

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2012
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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN 47126
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W0000	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: 4/11, 4/12, 4/13, 4/16 and 4/19/12</p> <p>Facility Number: 011664 Provider Number: 15G746 Aim Number: 200902010</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/25/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review for 2 of 2 sampled clients (#1 and #2) and for 2 additional clients (#3 and #4), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility had a documented system in place to ensure the behavior consultant/clinician (BC) was on site for at least 10 hours per week for behavioral services which included direct monitoring, assessment, intervention and staff training for the Extensive Support Needs home.</p> <p>Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2), the governing body failed to exercise general policy and operating direction over the facility to ensure the Qualified Developmental Disability Professional monitored, integrated and coordinated the clients' programs to ensure the appropriate members of the clients' Interdisciplinary Teams participated in meetings which involved the clients' behavioral needs. The governing body failed to exercise general policy and operating direction over the facility to ensure the QDDP reviewed and/or monitored clients' programs in</p>	W0104	<p>Corrective Action: (Specific) The Behavior Clinician will be retrained that the BC will be on site for 10 hours for direct monitoring, assessment, intervention and staff training for the Extensive Support Needs home. The Qualified Developmental Disability Professional will be retrained to ensure that all members of the IDT participate in meetings which involve the clients' behavioral needs. The QDDP will be retrained to ensure that client programs are reviewed, monitored, and assessments are obtained when needed to address the clients' identified needs.</p> <p>How others will be identified: (Systemic) The Behavior Clinician and the QDDP will monitor all IDTs to ensure that assessments and interventions are provided for the clients' needs. All appropriate members of the IDT will attend and document their participation in the meetings.</p> <p>Measures to be put in place: The Behavior Clinician will be retrained that the BC will be on site for 10 hours for direct monitoring, assessment, intervention and staff training for the Extensive Support Needs home. The date and hours will be</p>	05/19/2012			

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	<p>regard to obtaining assessments/re-assessments when needed, and to address the clients' identified needs.</p> <p>Findings include:</p> <p>1. The facility's internal incident reports and/or reportable incident reports were reviewed on 4/11/12 at 11:30 AM. The facility's internal and/or reportable incident reports indicated the following:</p> <p>-2/24/12 "[Client #2] became agitated and started having behaviors. He proceeded to make inappropriate comments to staff members, tried to pull the fire alarm, and attempted to elope the property. [Client #2] was administered his PRN (as needed) Haldol, 5 mg. (milligrams) to calm his behaviors.</p> <p>-2/23/12 "[Client #2] became agitated and started huffing and puffing. He began verbally threatening other clients and attempting to elope from the home. The PRN Haldol, 5mg. was administered to calm [client #2] down...."</p> <p>-2/20/12 "[Client #2] became agitated and started obsessing over staff. He became red in the face and neck. He was cussing and staff and was unable to calm down (sic). To prevent the behaviors</p>				<p>documented on the contact notes for the home. The Qualified Developmental Disability Professional will be retrained to ensure that all members of the IDT participate in meetings which involve the clients' behavioral needs. The QDDP will be retrained to ensure that client programs are reviewed, monitored, and assessments are obtained when needed to address the clients' identified needs.</p> <p>Monitoring of Corrective Action The Director of SGL/SL will have weekly meetings with the QDDP and BC to review all assessments and IDTs that have occurred in the home.</p>		

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	<p>from escalating, staff got the approval to administer his PRN Haldol, 5 mg...."</p> <p>-2/16/12 "The PC (program coordinator) was working with [client #2] to sign some paperwork. He (client #2) began talking about missing his mom and friend and became agitated. He became red in the face and neck and stated that no one will do anything for him. He was saying he didn't want to go to work and that he hated everyone. Staff was unable to redirect him and calm him so the approval for his PRN Haldol, 5 mg. was given...."</p> <p>The facility's internal incident report indicated client #2 required 3 staff to perform the YSIS (Your Safe, I'm Safe-behavioral technique/restraint) technique to a chair.</p> <p>-2/15/12 "[Client #2] became agitated and started having behaviors. He began pulling his own hair and attempting to tear the fire alarm off the wall. He became verbally and physically aggressive with staff. Staff was given approval to administer PRN, Haldol 5 mg...."</p> <p>-2/12/12 "[Client #2] became agitated and began having behaviors. He was wanting to pull the fire alarm and threatening to hurt others. Staff intervened and placed him in YSIS. Unable to get him to calm</p>			

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	<p>down, staff administered his PRN Haldol, 5 mg...."</p> <p>-2/11/12 "[Client #2] became aggressive and started having behaviors. Approval was given to administer his PRN Haldol, 5 mg...."</p> <p>-2/9/12 "[Client #2] began having behaviors and hit the mirror in the bathroom. Staff intervened and attempted to calm [client #2]. His behaviors continued to increase and he became very aggressive towards staff. He was placed in YSIS four times. Approval was given for [client #2] to take his PRN Haldol, 5 mg...."</p> <p>-2/6/12 "[Client #2] became agitated and started a behavior. He threatened to harm clients, staff, and himself. Staff intervened but [client #2] would not calm down. He was administered PRN Zyprexa (behavior) 10 mg. at 1:20 PM...."</p> <p>-2/4/12 "After multiple behaviors of attacking staff, [client #2] calms down for a brief second then jumps up (sic) flips over couch in LR (living room) #1. YSIS w/ (with) 3 people, leaving clients locked in office for their safety. Got [client #1] to go to his room shut door (sic). Redirect didn't work, Protocol on PRN was approved, but [client #2] refusing to</p>			

