

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G462	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2016
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 VAN BUSKIRK RD ANDERSON, IN 46011
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W 0000 Bldg. 00	<p>This visit was for a post certification revisit to an extended recertification and state licensure survey completed on April 19, 2016.</p> <p>Dates of Survey: June 9, 10, 14 and 15, 2016.</p> <p>Facility number: 000976 Provider number: 15G462 AIM number: 100235450</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 6/23/16.</p>	W 0000		
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (client #2), the facility neglected to implement policy and procedures to protect clients from</p>	W 0149	<p>W149 The direct support professionals working in the home will receive retraining on the behavior development plan and fall risk plan for client #2. This training will be</p>	07/15/2016

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>abuse, neglect and mistreatment. The facility failed to develop and implement effective corrective action to address a pattern of falls involving client #2. The facility failed to ensure adequate staffing levels to implement client #2's dining plan and supervision needs.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 6/9/16 from 6:10 PM until 7:35 PM. Staff #12 was the single staff on duty. While client #2 sat eating dinner, staff #12 left the table to answer the door. After client #2 left the table upon completion of his meal, he walked in and out of the kitchen where there was an open trash container, open containers of food and the kitchen sink. Client #2 repeatedly talked about super hero characters and purchasing new clothing at the mall during the observation. Client #2 changed his T-shirt during the observation because it had bleach stains on the shirt after commenting repeatedly about the bleach stains.</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) and investigations of abuse and neglect were reviewed on 6/10/16 at 12:57 PM and indicated the following:</p> <p>A BDDS report dated 6/4/16 indicated client #2 tripped over his feet going into his bedroom, causing an abrasion 1 inch in circumference to his forehead. The report indicated client #2 was wearing his helmet.</p>		<p>competency based to ensure understanding of the plans. The QIDP and behavior consultant are completing increased observations and visits at the day program to ensure plans are also being followed there and are effective in prevention of incidents including client to client aggression at that location. DSA is also ensuring that any incidents at the day program are properly investigated. DSA QIDP's and the administrator have met with administrative staff at the day program to ensure programming is in place per the needs of the clients who attend the program. DSA will continue to monitor and work with the day program to reduce occurrence of incidents. The administrator is ensuring that the QIDP reviews with the team any falls that client #2 sustains per his ISP and Unusually High Service Needs designation. The team will also review a completed investigation regarding any fall that will be assigned to be completed by a professional staff who is not responsible for supervision of the home to ensure objectivity. These team reviews include recommendations for corrective action to reduce chance of recurrence. The QIDP will report to the team the status of implementing any recommendations. The administrator will provide oversight</p>	

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	<p>Corrective action indicated staff were to continue to implement client #2's fall risk plan. There was no other evidence of corrective action to prevent future falls involving client #2.</p> <p>A BDDS report dated 4/24/16 indicated client #2 tripped over his feet while walking in the park and "fell to his knees, bumping his head on the ground. [Client #2] was wearing his helmet and only sustained very small (sic) (tip of pencil lead) an inch and a half above his right eyebrow just below the helmet line. He got up and resumed normal activities." The report did not indicate what type of injury client #2 received during the fall. Corrective action indicated "DSA will continue to monitor [client #2] for any falls for his health and safety and remind him to be careful."</p> <p>Client #2's record was reviewed on 6/10/16 at 1:20 PM. An Individual Support Plan dated 5/20/16 indicated client #2 was to wear a protective helmet during all waking hours. An Individual Plan Report dated 12/7/15 indicated client #2 "...suffers from dyskinesia as a side effect from his psychotropic medications. Dyskinesia causes [client #2] to be unsteady, and at a greater risk for falls...." A fall protocol dated 4/29/16 indicated client #2 "is at risk of falling secondary to unsteady gate (sic). [Client #2] requires assistance with any stairs. To reduce the risk of injury, we have instituted the following: [Client #2] should have assistance at all times where going up</p>		<p>to ensure this occurs. Client #2 is also scheduled for aPT evaluation on 7/13/16 to determine if there are other strategies that can be implemented to help reduce this client's potential for falls. Professional level staff also continue to routinely review for any need changes for any clients and for incident trends to ensure applicable plans are in place and current to the needs of all clients. The agency residential directors who have on-call responsibility for the home have all been retrained on staffing level requirements in the facility and their responsibility to ensure levels do remain appropriate. This specifies required ratios, supervision for client #2, and responsibility to provide an additional staff if a client in the home has a need for supervision by one staff, such as being taken to the doctor. The direct support professionals in the home have also been retrained on the required staffing levels for the home. Evidence of completed training is attached. The staffing levels have been determined per the needs of the clients in the home. The QIDP and other professional staff will continue to have an increased presence in the home to ensure plans and recommendations are being followed as well as adequate staff supervision is being provided. The frequency of visits is determined by the administrator</p>				

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	<p>and down stairs...Nonskid rug to be on bathroom before getting into shower. [Client #2] is to have staff stand behind/beside him while he is getting on and off the van to assist if needed. Rooms free of clutter and rugs are to be flat. Encourage [client #2] to wear shoes at all times. [Client #2] should not wear flip flops. Encourage [client #2] to walk slowly on uneven terrain and with small steps while staff is near him and especially while near obstacles that may be in his path of walking...." A Discussion note dated 6/13/16 by the QIDP/RD (Qualified Intellectual Disability Professional/Residential Director) and the Area Director (AD) indicated 3 BDDS reports had been reviewed including a 5/5/16 incident where client #2 physically assaulted a peer while at day services, an incident dated 5/10/16 in which client #2 was bitten by a peer, and on 5/12/16 client #2 was contained in a physical hold after becoming physically aggressive because his coach was not at practice. The decisions section of the note indicated "Continue to monitor-Continue UHSN status (Unusually High Service Needs)."</p> <p>A Psychotropic Medication Review dated 5/5/16 indicated client #2 "Has displayed 5 incidents of non-severe anger control problems and 3 incidents of physical assault. He has been sent home from day program a couple times for disordered behavior and continues to display disordered behavior once at home...He can be aggressive by grabbing, hit, scratch, pinch. He wears a</p>		<p>and will not be reduced to thenormal expectation of weekly until the administrative team has sufficientevidence of compliance with provision of adequate staffing and consistent andeffective implementation of behavior programs and risk plans. This includes anassessment of the effectiveness of plans that are in place. Staff will also be routinelyinterviewed regarding clients and their needs to ensure they do understand howto properly respond to the client's needs. Professional staff who completeobservations in the facility will document their observations and circulatethem to administrators for review to ensure all needs are properly beingaddressed. A summary of observations will be presented to the agency IST teameach month by the QIDP for discussion and to monitor any needed correctiveaction. Administrators will be included in completing visits of professionalpresence to the home. Administrators will not announce when their visits willoccur to management or direct support staff. The administrator will also continue to routinely reviewtime records of staff presence in the home to ensure adequate staffing levelsare provided and to ensure professional staff are present as directed. The administratorwill check time records when there are known instances of a</p>	

