions will be monitored to ensure no recurrence Managers supervise and train Direct Support Professional (DSP) staff members. The managers are supervised by the director who meets with them regularly. The director will ensure that the training takes place.</p>	

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	<p>clothing. On 4/15/15 at 11:20am, at the Day Service Site client #3 indicated she was wearing the same oversized blue jeans with a black belt which she had slept in.</p> <p>2. On 4/14/15 from 1:25pm until 5:48pm, and on 4/15/15 from 6:20am until 8:20am, client #4 wore a pink striped top with a low neckline to expose a dark red colored bra. From 1:25pm until 2:55pm, male GHS (Group Home Staff) #4 sat at the dining room table talking. Client #4 leaned forward multiple times onto the table while she was speaking with GHS #4 and her left breast covered with the red bra was exposed from the "V" neck of her striped pink top. When client #4 leaned backward into her chair each time after this occurred and client #4 shrugged her shoulders to shift her breast back into her shirt. No redirection was observed.</p> <p>On 4/24/15 at 9:10am, an interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) was conducted. The QIDPD indicated client #3 had oversized clothes and client #3 should wear clean clothing daily. The QIDPD indicated client #3 should wear a belt if her pants sagged to prevent client #3's pants from falling down to expose her body parts. The QIDPD indicated</p>			

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W 289 Bldg. 00	<p>client #3 dressed in the current style of oversized clothing. The QIDPD indicated the group home had male staff and female clients living and working there. The QIDPD indicated clients #3 and #4 should have been redirected during formal and informal opportunities to teach and encourage dignity.</p> <p>9-3-5(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based on record review and interview, for 1 of 2 sampled clients (client #2) who had physical restraints employed, the facility failed to clearly define client #2's specific bite release technique utilized in client #2's Behavior Support Plan (BSP).</p> <p>Findings include:</p> <p>Client #2's records were reviewed on 4/15/15 at 9:15am. Client #2's 5/29/14 ISP (Individual Support Plan) updated 1/29/15 and 3/30/15 BSP (Behavior Support Plan) included targeted behaviors of SIB (Self Injurious Behaviors) intentionally inflicting self</p>	W 289	<p>W 289 Management of Inappropriate Client Behavior – Bite Release Technique</p> <p>Corrective action for resident(s) found to have been affected The technique for implementing a bite release is part of the facility's Mandt training for managing problem behavior using the least restrictive measure possible. Wording for this technique will be added to the Behavior Support Plan (BSP).</p> <p>How facility will identify other residents potentially affected & what measures taken Wording for this technique will be added to the BSP of each resident for engages in biting behavior.</p>	05/24/2015			

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	<p>harm or injury. This behavior may take the form of but is not necessarily limited to: hitting her head, bending her fingers, trying to twist her ankle, biting herself, hitting her legs or arms on the ground or using items to cause bodily harm...Attempts: If any actual attempts to harm herself are made, staff must try to intervene to block the attempt while verbally redirecting her...If needed, use AWS (Anthony Wayne Services- former name of facility) trained Mandt (Integrated approach to preventing, de-escalating, and if necessary intervening with behaviors of individuals) procedures to try to remove the item from her possession...For all types of attempts to harm herself listed above or not listed, if [client #2] is not able to calm using normal techniques and is in imminent danger of hurting herself, staff should follow facility policy and procedures as necessary to protect her and others from harm...Acceptable Mandt interventions include the following blocks, holds, or restraints with a priority placed on using the least invasive/restrictive intervention that can provide safety...Physical release from biting if [client #2] bites herself and refuses to voluntarily stop. The bite release technique is to be repeated twice before implementing a restraint..." Client #2's plans did not include specific</p>		<p>Measures or systemic changes facility put in place to ensure no recurrence Bite release technique that already is trained across staff members on an annual basis will be added to the BSP. How corrective actions will be monitored to ensure no recurrence The Behavior Clinician (BC) is responsible for training DSP staff members on the BSP. The BC is supervised by the director who meets with her regularly. The director will ensure that the bite release technique is added to the BSP.</p>	

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W 327 Bldg. 00	<p>guidelines or definitions regarding the bite release technique.</p> <p>On 4/24/15 at 9:10am, an interview was conducted with the QIDPD (Qualified Intellectual Disabilities Professional Designee). The QIDPD indicated the specific holds used on client #2 were not defined and there were no written guidelines for the bite release technique. The QIDPD indicated the facility staff implemented the bite release technique on client #2 when client #2 tried to inflict self harm to herself and had bitten herself. The QIDPD stated client #2 bites herself "almost daily."</p> <p>9-3-5(a)</p> <p>483.460(a)(3)(iv) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Based on interview and record review, for 1 of 2 sampled clients (client #2), the facility failed to complete client #2's Mantoux (tuberculin skin test) and/or screening upon admission to the facility.</p>	W 327	<p>W 327Physician Services – TB Test Corrective action for resident(s) found to have been affectedThe TB test for client #2 was not available to the surveyor, but did take place on 5/8/14 and was read 5/11/14 (negative result). Another TB test took place on</p>	05/14/2015			