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	<p>take. Would not go to his room." A second internal incident report indicated client #2 started "...putting his fingers into his eyes trying to pop out his eyes...."</p> <p>-2/3/12 at 10:00 PM, "[Client #2] had been having behaviors all day, attacking staff and property destruction. Staff tried to verbally redirect [client #2] and tried to place him YSIS, when that wouldn't work staff called the nurse and she instructed them to administer the Haldol PRN...."</p> <p>-2/3/12 at 2:50 PM, "[Client #2] started to attack staff and threatening his housemates, staff tried to place him in YSIS and that wouldn't work called 911. When the police showed up to the house [client #2] calmed down and was administered a PRN, Zyprexa 10 mg...." The reportable incident report indicated client #2's behavior lasted 4 hours.</p> <p>The facility's 2/3/12 internal incident report indicated "Xtra (sic) staff from (group home) #2 came to help..." with client #2's behaviors. The internal incident report indicated client #2 required 3 staff to implement YSIS techniques. Another 2/3/12 internal incident report indicated client #2 indicated he would "...throw himself thru window to get 911 called...."</p>						

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	<p>-2/1/12 "Staff was showering [client #2] and he began making suicidal threats and threatening to beat and kill another consumer. Staff was given approval to administer [client #2's] PRN, Zyprexa 10 mg. It was given at 3:00 PM. There was no improvement after administration of the PRN and he would not calm down. 911 was called...."</p> <p>-2/1/12 at 3:00 PM, "[Client #2] began having a behavior and started getting aggressive. He was attempting to tear the fire alarm off the wall and staff verbally redirected him several times. He was becoming more violent and the behaviors were increasing. YSIS was used two times. Staff administered his PRN, Zyprexa 10mg. at 2:50 PM...."</p> <p>-1/29/12 "[Client #2] started to have behaviors and telling staff that he was going to kill them and rape them. Staff tried to verbally redirect him but when that wouldn't work staff tried to place him in YSIS. When staff tried to place [client #2] in YSIS he ran into the office and started to tell staff that he was going to kill them and watch them bleed. When staff was not able to calm him down they called 911. When the police showed up [client #2] was attacking staff, when [client #2] saw the police he calmed down. [Client #2] was transported to</p>						

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	<p>[name of hospital] where he was admitted...."</p> <p>-1/16/12 "[Client #2] became red in the face and started talking under his breath and pacing back and forth. Staff were unable to calm him and they were approved to administer his PRN Zyprexa 10mg. at 3:00 PM...After administration of the med, behaviors did not improve. He was becoming physically aggressive and threatening suicide...." The reportable incident report indicated client #2's behavior lasted for 1 hour and resulted with 911 being called.</p> <p>-1/14/12 "[Client #2] suddenly got agitated and red in the face. He hit staff and they placed him in YSIS. Staff was given approval for his PRN medication Zyprexa 10mg. at 1:13 PM...."</p> <p>-1/5/12 "[Client #2] started running around the house and became agitated. He became red in the face and threatening to kill himself. Staff attempted to verbally redirect him. He was not calming down so staff administered his PRN, olanzapine (behavior) 10mg @ 2:50 PM...."</p> <p>-12/28/11 "[Client #2] woke around 7:30 AM and immediately was angry and agitated. He was threatening to kill staff</p>			

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	<p>as well as himself. Staff intervened and were unable to redirect him to calm down. The nurse was notified and she advised staff to give [client #2] his PRN Zyprexa 10mg...."</p> <p>A second 12/28/11 reportable incident report indicated client #2 had demonstrated behaviors "throughout the day" and had barricaded himself into a peer's bedroom which resulted in staff calling 911 for assistance.</p> <p>-12/27/11 "[Client #2] became agitated. He started pacing and throwing furniture. Staff intervened and redirected him. His behaviors were increasing and he began breaking plastic hangers threatening to hurt staff with them....Olanzapine 10 MG was administered at 1:10 PM...."</p> <p>A second 12/27/11 reportable incident report indicated client #2 began making suicidal threats and threatened staff. The reportable incident report indicated 911 was called and the client was transported to the hospital for evaluation.</p> <p>-12/22/11 "On December 21, 2011, [client #2's] Interdisciplinary Team met to discuss the severity of his behaviors and determined that a PRN medication should be explored with his consulting psychiatrist. [Name of psychiatrist]</p>			

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	<p>agreed with the team's recommendation and prescribed Olanzapine 10mg PRN...On 12/22/11, 12/24/11, and 12/26/11, [client #2] exhibited behaviors in which he attempted to attack staff and threatened to harm himself and others. The team administered the PRN on all occasions...."</p> <p>Client #2's record was reviewed on 4/12/12 at 9:55 AM. Client #2's 12/29/11 History and Physical note from an emergency room visit indicated "...Will discuss with ResCare because they need to arrange behavioral therapy for this patient and involve the behavioral therapist for his behavior issues, and discharge him back to ResCare after discussing with them...."</p> <p>Client #2's Interdisciplinary Team (IDT) Meeting notes indicated the facility's BC was not present and/or did not provide input in regard to the client's behavior at the following IDT meetings which met in regard to the client's behaviors/approvals for PRNs:</p> <p>-2/26/12 -2/24/12 -2/23/12 -2/21/12 -2/20/12 -2/16/12</p>						