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	<p>helmet r/t (related to) dyskenesia (sic) . He has multiple falls. He did fall in the past and had a head bleed. He can be difficult to redirect...Staff report he had has not needed prn (as needed) haldol (anti-psychotic) for some time, doing well on current medications and do not want any changes as he is very difficult to get stabilized..." The review indicated client #2's medications would be continued as previously prescribed.</p> <p>A Behavior Development Program (BDP) dated May, 2016 in client #2's record indicated targeted behaviors of resistance (failure to comply with requests), physical assault (attempted or purposeful attacks directed at other people that may include but are not limited to: striking, kicking, pulling hair, violently pulling clothing or glasses, biting or throwing objects), self injurious behavior (forceful blow or bite, head hitting and head banging), non-severe anger control problems (screaming, crying, jumping up and down, banging objects, stamping his feet) and disordered behavior (agitation, wearing underclothes in public areas, changing clothing numerous times, drinking water excessively, attempting to bathe while clothed or more than twice daily). Client #2's plan indicated physical intervention requiring the use of two staff (elbow pin and take down to a mat), separation from others/staff placing themselves between client #2 and other clients when client #2 exhibits disordered behavior. A component in client #2's plan indicated "the IST (Individual Support Team) must identify 1)</p>		<p>staff being requiredto address a single consumer's need. Responsible Party: QIDP</p>		

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	<p>individuals with whom [client #2] is more likely to have conflict; 2) behavioral indicators as stated under disordered behavior that [client #2] requires additional staff supervision when around others...During the evenings and weekends, employ a grouping strategy in which [client #2] and the identified individuals are in different groups with different activities...." Staff were to redirect client #2 when he exhibited disordered behavior. The plan indicated staff were to employ planned ignoring when client #2 exhibited disordered behavior if redirection to activity was not successful. Agitated behavior included extreme perseveration about topics/items and staff were to redirect him to other topics. "Agitation ...sometimes results in physical assault." To address drinking water excessively, staff were to monitor his water intake during increased disordered behavior. If water intake exceeded 16 ounces within two hours, staff were to notify the nurse.</p> <p>A dining plan included in the record dated 4/29/16 indicated staff were to be seated at the table with client #2 at all times during meals and he was to receive a mechanical soft diet.</p> <p>A speech language pathologist's evaluation dated 4/19/16 in the record indicated "Recommend mechanical soft diet with ground meats with gravy added to meats. Sit upright with all oral intake and stay upright 30 minutes after meals. Use sip-controlled cups, small bites, small sips, alternate food</p>			

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	<p>and liquids, use child-sized utensils, crush medications when possible and give in puree, good oral care after meals, and supervision with oral intake. Finish meal with liquids."</p> <p>The Program Quality Coordinator PQC was interviewed on 6/10/16 at 2:50 PM and indicated client #2 had been placed on UHSN status in regards to his history of falls and client #2's IST (interdisciplinary team) and administrative staff were to monitor his falls for trends and ensure corrective action was developed and implemented to reduce reoccurrence.</p> <p>An Index Event Prevention Review by the QIDP/RD (undated) was reviewed on 6/14/16 at 5:36 PM. The date of the index event 6/4/16 indicated client #2 "had been perseverating on comic books and watching R rated movies. [Staff #13 and the House Manager] were planned ignoring (sic) at the time of the fall. [Client #2] had walked into his bedroom at a quick pace and tripped over his own footing. The floor was clear of all times and [client #2] was wearing his helmet per his fall risk plan." In the section "What could have been done to prevent the incident?" it indicated "Staff was following [client #2's] BDP (Behavior Development Program as written at the time of the incident." In the section "What can be done differently in the future to prevent similar incidents from happening?" it indicated "Staff will continue to implement [client #2's] BDP as written. Staff will continue to implement [client #2's] fall risk plan as</p>			

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	<p>written. Staff will continue to encourage [client #2] to slow down and take sitting breaks frequently." There was no evidence of additional action taken to address client #2's falls.</p> <p>An investigation into the fall involving client #2 on 6/4/16 was reviewed on 6/15/16 at 6:30 PM. A Consumer Fall Review dated 6/5/16 included in the investigation indicated client #2 sustained a 1 inch abrasion on his upper left forehead after he was walking "quickly" into his bedroom. Client #2 "tripped over his own foot and falling (sic) to the ground as a result." The review indicated an investigation was necessary "due to history of falls." A QIDP/RD note regarding the fall dated 6/5/16 indicated a similar summary of the Fall Review and indicated a recommendation to "Continue to implement [client #2's] fall risk plan as written." An addendum to the investigation on 6/4/16 dated 6/15/16 indicated the RM (Residential Manager) "was asked what caused [client #2] to be pacing and rushing and she states that [staff #5] had told him he would take him to look at comic books, likely at [store name]. [RM] states that she pulled [staff #5] aside and told him that he needed to ensure he was following his BDP and [store name] was a trigger for maladaptive behaviors for [client #2]." The addendum indicated staff #5 did not show up for work again after 6/4/16 and no longer worked at the group home. Findings indicated staff #5 "had been discussing items that were known triggers of disordered behavior with [client #2] before</p>			

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	<p>the fall,"client #2 was wearing his helmet at the time of the fall, and the separation plan was being followed at the time of the fall. Recommendations indicated "Continue fall risk plan as written. [Client #2] should have an appointment scheduled with his neurologist to review his fall risk plan and increase of recent falls with injury."</p> <p>The PQC was interviewed on 6/15/16 at 6:42 PM and indicated staff #13 had not implemented client #2's plan to address his perseverative behavior. The PQC indicated there should have been 2 staff on duty for meals and client #2 should be supervised while in the kitchen and around food due to a choking incident in the past.</p> <p>The facility's Preventing Abuse and Neglect policy dated 10/13 was reviewed on 6/14/16 at 5:09 PM and indicated "DSA, Inc. prohibits abuse, neglect, exploitation, mistreatment or violation of the rights of the consumers it serves...'Abuse' means the following:...Emotional/Verbal abuse including but is not limited to communicating with words or actions in a person's presence with intent to: (a) cause the individual to be placed in fear of retaliation;...cause the individual to be placed in fear of confinement or restraint;...cause the individual to experience emotional distress or humiliation...'Neglect' means failure to</p>			

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W 0157 Bldg. 00	<p>provide supervision, training, appropriate care, food, medical care or medical supervision to an individual...Immediately upon learning of an allegation of abuse/neglect, exploitation, sexual abuse and/or sexual exploitation or similar circumstances...staff are to immediately report the incident to the Residential Director on-call...."</p> <p>This deficiency was cited on April 19, 2016. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p>			

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	<p>Based on observation, record review and interview for 1 of 4 sampled clients (client #2), the facility failed to develop and implement effective corrective action to address a pattern of falls involving client #2. The facility failed to ensure adequate staffing levels to implement client #2's dining plan and supervision needs.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 6/9/16 from 6:10 PM until 7:35 PM. Staff #12 was the single staff on duty. While client #2 sat eating dinner, staff #12 left the table to answer the door. After client #2 left the table upon completion of his meal, he walked in and out of the kitchen where there was an open trash container, open containers of food and the kitchen sink. Client #2 repeatedly talked about super hero characters and purchasing new clothing at the mall during the observation. Client #2 changed his T-shirt during the observation because it had bleach stains on the shirt after commenting repeatedly about the bleach stains.</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) and investigations of abuse and neglect were reviewed on 6/10/16 at 12:57 PM and indicated the following:</p> <p>A BDDS report dated 6/4/16 indicated client #2 tripped over his feet going into his</p>	W 0157	<p>The direct support professionals working in the home will receive retraining on the behavior development plan and fall risk plan for client #2. This training will be competency based to ensure understanding of the plans. The administrator is ensuring that the QIDP reviews with the team any falls that client #2 sustains per his ISP and Unusually High Service Needs designation. The team will also review a completed investigation regarding any fall that will be assigned to be completed by a professional staff who is not responsible for supervision of the home to ensure objectivity. These team reviews include recommendations for corrective action to reduce chance of recurrence. The QIDP will report to the team the status of implementing any recommendations. The administrator will provide oversight to ensure this occurs. Client #2 is also scheduled for a PPT evaluation on 7/13/16 to determine if there are other strategies that can be implemented to help reduce this client's potential for falls. Professional level staff also continue to routinely review for any need changes for any clients and for incident trends to ensure applicable plans are in place and current to the needs of all clients. The agency residential directors who have on-call responsibility for the</p>	07/15/2016