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W 382 Bldg. 00	<p>Findings include:</p> <p>On 4/15/15 at 9:15am, client #2's record was reviewed. Client #2 was admitted to the facility on 4/29/14 from another provider. Client #2's 6/10/14 and 5/8/14 physician's visits did not include a completed Mantoux skin test.</p> <p>On 4/16/15 at 8:50am, an interview with the RN (Registered Nurse) was conducted. The RN indicated clients living in the group home should receive a yearly Mantoux/Tuberculin skin test and/or a tuberculosis screening. The RN indicated no further information was available for review.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 4 of 4 clients (clients #1, #2, #3, and #4), the facility failed to ensure client #1, #2, #3, and #4's medications were kept secured when not</p>			W 382	<p>5/11/15 and will be read by 5/14/15.</p> <p>How facility will identify other residents potentially affected & what measures takenAll residents potentially are affected, and corrective measures address the needs of all clients.Measures or systemic changes facility put in place to ensure no recurrencePost admission TB test did take place and documentation now is in place; annual TB test also administered and will be read within 3 days. How corrective actions will be monitored to ensure no recurrenceDirect Support Professional (DSP) staff members work with the facility Registered Nurse (RN) to ensure that health care needs are met for all residents. The nurse is supervised by the director who meets with her regularly. The director will ensure that the follow-up reading takes place and that documentation is available should the surveyor decide to revisit the facility.</p> <p>W 382 Drug Storage & Recordkeeping – Locked Medication Cart</p> <p>Corrective action for resident(s) found to have been affectedAll</p>		05/24/2015

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	<p>being administered.</p> <p>Findings include:</p> <p>On 4/14/15 from 1:25pm until 3:20pm, clients #1, #2, #3, and #4 were at the group home with GHS (Group Home Staff) #1 GHS #4, and GHS #7 and the medication cart which stored clients #1, #2, #3, and #4's medications was unlocked and open. During the observation from 1:25pm until 3:20pm, clients #1, #2, #3, and #4 entered and exited to access the room in which the cart was located without facility staff observing. At 3:20pm, GHS #7 and client #1 both indicated the medication cart was unlocked as they put away groceries. GHS #7 indicated the cart should be secured. At 3:20pm, GHS #1 indicated the medication cart should be locked and was not secured. At 3:20pm, GHS #1 locked the medication cart. At 4:40pm, GHS #1 indicated clients #1, #2, #3, and #4's medications were stored inside the medication cart and the medications should be kept secured.</p> <p>On 4/16/15 at 8:50am, an interview with the Agency Registered Nurse (RN) was conducted. The RN indicated medications at the group home should be kept secured when not being administered. The RN indicated the</p>		<p>Direct Support Professionals (DSPs) will receive training on ensuring that medication cart is properly locked.</p> <p>How facility will identify other residents potentially affected & what measures takenAll residents potentially are affected, and corrective measures address the needs of all clients.Measures or systemic changes facility put in place to ensure no recurrenceStaff training an a wall sign added in the medication room area as a reminder to keep medication cart locked.</p> <p>How corrective actions will be monitored to ensure no recurrenceManagers supervise and train Direct Support Professional (DSP) staff members. The managers are supervised by the director who meets with them regularly. The director will ensure that the training occurs and that the wall sign reminder is in place.</p>				

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	<p>facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>On 4/24/15 at 9:10am, an interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) was conducted. The QIDPD indicated medications should be kept locked and secured when not being administered. The QIDPD indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>On 4/17/15 at 2:00pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be kept secured when not being administered.</p> <p>On 4/16/15 at 9:00am, the facility's undated "Medication Pass Instructions" policy indicated staff were to follow the instructions and "...13. Return the medication to the cabinet and lock it...19. Medication cabinet must remain locked at all times...."</p> <p>9-3-6(a)</p>			