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	<p>-2/14/12 -2/12/12 -2/11/12 -2/6/12 -2/4/12 -2/3/12 -2/1/12</p> <p>Client #2's record and/or 2012 monthly notes did not indicate the BC documented monthly notes/behavior data in the client's record since 1/12.</p> <p>2. The facility's internal incident reports, reportable incident reports and/or investigations were reviewed on 4/11/12 at 11:30 AM. The facility's internal incident reports indicated the following:</p> <p>-3/30/12 at 4:05 AM, "...[Client #1] went to the bathroom then his bedroom. Started pounding on door, walls & (and) fire alarm...."</p> <p>-3/29/12 "[Client #1] was pounding his fist on the walls, throwing items and yelling..." at 4:40 AM in the morning.</p> <p>-3/18/12 at 5:40 AM, "...[Client #1] was yelling and banging his fist on the walls and staff attempted to redirect him to his room to a calm area...."</p> <p>Client #1's record was reviewed on</p>			

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	<p>4/12/12 at 11:40 AM. Client #1's 3/1/12 Individual Support Plan indicated client #1 was admitted to the group home on 2/1/12.</p> <p>Client #1's IDT meeting notes indicated the following:</p> <p>-4/3/12 "[Client #1] became upset for no apparent reason when he left the bathroom and went into his bedroom. He began hitting the walls, doors, and fire alarm. When the staff attempted to verbally re-direct him he became more agitated and physically aggressive towards the other staff. The staff implemented 2 man YSIS..."</p> <p>-3/29/12 "[Client #1] became upset for an unapparent reason. When staff tried to verbally redirect him from hitting the walls and throwing items. (sic) He (sic) attempted to try to hit the staff. He then began throwing items at the staff. Staff were unable to get him calm. Staff implemented YSIS...."</p> <p>-3/20/12 "[Client #1] became upset for an unapparent reason. He began hitting the walls and yelling. Staff attempted verbal redirection to his room. [Client #1] then came back into the living room throwing his toy and the T.V. remote. He then tried hitting and biting staff. Staff</p>			

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	<p>implemented YSIS...."</p> <p>Client #1's above mentioned IDT notes indicated the facility's BC was not involved and/or participated in the mentioned IDTs regarding client #1's behavior.</p> <p>The group home's Visitor record was reviewed on 4/12/12 at 1:05 PM. The Visitor record indicated the facility's BC documented he was present in the home on the following:</p> <p>-9/6/11 from 10:20 PM to 12:15 PM -8/22/11 1:15 PM to 2:30 PM -8/18/11 2:15 PM to 3:45 PM 5/24/11 2:30 PM with no end time.</p> <p>The BC's BMAN (Behavior Management) Contact Visit Notes were reviewed on 4/16/12 at 10:55 AM. The hand written notes indicated the BC clearly documented he was in the home and/or at the workshop on the following days:</p> <p>4/2/12 3/30/12 3/28/12 3/26/12 3/16/12 3/8/12 3/5/12 1/21/12 1/11/12</p>			

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	<p>1/10/12 1/9/12 12/21/11 12/13/11 11/27/11 11/16/11 11/14/11 11/9/11 11/8/11 10/29/11 10/26/11 10/21/11 10/18/11 10/7/11</p> <p>The BC's hand written notes did not specifically indicate when and/or what times the BC visited the homes to ensure the BC was in the home at least a minimum of 10 hours a week for clients #1, #2, #3 and #4.</p> <p>Interview with LPN #1 and the Qualified Developmental Disability Professional-Designee (QDDP-D) on 4/12/12 at 1:45 PM indicated they did not know how often the BC visited the group home.</p> <p>Interview with the BC on 4/13/12 at 8:21 AM when asked how often he was present in the group home, the BC stated "As often as I can." The BC indicated he was present for client #2's IDTs. The BC</p>			

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	<p>could not explain why his signature was not on the above mentioned IDT notes and/or why the IDT notes did not indicate the BC was present by phone. The BC indicated he was to be present in the home for 10 hours a week.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure the Qualified Developmental Disability Professional monitored, coordinated and/or integrated clients' programs in regard to addressing the clients' identified behavioral needs, obtaining accurate assessments and/or re-assessments of clients, and/or failing to ensure the clients' interdisciplinary teams involved the QDDP and/or other appropriate team members to address and/or meet the behavioral needs of clients #1 and #2. Please see W159.</p> <p>9-3-1(a)</p>			

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 1 of 7 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to document a thorough investigation in regard to an allegation of possible neglect.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 4/12/12 at 9:55 AM. Client #2's 1/29/12 Record of History and Physical indicated "...It is surprising that oxycodone (pain medication) showed up positive when he does not take that at home. However, Klonopin (anti-psychotic/behavior) is one of his listed medications and benzos were negative, so I am not sure if he is taking his medication or if he is trading medications with other people...."</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 4/11/12 at 11:30 AM. The facility's reportable incident reports from 12/11 to 4/11/12 and/or the facility's investigations from 4/11 to 4/12 indicated the facility did not document/investigate the above mentioned allegation of neglect regarding client #2.</p>	W0154	<p>Corrective Action: (Specific) The Quality Assurance Team will be retrained that all allegations of abuse, neglect (which includes medication issues) and/or injuries of unknown origin are thoroughly investigated.</p> <p>How others will be identified: All allegations of abuse, neglect (which includes medication issues) and /or injuries of unknown origin are thoroughly investigated.</p> <p>Measures to be put in place: The Quality Assurance Team will be retrained that all allegations of abuse, neglect (which includes medication issues) and/or injuries of unknown origin are thoroughly investigated.</p> <p>Monitoring of Corrective Action: The Executive Director reviews all investigations to ensure that all allegations of abuse, neglect (which includes medication issues) and/or injuries of unknown origin are thoroughly investigated.</p>	05/19/2012			