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	<p>bedroom, causing an abrasion 1 inch in circumference to his forehead. The report indicated client #2 was wearing his helmet. Corrective action indicated staff were to continue to implement client #2's fall risk plan. There was no other evidence of corrective action to prevent future falls involving client #2.</p> <p>A BDDS report dated 4/24/16 indicated client #2 tripped over his feet while walking in the park and "fell to his knees, bumping his head on the ground. [Client #2] was wearing his helmet and only sustained very small (sic) (tip of pencil lead) an inch and a half above his right eyebrow just below the helmet line. He got up and resumed normal activities." There was no indication of the type of injury client #2 received during the incident. Corrective action indicated "DSA will continue to monitor [client #2] for any falls for his health and safety and remind him to be careful."</p> <p>Client #2's record was reviewed on 6/10/16 at 1:20 PM. An Individual Support Plan dated 5/20/16 indicated client #2 was to wear a protective helmet during all waking hours. An Individual Plan Report dated 12/7/15 indicated client #2 "...suffers from dyskinesia as a side effect from his psychotropic medications. Dyskinesia causes [client #2] to be unsteady, and at a greater risk for falls...." A fall protocol dated 4/29/16 indicated client #2 "is at risk of falling secondary to unsteady gait (sic). [Client #2] requires assistance with any</p>		<p>home have all been retrained on staffing level requirements in the facility and their responsibility to ensure levels do remain appropriate. This specifies required ratios, supervision for client #2, and responsibility to provide an additional staff if a client in the home has a need for supervision by one staff, such as being taken to the doctor. The direct support professionals in the home have also been retrained on the required staffing levels for the home. Evidence of completed training is attached. The staffing levels have been determined per the needs of the clients in the home. The QIDP and other professional staff will continue to have an increased presence in the home to ensure plans and recommendations are being followed as well as adequate staff supervision is being provided. The frequency of visits is determined by the administrator and will not be reduced to the normal expectation of weekly until the administrative team has sufficient evidence of compliance with provision of adequate staffing and consistent and effective implementation of behavior programs and risk plans. This includes an assessment of the effectiveness of plans that are in place. Staff will also be routinely interviewed regarding clients and their needs to ensure they do understand how to properly</p>	

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	<p>stairs. To reduce the risk of injury, we have instituted the following: [Client #2] should have assistance at all times where going up and down stairs...Nonskid rug to be on bathroom before getting into shower. [Client #2] is to have staff stand behind/beside him while he is getting on and off the van to assist if needed. Rooms free of clutter and rugs are to be flat. Encourage [client #2] to wear shoes at all times. [Client #2] should not wear flip flops. Encourage [client #2] to walk slowly on uneven terrain and with small steps while staff is near him and especially while near obstacles that may be in his path of walking..." A Discussion note dated 6/13/16 by the QIDP/RD (Qualified Intellectual Disability Professional/Residential Director) and the Area Director (AD) indicated 3 BDDS reports had been reviewed including a 5/5/16 incident where client #2 physically assaulted a peer while at day services, an incident dated 5/10/16 in which client #2 was bitten by a peer, and on 5/12/16 client #2 was contained in a physical hold after becoming physically aggressive because his coach was not at practice. The decisions section of the note indicated "Continue to monitor-Continue UHSN status (Unusually High Service Needs)."</p> <p>A Psychotropic Medication Review dated 5/5/16 indicated client #2 "Has displayed 5 incidents of non-severe anger control problems and 3 incidents of physical assault. He has been sent home from day program a couple times for disordered behavior and</p>		<p>respond to the client's needs. Professional staff who complete observations in the facility will document their observations and circulate them to administrators for review to ensure all needs are properly being addressed. A summary of observations will be presented to the agency IST team each month by the QIDP for discussion and to monitor any needed corrective action. Administrators will be included in completing visits of professional presence to the home. Administrators will not announce when their visits will occur to management or direct support staff. The administrator will also continue to routinely review time records of staff presence in the home to ensure adequate staffing levels are provided and to ensure professional staff are present as directed. The administrator will check time records when there are known instances of a staff being required to address a single consumer's need. Responsible Party: QIDP</p>	

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	<p>continues to display disordered behavior once at home...He can be aggressive by grabbing, hit, scratch, pinch. He wears a helmet r/t (related to) dysknesia (sic) . He has multiple falls. He did fall in the past and had a head bleed. He can be difficult to redirect...Staff report he had has not needed prn (as needed) haldol (anti-psychotic) for some time, doing well on current medications and do not want any changes as he is very difficult to get stabilized..." The review indicated client #2's medications would be continued as previously prescribed.</p> <p>A Behavior Development Program (BDP) dated May, 2016 in client #2's record indicated targeted behaviors of resistance (failure to comply with requests), physical assault (attempted or purposeful attacks directed at other people that may include but are not limited to: striking, kicking, pulling hair, violently pulling clothing or glasses, biting or throwing objects), self injurious behavior (forceful blow or bite, head hitting and head banging), non-severe anger control problems (screaming, crying, jumping up and down, banging objects, stamping his feet) and disordered behavior (agitation, wearing underclothes in public areas, changing clothing numerous times, drinking water excessively, attempting to bathe while clothed or more than twice daily). Client #2's plan indicated physical intervention requiring the use of two staff (elbow pin and take down to a mat), separation from others/staff placing themselves between client #2 and other clients when client #2</p>			

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	<p>exhibits disordered behavior. A component in client #2's plan indicated "the IST (Individual Support Team) must identify 1) individuals with whom [client #2] is more likely to have conflict; 2) behavioral indicators as stated under disordered behavior that [client #2] requires additional staff supervision when around others...During the evenings and weekends, employ a grouping strategy in which [client #2] and the identified individuals are in different groups with different activities...." Staff were to redirect client #2 when he exhibited disordered behavior. The plan indicated staff were to employ planned ignoring when client #2 exhibited disordered behavior if redirection to activity was not successful. Agitated behavior included extreme perseveration about topics/items and staff were to redirect him to other topics. "Agitation ...sometimes results in physical assault." To address drinking water excessively, staff were to monitor his water intake during increased disordered behavior. If water intake exceeded 16 ounces within two hours, staff were to notify the nurse.</p> <p>A dining plan included in the record dated 4/29/16 indicated staff were to be seated at the table with client #2 at all times during meals and he was to receive a mechanical soft diet.</p> <p>A speech language pathologist's evaluation dated 4/19/16 in the record indicated "Recommend mechanical soft diet with ground meats with gravy added to meats. Sit</p>						