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W 436 Bldg. 00	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 2 sampled clients (client #1) and 2 additional clients (clients #3 and #4) with adaptive equipment, the facility failed to teach and encourage clients #1, #3, and #4 to wear their prescribed eye glasses at the group home.</p> <p>Findings include:</p> <p>On 4/14/15 from 1:25pm until 5:48pm, and on 4/15/15 from 6:20am until 8:20am, clients #1, #3, and #4 were at the group home with GHS (Group Home Staff) #1 GHS #2, GHS #3, GHS #4, GHS #5, GHS #6, and GHS #7. During both observations clients #1, #3, and #4 did not wear their prescribed eye glasses. During both observation periods clients #1, #3, and #4 watched television, looked at magazines, completed tracing their names on paper with a pencil, walked throughout the group home, dialed the telephone, completed medication administration, consumed meals, and</p>	W 436	<p>W 436Space & Equipment – Wearing EyeglassesCorrective action for resident(s) found to have been affectedA reminder to prompt clients to wear their eyeglasses is on the MAR. This reminder will be reviewed with DSPs. They will receive training on the requirement of wearing prescribed glasses, which is similar to taking prescribed medication.</p> <p>How facility will identify other residents potentially affected & what measures takenAll residents potentially are affected, and corrective measures address the needs of all clients.Measures or systemic changes facility put in place to ensure no recurrenceTraining will occur, including training on the importance of actually wearing prescribed glasses.</p> <p>How corrective actions will be monitored to ensure no recurrenceManagers supervise and train Direct Support Professional (DSP) staff members. The managers are supervised by the director who meets with them regularly. The</p>	05/24/2015			

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	<p>cleaned their bedrooms. During both observation periods clients #1, #3, and #4 were not observed to be taught or encouraged to wear their prescribed eye glasses.</p> <p>On 4/15/15 at 10:30am, client #1's record was reviewed. Client #1's 4/21/14 ISP (Individual Support Plan) updated 1/2015, 4/2014 BSP (Behavior Support Plan), and 4/2014 FA (Functional Assessment) indicated she wore prescribed eye glasses and did not include a goal/objective to teach client #1 to wear her eye glasses at the group home. Client #1's ISP indicated client #1 "does have glasses but often refuses to wear them. Staff will clean and encourage daily usage of glasses and document on the MARs (Medication Administration Record) daily." Client #1's 4/2015 MAR indicated "Encourage to wear glasses daily, document on back of treatment sheet if refuses to wear glasses." The back of the sheet indicated client #1 refused to wear her glasses 4/15/15, 4/9/15, and 4/4/15.</p> <p>On 4/17/15 at 11:30am, client #3's record was reviewed. Client #3's 4/21/14 ISP updated on 1/29/15 indicated she wore prescribed eye glasses and did not include a goal/objective to teach client #3 to wear her eye glasses at the group</p>		director will ensure that the training occurs.	

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	<p>home. Client #3's ISP indicated client #3 "has glasses but often refuses to wear them. Staff will cue to wear and clean daily and document both on the MARs (Medication Administration Record)." Client #3's 4/2015 MAR indicated "Glasses to be checked and cleansed every AM (Morning). Notify nurse if glasses need repaired." Client #3's MAR indicated "refused" to wear eye glasses on 4/15/15, 4/11/15, 4/8/15, 4/5/15, and 4/4/15.</p> <p>On 4/15/15 at 11:00am, client #4's record was reviewed. Client #4's 4/21/14 ISP and 4/2014 BSP indicated she wore prescribed eye glasses and did not include a goal/objective to teach client #4 to wear her eye glasses at the group home. Client #4's ISP indicated client #4 "has glasses but often refuses to wear. Staff will clean and encourage usage. Both will be monitored on the MAR (Medication Administration Record)." Client #4's 4/2015 MAR indicated "Glasses to be checked and cleansed every AM (Morning). Notify nurse if glasses need repaired." Client #4's MAR indicated she "refused" her glasses on 4/15, 4/11, 4/9, and 4/7/15. Client #4's 1/10/14 vision assessment indicated she wore prescribed eye glasses to see.</p> <p>On 4/24/15 at 9:10am, an interview was</p>			

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	<p>conducted with the QIDPD (Qualified Intellectual Disabilities Professional Designee). The QIDPD indicated clients #1, #3, and #4 wore prescribed eye glasses to see. The QIDPD indicated clients #1, #3, and #4 should have been taught and encouraged to wear their prescribed eye glasses during formal and informal opportunities. The QIDPD indicated each client should be taught and encouraged to wear their glasses throughout the day and the data was collected once a day on the MARs. The QIDPD indicated clients #1, #3, and #4 eye glasses were usually kept in each clients' bedroom and stated she had "no idea" if clients #1, #3, and #4's eye glasses were in good repair.</p> <p>9-3-7(a)</p>			