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	<p>Interview with the Qualified Developmental Disability Professional-Designee (QDDP-D) and LPN #1 on 4/12/12 at 1:45 PM indicated they were aware of the doctor's concern/allegation. LPN #1 indicated she started looking into the doctor's concerns when she learned of the oxycodone being found in client #2's system. LPN #1 and the QDDP-D indicated client #2 received Klonopin on a routine basis for behavior. LPN #1 indicated once she started checking client #2's record, client #2 had a bladder scope procedure done where the client was given oxycodone for pain. LPN #1 indicated the client had received the medication days before he was taken to the emergency room for his behaviors. LPN #1 and the QDDP-D did not know why the Klonopin did not show up in client #2's system when it was tested.</p> <p>Interview with administrative staff #2 on 4/13/12 at 8:21 AM, LPN #1 and the Director of Nursing Services (DNS) indicated client #2 did not take Oxycodone. The DNS indicated client #2 had received Oxycodone for a procedure a couple of days prior to going to the emergency room. The DNS indicated they did not know this until they started looking into the allegation. The DNS and/or LPN #1 indicated there was no</p>			

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	documentation completed in regard to the allegation of neglect. Administrative staff #2 indicated the facility did not document and/or conduct a thorough investigation in regard to the allegation of possible neglect with client #2. 9-3-2(a)			

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W0159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on observation, interview and record for 2 of 2 sampled clients (#1 and #2), the Qualified Developmental Disability Professional (QDDP) failed to monitor, coordinate and/or integrate clients' programs in regard to addressing the clients' identified behavioral needs, obtaining accurate assessments and/or re-assessments of clients, and/or failing to ensure the clients' interdisciplinary teams involved the QDDP and/or other appropriate team members to address and/or meet the behavioral needs of the clients.</p> <p>Findings include:</p> <p>1. The facility's 4/11/12 Qualified Mental Retardation Professional (QDDP) State Form 48318 was reviewed on 4/11/12 at 3:40 PM. The QDDP form indicated administrative staff #2 was the QDDP for the group home and staff #1 was the QDDP-D for the group home. The 4/11/12 form indicated administrative staff #3 was the Behavior Specialist/consultant for the group home.</p> <p>Client #2's record was reviewed on</p>	W0159	<p>Corrective Action: (Specific) The Qualified Developmental Disability Professional will be retrained to ensure that all members of the IDT participate in meetings which involve the clients' behavioral needs. The QDDP will be retrained to ensure that client programs are reviewed, monitored, and assessments/reassessments are obtained when needed to address the clients' identified needs. How others will be identified: (Systemic) The Qualified Developmental Disability Professional will be retrained to ensure that all members of the IDT participate in meetings which involve the clients' behavioral needs. The QDDP will be retrained to ensure that client programs are reviewed, monitored, and assessments are obtained when needed to address the clients' identified needs. Measures to be put in place: . The Qualified Developmental Disability Professional will be retrained to ensure that all members of the IDT participate in meetings which involve the clients' behavioral needs. The QDDP will be retrained to ensure that client programs are reviewed,</p>	05/19/2012			

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	<p>4/12/12 at 9:55 AM. Client #2's Interdisciplinary Team (IDT) Meeting notes indicated the facility's BC and/or the facility's nurse were not present and/or did not provide input in regard to the client's behavior at the following IDT meetings which met in regard to the client's behaviors/approvals for PRNs (as needed behavior medication):</p> <p>-2/26/12 -2/24/12 -2/23/12 -2/21/12 -2/20/12 -2/16/12 -2/14/12 -2/12/12 -2/11/12 -2/6/12 -2/4/12 -2/3/12 -2/1/12</p> <p>The above mentioned IDT notes also indicated the QDDP was not present and/or reviewed the IDT notes written by the QDDP-D. Client #2's record/IDT notes indicated administrative staff #2 was only present, by phone, for one IDT which was held on 2/15/12.</p> <p>2. Client #1's record was reviewed on 4/12/12 at 11:40 AM. Client #1's 3/1/12 Individual Support Plan indicated client</p>		<p>monitored, and assessments/reassessments are obtained when needed to address the clients' identified needs. Monitoring of Corrective Action: The Qualified Developmental Disability Professional will be retrained to ensure that all members of the IDT participate in meetings which involve the clients' behavioral needs. The QDDP will be retrained to ensure that client programs are reviewed, monitored, and assessments/reassessments are obtained when needed to address the clients' identified needs.</p>				

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	<p>#1 was admitted to the group home on 2/1/12.</p> <p>Client #1's IDT meeting notes indicated the following:</p> <p>-4/3/12 "[Client #1] became upset for no apparent reason when he left the bathroom and went into his bedroom. He began hitting the walls, doors, and fire alarm. When the staff attempted to verbally re-direct him he became more agitated and physically aggressive towards the other staff. The staff implemented 2 man YSIS...."</p> <p>-3/29/12 "[Client #1] became upset for an unapparent reason. When staff tried to verbally redirect him from hitting the walls and throwing items. (sic) He (sic) attempted to try to hit the staff. He then began throwing items at the staff. Staff were unable to get him calm. Staff implemented YSIS...."</p> <p>-3/20/12 "[Client #1] became upset for an unapparent reason. He began hitting the walls and yelling. Staff attempted verbal redirection to his room. [Client #1] then came back into the living room throwing his toy and the T.V. remote. He then tried hitting and biting staff. Staff implemented YSIS...."</p>			