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	<p>upright with all oral intake and stay upright 30 minutes after meals. Use sip-controlled cups, small bites, small sips, alternate food and liquids, use child-sized utensils, crush medications when possible and give in puree, good oral care after meals, and supervision with oral intake. Finish meal with liquids."</p> <p>The Program Quality Coordinator PQC was interviewed on 6/10/16 at 2:50 PM and indicated client #2 had been placed on UHSN status in regards to his history of falls and client #2's IST (interdisciplinary team) and administrative staff were to monitor his falls for trends and ensure corrective action was developed and implemented to reduce reoccurrence.</p> <p>An Index Event Prevention Review by the QIDP/RD (undated) was reviewed on 6/14/16 at 5:36 PM. The date of the index event 6/4/16 indicated client #2 "had been perseverating on comic books and watching R rated movies. [Staff #13 and the House Manager] were planned ignoring (sic) at the time of the fall. [Client #2] had walked into his bedroom at a quick pace and tripped over his own footing. The floor was clear of all times and [client #2] was wearing his helmet per his fall risk plan." In the section "What could have been done to prevent the incident?" it indicated "Staff was following [client #2's] BDP (Behavior Development Program as written at the time of the incident." In the section "What can be done differently in the future to prevent similar incidents from happening?" it indicated</p>			

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	<p>"Staff will continue to implement [client #2's] BDP as written. Staff will continue to implement [client #2's] fall risk plan as written. Staff will continue to encourage [client #2] to slow down and take sitting breaks frequently." There was no evidence of additional action taken to address client #2's falls.</p> <p>An investigation into the fall involving client #2 on 6/4/16 was reviewed on 6/15/16 at 6:30 PM. A Consumer Fall Review dated 6/5/16 included in the investigation indicated client #2 sustained a 1 inch abrasion on his upper left forehead after he was walking "quickly" into his bedroom. Client #2 "tripped over his own foot and falling (sic) to the ground as a result." The review indicated an investigation was necessary "due to history of falls." A QIDP/RD note regarding the fall dated 6/5/16 indicated a similar summary of the Fall Review and indicated a recommendation to "Continue to implement [client #2's] fall risk plan as written." An addendum to the investigation on 6/4/16 dated 6/15/16 indicated the RM (Residential Manager) "was asked what caused [client #2] to be pacing and rushing and she states that [staff #5] had told him he would take him to look at comic books, likely at [store name]. [RM] states that she pulled [staff #5] aside and told him that he needed to ensure he was following his BDP and [store name] was a trigger for maladaptive behaviors for [client #2]." The addendum indicated staff #5 did not show up for work again after 6/4/16 and no longer worked at the group</p>			

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W 0186	<p>home. Findings indicated staff #5 "had been discussing items that were known triggers of disordered behavior with [client #2] before the fall,"client #2 was wearing his helmet at the time of the fall, and the separation plan was being followed at the time of the fall. Recommendations indicated "Continue fall risk plan as written. [Client #2] should have an appointment scheduled with his neurologist to review his fall risk plan and increase of recent falls with injury."</p> <p>The PQC was interviewed on 6/15/16 at 6:42 PM and indicated staff #13 had not implemented client #2's plan to address his perseverative behavior. The PQC indicated there should have been 2 staff on duty for meals and client #2 should be supervised while in the kitchen and around food due to a choking incident in the past. The PQC indicated there was no additional corrective action to address client #2's falls other than what was recommended in the investigation on 6/4/16.</p> <p>This deficiency was cited on April 19, 2016. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2)</p>						

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Bldg. 00	<p>DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based upon observation, record review and interview, the facility failed to ensure there were adequate staff to meet the identified needs of 1 of 4 sampled clients (client #2).</p> <p>Findings include:</p> <p>Observations were completed at the group home on 6/9/16 from 6:10 PM until 7:35 PM. Staff #12 was the single staff on duty. While client #2 sat eating dinner, staff #12 left the table to answer the door. After client #2 left the table upon completion of his meal, he walked in and out of the kitchen where there was an open trash container, open containers of food and the kitchen sink. Client #2 repeatedly talked about super hero characters and purchasing new clothing at the mall during the observation. Client #2 changed his T-shirt during the observation because it had bleach stains on the shirt after commenting repeatedly about the bleach stains.</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS)</p>	W 0186	<p>The agency residential directors who have on-call responsibility for the home have all been retrained on staffing level requirements in the facility and their responsibility to ensure levels do remain appropriate. This specifies required ratios, supervision for client #2, and responsibility to provide an additional staff if a client in the home has a need for supervision by one staff, such as being taken to the doctor. The direct support professionals in the home have also been retrained on the required staffing levels for the home. Evidence of completed training is attached. The staffing levels have been determined per the needs of the clients in the home. The QIDP and other professional staff will continue to have an increased presence in the home to ensure plans and recommendations are being followed as well as adequate staff supervision is being provided. The frequency of visits is determined by the administrator and will not be reduced to thenormal expectation of weekly</p>	07/15/2016			

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	<p>and investigations of abuse and neglect were reviewed on 6/10/16 at 12:57 PM and indicated the following:</p> <p>A BDDS report dated 6/4/16 client #2 tripped over his feet going into his bedroom, causing an abrasion 1 inch in circumference to his forehead. The report indicated client #2 was wearing his helmet. Corrective action indicated staff were to continue to implement client #2's fall risk plan. There was no other evidence of corrective action to prevent future falls involving client #2.</p> <p>A BDDS report dated 4/24/16 indicated client #2 tripped over his feet while walking in the park and "fell to his knees, bumping his head on the ground. [Client #2] was wearing his helmet and only sustained very small (tip of pencil lead) an inch and a half above his right eyebrow just below the helmet line. He got up and resumed normal activities." Corrective action indicated "DSA will continue to monitor [client #2] for any falls for his health and safety and remind him to be careful."</p> <p>Client #2's record was reviewed on 6/10/16 at 1:20 PM. An Individual Support Plan dated 5/20/16 indicated client #2 was to wear a protective helmet during all waking hours. An Individual Pan Report dated 12/7/15 indicated client #2 "...suffers from dyskinesia as a side effect from his psychotropic medications. Dyskinesia causes [client #2] to be unsteady, and at a greater risk for falls...." A fall protocol reviewed on</p>		<p>until the administrative team has sufficient evidence of compliance with provision of adequate staffing and consistent and effective implementation of behavior programs and risk plans. This includes an assessment of the effectiveness of plans that are in place. Staff will also be routinely interviewed regarding clients and their needs to ensure they do understand how to properly respond to the client's needs. Professional staff who complete observations in the facility will document their observations and circulate them to administrators for review to ensure all needs are properly being addressed. A summary of observations will be presented to the agency IST team each month by the QIDP for discussion and to monitor any needed corrective action. Administrators will be included in completing visits of professional presence to the home. Administrators will not announce when their visits will occur to management or direct support staff. The administrator will also continue to routinely review time records of staff presence in the home to ensure adequate staffing levels are provided and to ensure professional staff are present as directed. The administrator will check time records when there are known instances of a staff being required to address a single consumer's need.</p>	

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	<p>4/29/16 indicated client #2 "is at risk of falling secondary to unsteady gate (sic). [Client #2] requires assistance with any stairs. To reduce the risk of injury, we have instituted the following: [Client #2] should have assistance at all times where going up and down stairs...Nonskid rug to be on bathroom before getting into shower. [Client #2] is to have staff stand behind/beside him while he is getting on and off the van to assist if needed. Rooms free of clutter and rugs are to be flat. Encourage [client #2] to wear shoes at all times. [Client #2] should not wear flip flops. Encourage [client #2] to walk slowly on uneven terrain and with small steps while staff is near him and especially while near obstacles that may be in his path of walking...." A Discussion note dated 6/13/16 by the QIDP/RD (Qualified Intellectual Disability Professional/Residential Director) and the Area Director (AD) indicated 3 BDDS reports had been reviewed including a 5/5/16 incident where client #2 physically assaulted a peer while at day services, an incident dated 5/10/16 in which client #2 was bitten by a peer, and on 5/12/16 client #2 was contained in a physical hold after becoming physically aggressive because his coach was not at practice. The decisions section of the note indicated "Continue to monitor-Continue UHSN status (Unusually High Service Needs).</p> <p>A Psychotropic Medication Review dated 5/5/16 indicated client #2 "Has displayed 5 incidents of non-severe anger control</p>		Responsible Party: QIDP	

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	<p>problems and 3 incidents of physical assault. He has been sent home from day program a couple times for disordered behavior and continue to display disordered behavior once at home...He can be aggressive by grabbing, hit scratch, pinch. He wears a helmet r/t (related to) dysknesia (sic) . He has multiple falls. He did fall in the past and had a head bleed. He can be difficult to redirect...Staff report had has not needed prn (as needed) haldol (anti-psychotic) for some time, doing well on current medications and do not want any changes as he is very difficult to get stabilized...." The review indicated client #2's medications would be continued as previously prescribed.</p> <p>A Behavior Development Program (BDP) dated May, 2016 in client #2's record indicated targeted behaviors of resistance (failure to comply with requests), physical assault (attempted or purposeful attacks directed at other people that may include but are not limited to: striking, kicking, pulling hair, violently pulling clothing or glasses, biting or throwing objects), self injurious behavior (forceful blow or bite, head hitting and head banging), non-severe anger control problems (screaming, crying, jumping up and down, banging objects, stamping his feet) and disordered behavior (agitation, wearing underclothes in public areas), changing clothing numerous times, drinking water excessively, attempting to bathe while clothed or more than twice daily). Client #2's plan indicated physical intervention requiring the use of two staff (elbow pin and</p>			

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	<p>take down to a mat), separation from others/staff placing themselves between client #2 and other clients when client #2 exhibits disordered behavior. A component in client #2's plan indicated "the IST (Individual Support Team) must identify 1) individuals with whom [client #2] is more likely to have conflict; 2) behavioral indicators as stated under disordered behavior that [client #2] requires additional staff supervision when around others...During the evenings and weekends, employ a grouping strategy in which [client #2] and the identified individuals are in different groups with different activities...." Staff were to redirect client #2 when he exhibited disordered behavior. The plan indicated staff were to employ planned ignoring when client #2 exhibited disordered behavior if redirection to activity was not successful. Agitated behavior included extreme perseveration about topics/items and staff were to redirect him to other topics. Agitation ...sometimes results in physical assault. To address drinking water excessively, staff were to monitor his water intake during increased disordered behavior. If water intake exceeded 16 ounces within two hours, staff were to notify the nurse.</p> <p>A dining plan included in the record dated 4/29/16 indicated staff were to be seated at the table with client #2 at all times during meals and he was to receive a mechanical soft diet.</p> <p>A speech language pathologist's evaluation</p>			

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	<p>dated 4/19/16 in the record indicated "Recommend mechanical soft diet with ground meats with gravy added to meats. Sit upright with all oral intake and stay upright 30 minutes after meals. Use sip-controlled cups, small bites, small sips, alternate food and liquids, use child-sized utensils, crush medications when possible and give in puree, good oral care after meals, and supervision with oral intake. Finish meal with liquids."</p> <p>An Index Event Prevention Review by the QIDP/RD (review undated) was reviewed on 6/14/16 at 5:36 PM. The date of the index event 6/4/16 indicated client #2 "had been perseverating on comic books and watching R rated movies. [Staff #13 and the House Manager] were planned ignoring (sic) at the time of the fall. [Client #2] had walked into his bedroom at a quick pace and tripped over his own footing. The floor was clear of all times and [client #2] was wearing his helmet per his fall risk plan." In the section "What could have been done to prevent the incident?" indicated "Staff was following [client #2's] BDP (Behavior Development Program as written at the time of the incident." In the section "What can be done differently in the future to prevent similar incidents from happening?" indicated "Staff will continue to implement [client #2's] BDP as written. Staff will continue to implement [client #2's] fall risk plan as written. Staff will continue to encourage [client #2] to slow down and take sitting breaks frequently." There was no evidence of additional action taken to address client #2's</p>			

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	<p>falls.</p> <p>An investigation into the fall involving client #2 on 6/4/16 was reviewed on 6/15/16 at 6:30 PM. A Consumer Fall Review dated 6/5/16 included in the investigation indicated client #2 sustained a 1 inch abrasion on his upper left forehead after he was walking "quickly" into his bedroom. Client #2 "tripped over his own foot and falling to the ground as a result." The review indicated an investigation was necessary "due to history of falls." A QIDP/RD note regarding the fall dated 6/5/16 indicated a similar summary of the Fall Review and indicated a recommendation to "Continue to implement [client #2's] fall risk plan as written." An addendum to the investigation on 6/4/16 dated 6/15/16 indicated the RM (Residential Manager) "was asked what caused [client #2] to be pacing and rushing and she states that [staff #5] had told him he would take him to look at comic books, likely at [store name]. [RM] states that she pulled [staff #5] aside and told him that he needed to ensure he was following his BDP and [store name] was a trigger for maladaptive behaviors for [client #2]." The addendum indicated staff #5 did not show up for work again after 6/4/16 and no longer worked at the group home. Findings indicated staff #5 "had been discussing items that were known trigger of disordered behavior with [client #2] before the fall,"client #2 was wearing his helmet at the time of the fall, and the separation plan was being followed at the time of the fall. Recommendations indicated "Continue fall</p>			

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W 0191 Bldg. 00	<p>risk plan as written. [Client #2] should have an appointment scheduled with his neurologist to review his fall risk plan and increase of recent falls with injury."</p> <p>The PQC was interviewed on 6/15/16 at 6:42 PM and indicated staff #13 had not implemented client #2's plan to address his perseverative behavior. The PQC indicated there should have been 2 staff on duty for meals and client #2 should be supervised while in the kitchen and around food due to a choking incident in the past.</p> <p>This deficiency was cited on April 19, 2016. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-3(a)</p> <p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs.</p> <p>Based upon observation, record review and interview, the facility failed to ensure for 1 of 4 sampled clients (client #2) to ensure staff were trained to implement client #2's</p>	W 0191	The QIDP is responsible for ensuring the staff who work in the facility are adequately trained on the behavior programs and other risk plans for all clients. The QIDP will ensure that	07/15/2016			