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	<p>Client #1's above mentioned IDT notes indicated the facility's BC and/or the facility's nurse were not involved and/or participated in the mentioned IDTs regarding client #1's behavior and PRN usage. The above mentioned IDT notes also indicated administrative staff #2 did not participate in and/or review the above mentioned IDT notes written by the QDDP-D.</p> <p>Interview with the BC, administrative staff #2, LPN #1, and the QDDP-D on 4/13/12 at 8:21 AM indicated client #1 and #2's IDT met to review the client's behavior, behavior management techniques utilized and/or to approve the client #2's PRN usage. The BC indicated he was present for client #2's IDTs. The BC could not explain why his signature was not on the above mentioned IDT notes and/or why the IDT notes did not indicate the BC was present by phone. LPN #1 indicated she had been called and/or gave approval for the staff to administer client #2's PRN behavior medication. The BC, administrative staff #2, LPN #1 and the QDDP could not explain why the appropriate team members did not attend and/or sign the IDT notes.</p> <p>3. The QDDP failed to monitor and/or to coordinate client #1 and #2's programs to</p>				

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	<p>ensure accurate assessments and/or re-assessments were obtained in regard to the clients' behaviors and to obtain assessments (visual, dental sensorimotor and/or speech) within 30 days of the clients being admitted to the group home. Please see W210.</p> <p>4. The QDDP failed to monitor client #1 and #2's programs in regard to addressing identified behavioral needs of the clients. Please see W227.</p> <p>9-3-3(a)</p>			

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W0210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2), the clients' Interdisciplinary Teams (IDTs), failed to assess and/or re-assess client #2's behavior/fluid consumption. The clients' IDTs failed to re-assess client #2's PRN (as needed) behavior medication protocol for its effectiveness, and to obtain accurate assessments (visual, dental, hearing, speech and/or sensorimotor skills) within 30 days of admission for clients #2 and #3.</p> <p>Findings include:</p> <p>1. The facility's internal incident reports and/or reportable incident reports were reviewed on 4/11/12 at 11:30 AM. The facility's internal and/or reportable incident reports indicated the following:</p> <p>-2/24/12 "[Client #2] became agitated and started having behaviors. He proceeded to make inappropriate comments to staff members, tried to pull the fire alarm, and attempted to elope the property. [Client #2] was administered his PRN (as</p>	W0210	<p>Corrective Action: (Specific) The Program Coordinator and the Nurse will be retrained that behavior medication protocol needs to be re-assessed when needed to ensure its effectiveness. The Program Coordinator and the Nurse will be retrained that accurate assessments, such as visual, dental, hearing, speech and/or sensor motor skills are obtained within 30 days of admission.</p> <p>How others will be identified: (Systemic) All Program Coordinators are trained that accurate assessments that are needed within 30 days of admission are obtained.</p> <p>Measures to be put in place: The Program Coordinator and the Nurse will be retrained that behavior medication protocol needs to be re-assessed when needed to ensure its effectiveness. The Program Coordinator and the Nurse will be retrained that accurate assessments, such as visual, dental, hearing, speech and/or sensor motor skills are obtained within 30 days of admission.</p> <p>Monitoring of Corrective Action: The Director of Nursing and the Operations Manager for</p>	05/19/2012			

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	<p>needed) Haldol, 5 mg. (milligrams) to calm his behaviors. The reportable incident report indicated client #2's behavior lasted for 30 minutes.</p> <p>-2/23/12 "[Client #2] became agitated and started huffing and puffing. He began verbally threatening other clients and attempting to elope from the home. The PRN Haldol, 5mg. was administered to calm [client #2] down...." The reportable incident report indicated client #2's behavior lasted for 2 hours.</p> <p>-2/20/12 "[Client #2] became agitated and started obsessing over staff. He became red in the face and neck. He was cussing and staff and was unable to calm down (sic). To prevent the behaviors from escalating, staff got the approval to administer his PRN Haldol, 5 mg...." The reportable incident report indicated client #2's behavior lasted for 30 minutes.</p> <p>-2/16/12 "The PC (program coordinator) was working with [client #2] to sign some paperwork. He (client #2) began talking about missing his mom and friend and became agitated. He became red in the face and neck and stated that no one will do anything for him. He was saying he didn't want to go to work and that he hated everyone. Staff was unable to redirect him and calm him so the approval</p>		SGL will monitor the PC and the Nurse to ensure that all assessments needed within 30 days of admission are obtained.				

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	<p>for his PRN Haldol, 5 mg. was given...."</p> <p>The reportable incident report indicated client #2's behavior lasted for 30 minutes.</p> <p>-2/15/12 "[Client #2] became agitated and started having behaviors. He began pulling his own hair and attempting to tear the fire alarm off the wall. He became verbally and physically aggressive with staff. Staff was given approval to administer PRN, Haldol 5 mg....." The reportable incident report indicated client #2's behavior lasted for 30 minutes.</p> <p>-2/12/12 "[Client #2] became agitated and began having behaviors. He was wanting to pull the fire alarm and threatening to hurt others. Staff intervened and placed him in YSIS (Your Safe, I'm Safe-behavioral technique/restraint). Unable to get him to calm down, staff administered his PRN Haldol, 5 mg...." The 2/12/12 reportable incident report indicated client #2's behavior lasted for 45 minutes.</p> <p>-2/11/12 "[Client #2] became aggressive and started having behaviors. Approval was given to administer his PRN Haldol, 5 mg...." The reportable incident report indicated client #2's behavior lasted 30 minutes.</p>			

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	<p>-2/9/12 "[Client #2] began having behaviors and hit the mirror in the bathroom. Staff intervened and attempted to calm [client #2]. His behaviors continued to increase and he became very aggressive towards staff. He was placed in YSIS four times. Approval was given for [client #2] to take his PRN Haldol, 5 mg...." The reportable incident report indicated client #2's behavior lasted for 1.5 hours.</p> <p>-2/6/12 "[Client #2] became agitated and started a behavior. He threatened to harm clients, staff, and himself. Staff intervened but [client #2] would not calm down. He was administered PRN Zyprexa (behavior) 10 mg. at 1:20 PM...." The reportable incident report indicated client #2's behavior lasted 30 minutes.</p> <p>-2/4/12 "After multiple behaviors of attacking staff, [client #2] calms down for a brief second then jumps up (sic) flips over couch in LR (living room) #1. YSIS w/ (with) 3 people, leaving clients locked in office for their safety. Got [client #1] to go to his room shut door (sic). Redirect didn't work, Protocol on PRN was approved, but [client #2] refusing to take. Would not go to his room." The internal incident report did not indicate how long client #2's behavior lasted.</p>			