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	<p>dining plan and behavioral needs.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 6/9/16 from 6:10 PM until 7:35 PM. Staff #12 was the single staff on duty. While client #2 sat eating dinner, staff #12 left the table to answer the door. After client #2 left the table upon completion of his meal, he walked in and out of the kitchen where there was an open trash container, open containers of food and the kitchen sink. Client #2 repeatedly talked about super hero characters and purchasing new clothing at the mall during the observation. Client #2 changed his T-shirt during the observation because it had bleach stains on the shirt after commenting repeatedly about the bleach stains.</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) and investigations of abuse and neglect were reviewed on 6/10/16 at 12:57 PM and indicated the following:</p> <p>A BDDS report dated 6/4/16 client #2 tripped over his feet going into his bedroom, causing an abrasion 1 inch in circumference to his forehead. The report indicated client #2 was wearing his helmet. Corrective action indicated staff were to continue to implement client #2's fall risk plan. There was no other evidence of corrective action to prevent future falls involving client #2.</p>		<p>any staff who are working in thehome and are responsible for supervision of clients are trained on the clients'needs, including behavior programs and risk plans. This training will become competency based to ensure staff retain the information. The QIDP will ensure all training provided is documentedper agency policy. The QIDP is also training staff on the needs of client #2and his housemates that work in nearby DSA homes in the event they are neededto work at this home. The administrator will routinely compare training recordswhen reviewing time records for staff that work in the home to ensure they havebeen adequately trained. This has included ensuring that the staff that wasworking with client #2 during the observation on 6/9/16 has been trained on the needs of client #2 and his housemates. The direct support professionals working in the home will beretrained on the behavior development plan and fall risk plan for client #2.This training will be competency based to ensure understanding of the plans. The QIDP and other professional staff will continue to havean increased presence in the home to ensure staff demonstrate knowledge andcompetency in following behavior programs and risk plans for all clients in thehome. The frequency of visits isdetermined by the administrator and will not be</p>	

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	<p>A BDDS report dated 4/24/16 indicated client #2 tripped over his feet while walking in the park and "fell to his knees, bumping his head on the ground. [Client #2] was wearing his helmet and only sustained very small (sic) (tip of pencil lead) an inch and a half above his right eyebrow just below the helmet line. He got up and resumed normal activities." There was no indication in the report of the type of injury client #2 received. Corrective action indicated "DSA will continue to monitor [client #2] for any falls for his health and safety and remind him to be careful."</p> <p>Client #2's record was reviewed on 6/10/16 at 1:20 PM. An Individual Support Plan dated 5/20/16 indicated client #2 was to wear a protective helmet during all waking hours. An Individual Plan Report dated 12/7/15 indicated client #2 "...suffers from dyskinesia as a side effect from his psychotropic medications. Dyskinesia causes [client #2] to be unsteady, and at a greater risk for falls...." A fall protocol dated on 4/29/16 indicated client #2 "is at risk of falling secondary to unsteady gate (sic). [Client #2] requires assistance with any stairs. To reduce the risk of injury, we have instituted the following: [Client #2] should have assistance at all times where going up and down stairs...Nonskid rug to be on bathroom before getting into shower. [Client #2] is to have staff stand behind/beside him while he is getting on and off the van to assist if needed. Rooms free of clutter and rugs are to be flat. Encourage [client #2] to</p>		<p>reduced to the normal expectation of weekly until the administrative team has sufficient evidence of compliance with provision of adequate staffing and consistent and effective implementation of behavior programs and risk plans. This includes an assessment of the effectiveness of plans that are in place. Staff will also be routinely interviewed regarding clients and their needs to ensure they do understand how to properly respond to the client's needs. Professional staff who complete observations in the facility will document their observations and circulate them to administrators for review to ensure all needs are properly being addressed. A summary of observations will be presented to the agency IST team each month by the QIDP for discussion and to monitor any needed corrective action. Administrators will be included in completing visits of professional presence to the home. Administrators will not announce when their visits will occur to management or direct support staff. Responsible Party: QIDP</p>	

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	<p>wear shoes at all times. [Client #2] should not wear flip flops. Encourage [client #2] to walk slowly on uneven terrain and with small steps while staff is near him and especially while near obstacles that may be in his path of walking...." A Discussion note dated 6/13/16 by the QIDP/RD (Qualified Intellectual Disability Professional/Residential Director) and the Area Director (AD) indicated 3 BDDS reports had been reviewed including a 5/5/16 incident where client #2 physically assaulted a peer while at day services, an incident dated 5/10/16 in which client #2 was bitten by a peer, and on 5/12/16 client #2 was contained in a physical hold after becoming physically aggressive because his coach was not at practice. The decisions section of the note indicated "Continue to monitor-Continue UHSN status (Unusually High Service Needs)."</p> <p>A Behavior Development Program (BDP) dated May, 2016 in client #2's record indicated targeted behaviors of resistance (failure to comply with requests), physical assault (attempted or purposeful attacks directed at other people that may include but are not limited to: striking, kicking, pulling hair, violently pulling clothing or glasses, biting or throwing objects), self injurious behavior (forceful blow or bite, head hitting and head banging), non-severe anger control problems (screaming, crying, jumping up and down, banging objects, stamping his feet) and disordered behavior (agitation, wearing underclothes in public areas),</p>			

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	<p>changing clothing numerous times, drinking water excessively, attempting to bathe while clothed or more than twice daily). A component in client #2's plan indicated "the IST (Individual Support Team) must identify 1) individuals with whom [client #2] is more likely to have conflict; 2) behavioral indicators as stated under disordered behavior that [client #2] requires additional staff supervision when around others...Staff were to redirect client #2 when he exhibited disordered behavior. The plan indicated staff were to employ planned ignoring when client #2 exhibited disordered behavior if redirection to activity was not successful. Agitated behavior included extreme perseveration about topics/items and staff were to redirect him to other topics. Agitation ...sometimes results in physical assault. To address drinking water excessively, staff were to monitor his water intake during increased disordered behavior. If water intake exceeded 16 ounces within two hours, staff were to notify the nurse.</p> <p>A dining plan included in the record dated 4/29/16 indicated staff were to be seated at the table with client #2 at all times during meals and he was to receive a mechanical soft diet.</p> <p>A speech language pathologist's evaluation dated 4/19/16 in the record indicated "Recommend mechanical soft diet with ground meats with gravy added to meats. Sit upright with all oral intake and stay upright 30 minutes after meals. Use sip-controlled</p>			

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	<p>cups, small bites, small sips, alternate food and liquids, use child-sized utensils, crush medications when possible and give in puree, good oral care after meals, and supervision with oral intake. Finish meal with liquids."</p> <p>An Index Event Prevention Review by the QIDP/RD (review undated) was reviewed on 6/14/16 at 5:36 PM. The date of the index event 6/4/16 indicated client #2 "had been perseverating on comic books and watching R rated movies. [Staff #13 and the House Manager] were planned ignoring (sic) at the time of the fall. [Client #2] had walked into his bedroom at a quick pace and tripped over his own footing. The floor was clear of all times and [client #2] was wearing his helmet per his fall risk plan." In the section "What could have been done to prevent the incident?" indicated "Staff was following [client #2's] BDP (Behavior Development Program as written at the time of the incident." In the section "What can be done differently in the future to prevent similar incidents from happening?" indicated "Staff will continue to implement [client #2's] BDP as written. Staff will continue to implement [client #2's] fall risk plan as written. Staff will continue to encourage [client #2] to slow down and take sitting breaks frequently." There was no evidence of additional action taken to address client #2's falls.</p> <p>An investigation into the fall involving client #2 on 6/4/16 was reviewed on 6/15/16 at 6:30 PM. A Consumer Fall Review dated</p>			

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	6/5/16 included in the investigation indicated client #2 sustained a 1 inch abrasion on his upper left forehead after he was walking "quickly" into his bedroom. Client #2 "tripped over his own foot and falling to the ground as a result." The review indicated an investigation was necessary "due to history of falls." A QIDP/RD note regarding the fall dated 6/5/16 indicated a similar summary of the Fall Review and indicated a recommendation to "Continue to implement [client #2's] fall risk plan as written." An addendum to the investigation on 6/4/16 dated 6/15/16 indicated the RM (Residential Manager) "was asked what caused [client #2] to be pacing and rushing and she states that [staff #5] had told him he would take him to look at comic books, likely at [store name]. [RM] states that she pulled [staff #5] aside and told him that he needed to ensure he was following his BDP and [store name] was a trigger for maladaptive behaviors for [client #2]." The addendum indicated staff #5 did not show up for work again after 6/4/16 and no longer worked at the group home. Findings indicated staff #5 "had been discussing items that were known trigger of disordered behavior with [client #2] before the fall,"client #2 was wearing his helmet at the time of the fall, and the separation plan was being followed at the time of the fall. Recommendations indicated "Continue fall risk plan as written. [Client #2] should have an appointment scheduled with his neurologist to review his fall risk plan and increase of recent falls with injury."			

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W 0249 Bldg. 00	<p>The PQC was interviewed on 6/15/16 at 6:42 PM and indicated staff #13 had not implemented staff training regarding client #2's plan to address his perseverative behavior. The PQC indicated client #2 should be supervised while in the kitchen and around food due to a choking incident in the past and staff should have implemented training provided to implement his plan.</p> <p>This deficiency was cited on April 19, 2016. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-3(a)</p> <p>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.</p> <p>Based upon observation, interview and record review, the facility failed for 1 of</p>	W 0249	The QIDP is responsible for ensuring the staff who work in the facility are adequately trained on the behavior	07/15/2016	

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	<p>4 sampled clients (client #2) to ensure he was supervised to implement his dining plan, risk plans and behavior plan.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 6/9/16 from 6:10 PM until 7:35 PM. Staff #12 was the single staff on duty. While client #2 sat eating dinner, staff #12 left the table to answer the door. After client #2 left the table upon completion of his meal, he walked in and out of the kitchen where there was an open trash container, open containers of food and the kitchen sink. Client #2 repeatedly talked about super hero characters and purchasing new clothing at the mall during the observation. Client #2 changed his T-shirt during the observation because it had bleach stains on the shirt after commenting repeatedly about the bleach stains.</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) and investigations of abuse and neglect were reviewed on 6/10/16 at 12:57 PM and indicated the following:</p> <p>A BDDS report dated 6/4/16 indicated client #2 tripped over his feet going into his bedroom, causing an abrasion 1 inch in circumference to his forehead. The report indicated client #2 was wearing his helmet. Corrective action indicated staff were to continue to implement client #2's fall risk plan. There was no other evidence of</p>		<p>programs and other risk plans for all clients. The QIDP will ensure that any staff who are working in the home and are responsible for supervision of clients are trained on the clients' needs, including behavior programs and risk plans. This training will be competency based to ensure staff retain the information. The QIDP will ensure all training provided is documented per agency policy. The QIDP is also training staff on the needs of client #2 and his housemates that work in nearby DSA homes in the event they are needed to work at this home. The administrator will routinely compare training records when reviewing time records for staff that work in the home to ensure they have been adequately trained. This has included ensuring that the staff that was working with client #2 during the observation on 6/9/16 has been trained on the needs of client #2 and his housemates. The direct support professionals working in the home will be retrained on the behavior development plan and fall risk plan for client #2. This training was competency based to ensure understanding of the plans. The agency residential directors who have on-call responsibility for the home have all been retrained on staffing level requirements in the facility and their responsibility to ensure levels do remain appropriate. This specifies required ratios,</p>	

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	<p>corrective action to prevent future falls involving client #2.</p> <p>Client #2's record was reviewed on 6/10/16 at 1:20 PM. An Individual Support Plan dated 5/20/16 indicated client #2 was to wear a protective helmet during all waking hours. An Individual Plan Report dated 12/7/15 indicated client #2 "...suffers from dyskinesia as a side effect from his psychotropic medications. Dyskinesia causes [client #2] to be unsteady, and at a greater risk for falls...." A fall protocol dated 4/29/16 indicated client #2 "is at risk of falling secondary to unsteady gate (sic). [Client #2] requires assistance with any stairs. To reduce the risk of injury, we have instituted the following: [Client #2] should have assistance at all times where going up and down stairs...Nonskid rug to be on bathroom before getting into shower. [Client #2] is to have staff stand behind/beside him while he is getting on and off the van to assist if needed. Rooms free of clutter and rugs are to be flat. Encourage [client #2] to wear shoes at all times. [Client #2] should not wear flip flops. Encourage [client #2] to walk slowly on uneven terrain and with small steps while staff is near him and especially while near obstacles that may be in his path of walking...."</p> <p>A Psychotropic Medication Review dated 5/5/16 indicated client #2 "Has displayed 5 incidents of non-severe anger control problems and 3 incidents of physical assault. He has been sent home from day program a</p>		<p>supervision for client #2, and responsibility to provide anadditional staff if a client in the home has a need for supervision by onestaff, such as being taken to the doctor. The direct support professionals in thehome have also been retrained on the required staffing levels for the home. Evidenceof completed training is attached. The staffing levels have been determined perthe needs of the clients in the home. The QIDP and other professional staff will continue to havean increased presence in the home to ensure plans and recommendations are beingfollowed as well as adequate staff supervision is being provided. The frequencyof visits is determined by the administrator and will not be reduced to thenormal expectation of weekly until the administrative team has sufficientevidence of compliance with provision of adequate staffing and consistent andeffective implementation of behavior programs and risk plans. This includes anassessment of the effectiveness of plans that are in place. Staff will also be routinelyinterviewed regarding clients and their needs to ensure they do understand howto properly respond to the client's needs. Professional staff who completeobservations in the facility will document their observations and circulatethem to administrators</p>	

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	<p>couple times for disordered behavior and continues to display disordered behavior once at home...He can be aggressive by grabbing, hit scratch, pinch. He wears a helmet r/t (related to) dyskenesia (sic) . He has multiple falls. He did fall in the past and had a head bleed. He can be difficult to redirect...."</p> <p>A Behavior Development Program (BDP) dated May, 2016 in client #2's record indicated targeted behaviors of resistance (failure to comply with requests), physical assault (attempted or purposeful attacks directed at other people that may include but are not limited to: striking, kicking, pulling hair, violently pulling clothing or glasses, biting or throwing objects), self injurious behavior (forceful blow or bite, head hitting and head banging), non-severe anger control problems (screaming, crying, jumping up and down, banging objects, stamping his feet) and disordered behavior (agitation, wearing underclothes in public areas, changing clothing numerous times, drinking water excessively, attempting to bathe while clothed or more than twice daily). Client #2's plan indicated physical intervention requiring the use of two staff (elbow pin and take down to a mat), separation from others/staff placing themselves between client #2 and other clients when client #2 exhibits disordered behavior. A component in client #2's plan indicated "the IST (Individual Support Team) must identify 1) individuals with whom [client #2] is more likely to have conflict; 2) behavioral</p>		<p>for review to ensure all needs are properly being addressed. A summary of observations will be presented to the agency IST team each month by the QIDP for discussion and to monitor any needed corrective action. Administrators will be included in completing visits of professional presence to the home. Administrators will not announce when their visits will occur to management or direct support staff. The administrator will also continue to routinely review time records of staff presence in the home to ensure adequate staffing levels are provided and to ensure professional staff are present as directed. The administrator will check time records when there are known instances of a staff being required to address a single consumer's need. Responsible Party: QIDP</p>	