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	<p>-2/3/12 at 10:00 PM, "[Client #2] had been having behaviors all day, attacking staff and property destruction. Staff tried to verbally redirect [client #2] and tried to place him YSIS, when that wouldn't work staff called the nurse and she instructed them to administer the Haldol PRN...." The reportable incident report indicated client #2's behavior lasted for 1 hour.</p> <p>A 4/9/12 follow-up report to the 2/3/12 incident indicated "Please report the outcome of team review of incident and recommendations given to reduce the amount of PRN's given. Does the current PRN medication remain effective?..."</p> <p>-2/3/12 at 2:50 PM, "[Client #2] started to attack staff and threatening his housemates, staff tried to place him in YSIS and that wouldn't work called 911. When the police showed up to the house [client #2] calmed down and was administered a PRN, Zyprexa 10 mg...." The reportable incident report indicated client #2's behavior lasted 4 hours.</p> <p>-2/1/12 "Staff was showering [client #2] and he began making suicidal threats and threatening to beat and kill another consumer. Staff was given approval to administer [client #2's] PRN, Zyprexa 10 mg. It was given at 3:00 PM. There was no improvement after administration of</p>						

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	<p>the PRN and he would not calm down. 911 was called...."</p> <p>-2/1/12 at 3:00 PM, "[Client #2] began having a behavior and started getting aggressive. He was attempting to tear the fire alarm off the wall and staff verbally redirected him several times. He was becoming more violent and the behaviors were increasing. YSIS was used two times. Staff administered his PRN, Zyprexa 10mg. at 2:50 PM...." The reportable incident report indicated client #2's behavior lasted for 45 minutes.</p> <p>-1/16/12 "[Client #2] became red in the face and started talking under his breath and pacing back and forth. Staff were unable to calm him and they were approved to administer his PRN Zyprexa 10mg. at 3:00 PM...After administration of the med, behaviors did not improve. He was becoming physically aggressive and threatening suicide...." The reportable incident report indicated client #2's behavior lasted for 1 hour and resulted with 911 being called.</p> <p>-1/14/12 "[Client #2] suddenly got agitated and red in the face. He hit staff and they placed him in YSIS. Staff was given approval for his PRN medication Zyprexa 10mg. at 1:13 PM...." The reportable incident report indicated client</p>			

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	<p>#2's behavior lasted for 45 minutes.</p> <p>-1/5/12 "[Client #2] started running around the house and became agitated. He became red in the face and threatening to kill himself. Staff attempted to verbally redirect him. He was not calming down so staff administered his PRN, olanzapine (behavior) 10mg @ 2:50 PM...." The reportable incident report indicated client #2's behavior lasted 20 minutes.</p> <p>-12/28/11 "[Client #2] woke around 7:30 AM and immediately was angry and agitated. He was threatening to kill staff as well as himself. Staff intervened and were unable to redirect him to calm down. The nurse was notified and she advised staff to give [client #2] his PRN Zyprexa 10mg...." The reportable incident report indicated client # 2's behavior lasted for 40 minutes.</p> <p>-12/27/11 "[Client #2] became agitated. He started pacing and throwing furniture. Staff intervened and redirected him. His behaviors were increasing and he began breaking plastic hangers threatening to hurt staff with them....Olanzapine 10 MG was administered at 1:10 PM...." The reportable incident report indicated client #2's behavior lasted for 1 hour.</p>			

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	<p>-12/22/11 "On December 21, 2011, [client #2] Interdisciplinary Team met to discuss the severity of his behaviors and determined that a PRN medication should be explored with his consulting psychiatrist. [Name of psychiatrist] agreed with the team's recommendation and prescribed Olanzapine 10mg PRN...On 12/22/11, 12/24/11, and 12/26/11, [client #2] exhibited behaviors in which he attempted to attack staff and threatened to harm himself and others. The team administered the PRN on all occasions...."</p> <p>Client #2's record was reviewed on 4/12/12 at 9:55 AM. Client #2's 3/26/12 physician's orders indicated the client had an order for Haloperidol (Haldol) 5 milligrams every 6 hours PRN for aggression related to client #2's Intermittent Explosive Disorder. The 3/26/12 physician's order indicated the Haldol PRN was started on 2/5/12.</p> <p>Client #2's 3/5/12 Behavior Support Plan (BSP) protocol for the PRN usage indicated the following:</p> <p>"...If [client #2] begins to exhibit: Breathing at a faster pace Begins pacing Begins to redden in the face Makes a threat to engage in physical</p>						

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	<p>aggression or property destruction Runs or exits house rapidly Engages in physical aggression Immediately notify the nurse of the behavior clinician and begin the PRN protocol -The nurse or the behavior consultant will consult with each other and make the determination if the PRN should be given -The nurse will send out HRC (Human Rights Committee) request -Upon receiving the HRC approvals the nurse will call the home and instruct staff to administer the PRN."</p> <p>Client #2's IDT notes indicated client #2's IDT met to approve the use/administration of the Haldol PRN and to get HRC approval for its use on 2/26, 2/24, 2/23, 2/21, 2/20, 2/16, 2/15, 2/14, 2/12, 2/11, 2/9, 2/6, 2/4 and 2/1/12 for the use of PRN Zyprexa. Client #2's above mentioned IDT notes indicated the following "Meeting Minutes: The team met to discuss the approval to administer the PRN medication for [client #2]...Per PRN protocol the team is contacted and recommends that the PRN medication is to be given to prevent the behaviors from escalating. HRC approval is being requested to administer the PRN medication as prescribed by his psychiatrist."</p>				