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	<p>indicators as stated under disordered behavior that [client #2] requires additional staff supervision when around others...During the evenings and weekends, employ a grouping strategy in which [client #2] and the identified individuals are in different groups with different activities...." Staff were to redirect client #2 when he exhibited disordered behavior. The plan indicated staff were to employ planned ignoring when client #2 exhibited disordered behavior if redirection to activity was not successful. Agitated behavior included extreme perseveration about topics/items and staff were to redirect him to other topics. "Agitation ...sometimes results in physical assault." To address drinking water excessively, staff were to monitor his water intake during increased disordered behavior. If water intake exceeded 16 ounces within two hours, staff were to notify the nurse.</p> <p>A dining plan included in the record dated 4/29/16 indicated staff were to be seated at the table with client #2 at all times during meals and he was to receive a mechanical soft diet.</p> <p>A speech language pathologist's evaluation dated 4/19/16 in the record indicated "Recommend mechanical soft diet with ground meats with gravy added to meats. Sit upright with all oral intake and stay upright 30 minutes after meals. Use sip-controlled cups, small bites, small sips, alternate food and liquids, use child-sized utensils, crush medications when possible and give in puree,</p>			

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	<p>good oral care after meals, and supervision with oral intake. Finish meal with liquids."</p> <p>An investigation into the fall involving client #2 on 6/4/16 was reviewed on 6/15/16 at 6:30 PM. A Consumer Fall Review dated 6/5/16 included in the investigation indicated client #2 sustained a 1 inch abrasion on his upper left forehead after he was walking "quickly" into his bedroom. Client #2 "tripped over his own foot and falling (sic) to the ground as a result." The review indicated an investigation was necessary "due to history of falls." A QIDP/RD note regarding the fall dated 6/5/16 indicated a similar summary of the Fall Review and indicated a recommendation to "Continue to implement [client #2's] fall risk plan as written." An addendum to the investigation on 6/4/16 dated 6/15/16 indicated the RM (Residential Manager) "was asked what caused [client #2] to be pacing and rushing and she states that [staff #5] had told him he would take him to look at comic books, likely at [store name]. [RM] states that she pulled [staff #5] aside and told him that he needed to ensure he was following his BDP and [store name] was a trigger for maladaptive behaviors for [client #2]." The addendum indicated staff #5 did not show up for work again after 6/4/16 and no longer worked at the group home. Findings indicated staff #5 "had been discussing items that were known triggers of disordered behavior with [client #2] before the fall,"client #2 was wearing his helmet at the time of the fall, and the separation plan was being followed at the time of the fall.</p>			

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W 0331 Bldg. 00	<p>Recommendations indicated "Continue fall risk plan as written. [Client #2] should have an appointment scheduled with his neurologist to review his fall risk plan and increase of recent falls with injury."</p> <p>The PQC was interviewed on 6/15/16 at 6:42 PM and indicated staff #13 had not implemented client #2's plan to address his perseverative behavior. The PQC indicated client #2 should be supervised while in the kitchen and around food due to a choking incident in the past.</p> <p>This deficiency was cited on April 19, 2016. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based upon record review and interview for 1 of 4 sampled clients (client #2), the</p>	W 0331	The agency nurse will ensure adequate assessment for signsof	07/15/2016

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	<p>facility's nursing services failed to implement procedures to assess for head injury.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) and investigations of abuse and neglect were reviewed on 6/10/16 at 12:57 PM and indicated the following:</p> <p>A BDDS report dated 6/4/16 client #2 tripped over his feet going into his bedroom, causing an abrasion 1 inch in circumference to his forehead. The report indicated client #2 was wearing his helmet. Corrective action indicated staff were to continue to implement client #2's fall risk plan. There was no other evidence of corrective action to prevent future falls involving client #2.</p> <p>A BDDS report dated 4/24/16 indicated client #2 tripped over his feet while walking in the park and "fell to his knees, bumping his head on the ground. [Client #2] was wearing his helmet and only sustained very small (sic) (tip of pencil lead) an inch and a half above his right eyebrow just below the helmet line. He got up and resumed normal activities." The report did not indicate what type of injury client #2 received as a result of the fall. Corrective action indicated "DSA will continue to monitor [client #2] for any falls for his health and safety and remind him to be careful."</p>		<p>head injury when notified that a client has hit their head in any manner. Thenurse will adequately document their response and assessment method used,including the results. The nurse will be trained on this requirement.</p> <p>Theadministrator will routinely review nursing documentation to ensure this occursand will do so for any reported potential head injuries. The agency has also implementeda post head injury symptom checklist to be completed by direct supportprofessionals to aid in monitoring for any symptoms of serious injury that maydevelop for 7 days following any incident in which the head is hit. This was developedand implemented by a nurse. Staff willbe directed to report any symptoms on the checklist that present to the nurseimmediately.</p> <p>The QIDP and nurse are notified of any incident in which a clienthits their head. They will give directive for this checklist to be completedand will monitor the documentation to ensure it is completed. The administratorwill also review documentation routinely to ensure the checklist is used whenneeded and that any concerns are adequately reported and addressed.</p> <p>Responsible Party: Nurse</p>		

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	<p>Client #2's record was reviewed on 6/10/16 at 1:20 PM. A fall protocol reviewed on 4/29/16 indicated client #2 "is at risk of falling secondary to unsteady gait (sic). [Client #2] requires assistance with any stairs. To reduce the risk of injury, we have instituted the following: [Client #2] should have assistance at all times where going up and down stairs...Nonskid rug to be on bathroom before getting into shower. [Client #2] is to have staff stand behind/beside him while he is getting on and off the van to assist if needed. Rooms free of clutter and rugs are to be flat. Encourage [client #2] to wear shoes at all times. [Client #2] should not wear flip flops. Encourage [client #2] to walk slowly on uneven terrain and with small steps while staff is near him and especially while near obstacles that may be in his path of walking...." There was no evidence in the fall risk plan for staff to implement assessment of client #2's symptoms of head injury in the fall risk protocol if client #2 fell and hit his head. There was no evidence in the record of an assessment of client #2's symptoms of head injury after he sustained falls on 4/24/16 and on 6/4/16 in which he hit his head.</p> <p>A Psychotropic Medication Review dated 5/5/16 indicated "...He wears a helmet r/t (related to) dysknesia (sic) . He has multiple falls. He did fall in the past and had a head bleed...."</p> <p>The PQC (Program Quality Coordinator) was interviewed on 6/15/16 at 6:42 PM and</p>			

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W 9999 Bldg. 00	indicated there was a new protocol for staff to monitor clients for symptoms of head injury, but it had not been implemented after client #2's fall on 6/4/16. 9-3-6(a)	W 9999	there is no information listed for W9999 on the 2567 or here to respond to	07/15/2016	