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	<p>Client #2's above mentioned IDT notes indicated client #2's IDT did not assess and/or re-assess the effectiveness of the client's PRN and/or re-assess how the PRN was being administered to ensure its effectiveness to decrease and/or stop the client's aggressive behavior. Client #2's IDT notes also did not indicate the IDT re-assessed the need for the use of the PRN injection.</p> <p>Interview with administrative staff #1 on 4/11/12 at 11:32 AM indicated client #2 had not been administered a PRN since 2/12. Administrative staff #1 stated "He (client #2) was getting one (a PRN) daily." Administrative staff #1 stated client #2 received the PRN as "he attacks staff, beats them up, threatens to kill them and drink their blood."</p> <p>Interview with staff #3 on 4/12/12 at 7:22 AM indicated client #2 had hurt 2 staff due to his physical aggression/attacks.</p> <p>Interview with staff #2 on 4/12/12 at 7:30 AM indicated client #2 had behaviors which lasted up to 6 hours in the past. Staff #2 stated "It was awful for a long time."</p> <p>Interview with LPN #1 and the Qualified Developmental Disability Professional-Designee (QDDP) on</p>						

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	<p>4/12/12 at 1:45 PM indicated client #2 required the use of PRN Haldol to help control the client's behavior when he became upset. LPN #1 and the QDDP-D indicated the group home staff would call the nurse and the behavior specialist for approval to use the PRN medication. The QDDP-D and LPN #1 indicated three HRC members would need to be called to obtain approval to administer the PRN medication to client #2. The QDDP-D indicated these approvals would need to be obtained each time prior to administration of the PRN. When asked how long it took for staff to get approval to use the PRN when client #2 was a danger to himself and/or others, LPN #1 stated "Can vary." The QDDP-D stated "It is an understatement. It can take 3 minutes to 1 hour."</p> <p>Interview with LPN #1, the Behavior Consultant/Clinician (BC), the QDDP-D and the Director of Nursing Services (DNS) on 4/13/12 at 8:21 AM indicated client #2 required the use of PRN medication. The BC indicated client #2's behavior had improved since Clozaril (behavior medication) was added to the client's routine medications. The BC stated client #2's PRN was to be used when the client became upset and was "red in the face." The BC stated "When he (client #2) exhibited precursor</p>						

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	<p>behavior, redness and making threats." The BC, the DNS, LPN #1 and the QDDP indicated facility staff would need to call the nurse, and/or the BC prior to each use, and then they would obtain approval from the facility's HRC committee prior to each use. The BC indicated this was the facility's policy in administering PRN behavior medication. The BC indicated client #2 had received many PRNs due to the client's behavior/aggression. When asked if the client's IDT had assessed the effectiveness of the PRN and/or its protocol in how it was being approved, the BC indicated the client's IDT had discussed if the client's PRN was getting into the client's system and if the medication was being effective. The BC could not provide documentation and/or IDT note where client #2's IDT specifically discussed/re-assessed the client's PRN usage, and/or how the PRN was being administered to ensure its effectiveness to decrease and/or stop the client's aggressive behavior.</p> <p>2. During the 4/12/12 observation period between 6:04 AM and 11:15 AM, at the group home, client #2 received his morning medications (Clozaril, Clonazepam, Lexapro and Lithium Carbonate-behavior medications) at 8:03 AM. At 8:10 AM, client #2 had an 8 ounce cup of milk and juice with</p>			

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	<p>breakfast. At 8:30 AM, when client #2 took his dishes to the kitchen to place in the sink, client #2 asked staff for some water. Client #2 retrieved an 8 ounce cup and drank 2 8 ounce cups of water from the sink. At 8:35 AM, client #2 was loading the dishwasher and turned back to the sink and drank 3 more 8 ounce cups of water from the running water at the sink, when staff #3 told client #2 he had drunk enough water. Interview with staff #3 on 4/12/12 at 8:35 AM when asked how much water client #2 drank, staff #3 stated, "Moderate amounts, but not as much as [client #3]. We monitor him (client #2) so he does not flush meds."</p> <p>Client #2's record was reviewed on 4/12/12 at 9:55 AM. Client #2's 6/30/11 Individual Support Plan (ISP) did not indicate the facility was collecting data and/or had assessed how much water client #2 consumed to ensure the client did not consume enough water to affect his behavioral medications.</p> <p>Interview with the DNS, LPN #1 and the QDDP-D on 4/13/12 at 8:21 AM indicated client #2 would drink drink 3 glasses of fluids/drinks with meals. The QDDP-D and LPN #1 indicated the client's urologist had been concerned about the amount of fluids client #2 received as the client had a problem with</p>						

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	<p>bed wetting and had a diagnosis of Enuresis. The QDDP-D, LPN #1 and DNS indicated the facility had not assessed client #2's fluid consumption to ensure the amount of fluid consumption did not affect the client's behavioral medications.</p> <p>3. Client #2's record was reviewed on 4/12/12 at 9:55 AM. Client #2's 6/30/11 ISP indicated client #2 was admitted to the group home on 6/1/11. Client #2's record and/or 5/29/11 physical examination indicated client #2 did not have a visual examination/assessment completed within 30 days of being admitted to the group home as no visual examination could be found in client #2's record.</p> <p>Interview with LPN #1 and the QDDP-D on 4/13/12 at 8:21 AM indicated client #2's vision had not been assessed since the client was admitted to the group home.</p> <p>4. During the 4/11/12 observation period between 4:30 PM and 6:45 PM and the 4/12/12 observation period between 6:04 AM and 11:15 AM, at the group home, client #1 was non-verbal in communication in that the client did not speak.</p>			

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	<p>Client #1's record was reviewed on 4/12/12 at 11:40 AM. Client #1's 3/1/12 ISP indicated client #1 was admitted to the group home on 2/1/12. Client #1's 3/1/12 ISP and/or record indicated client #1's speech had not been assessed since the client was admitted to the group home as no speech assessment was present in the client's record. Client #1's 3/1/12 ISP and/or record also indicated client #1 did not have a dental, hearing and/or sensorimotor assessments completed within 30 days of being admitted to the group home.</p> <p>Interview with the QDDP-D and LPN #1 on 4/13/12 at 8:21 AM indicated client #1 had not seen a dentist yet, but they were in the process of scheduling one. The QDDP-D and LPN #1 indicated client #1 had not had a hearing assessment as the facility was in the process of locating/obtaining another audiologist who would see the clients as the previous one retired. The QDDP-D indicated she was still waiting on a referral from the doctor for client #1 to be referred for speech and sensorimotor evaluations.</p> <p>9-3-4(a)</p>						

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W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on interview and record review for 2 of 2 sampled clients (#1 and #2), the clients' Individual Support Plans (ISPs) failed to address client #2's identified behavioral need in regard to suicide attempts/ideation and client #1's identified need in regard to not sleeping at night.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/11/12 at 11:30 AM. The facility's internal incident reports, reportable incident reports and/or investigations indicated the following:</p> <p>-2/4/12 The internal incident report indicated "...[Client #2] starts putting his fingers into his eyes trying to pop out his eyes...." The internal incident report indicated " Type of Incident (Circle One): ...Suicide Threats...."</p> <p>-2/3/12 Client #2 threatened to throw himself through the window to get 911 called.</p>	W0227	<p>Corrective Action: (Specific) Client #2's ISP /BSP will be revised to appropriately address his suicide attempts/ideation. Client #1's ISP/BSP will also be revised to identify and address the identified need in regard to not sleeping at night.</p> <p>How others will be identified: (Systemic) Suicide attempts/ideation of all clients will be included in their ISPs/BSPs. Not sleeping at night will be addressed in all clients' ISP/BSP.</p> <p>Measures to be put in place: Client #2's ISP /BSP will be revised to appropriately address his suicide attempts/ideation. Client #1's ISP/BSP will also be revised to identify and address the identified need in regard to not sleeping at night.</p> <p>Monitoring of Corrective Action: All ISPs will be reviewed by the Operations Manager of the Director of SGL to ensure all elements of a client's identified needs such as, suicidal ideation and not sleeping at night are appropriately addressed.</p>	05/19/2012			

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	<p>-2/1/12 "Staff was showering [client #2] and he began making suicidal threats...911 was called and [client #2] was transported to the ER (emergency room) via ambulance...."</p> <p>-1/16/12 "[Client #2] was red in face, pacing back and forth and started talking under his breath. Unable to calm him. PRN (as needed) Zyprexa 10 mg. (milligrams) administered...." The reportable incident report indicated client #2 was "threatening suicide" and 911 was called and the client was transported to the hospital for an evaluation.</p> <p>-1/5/12 "[Client #2] started running around the house and became agitated. He became red in the face and threatening to kill himself...."</p> <p>12/28/11 at 8:30 PM, "...His (client #2's) behaviors continued to escalate to the point where [client #2] locked himself in a peer's room and barricaded the door. At this point staff determined 911 needed to be called to take him to the ER for evaluation...."</p> <p>-12/28/11 at 12:20 PM, "[Client #2] woke up around 7:30 AM and immediately was angry and agitated. He was threatening to kill staff as well as himself...."</p>			

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	<p>-12/27/11 Client #2's "...behaviors continued to increase and he began threatening staff and making suicidal threats. 911 was called and he was transported to the ER via ambulance...."</p> <p>Client #2's record was reviewed on 4/12/12 at 9:55 AM. Client #2's 2/6/12 IDT (interdisciplinary team) Meeting note indicated "The team met and discussed the behaviors displayed by [client #2]. The team agrees at this time to implement a suicide protocol due to [client #2] has been given his PRN (as needed behavior medication) due to his behaviors and he is still discussing suicidal tendencies."</p> <p>Client #2's ER Visit note indicated client #2 was seen in the ER on 2/1/12 due to "...Depression suicidal threats and gestures...."</p> <p>Client #2's 6/30/11 ISP and/or 3/5/12 Behavior Support Plan (BSP) indicated client #2 demonstrated a targeted behavior of self-injury. The 3/5/12 BSP indicated the self-injury was defined as "anytime he is banging his head against a hard surface that has the potential to cause redness, bruising or swelling." Client #2's 3/5/12 BSP and/or 6/30/11 ISP did not indicate the client had a suicide protocol in place and/or address the client's</p>						

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	<p>identified behavioral need in regard to suicide threats and/or attempts.</p> <p>Interview with the Behavior Consultant/Clinician (BC) and administrative staff #2 on 4/13/12 at 8:21 AM indicated client #2 would attempt to harm himself and/or threaten suicide. Administrative staff #2 indicated he thought client #2's 3/5/12 BSP addressed suicide threats and gestures. The BC indicated client #2's 3/5/12 BSP did not address client #2's identified behavioral need in regard to suicide threats and/or attempts.</p> <p>2. The facility's internal incident reports, reportable incident reports and/or investigations were reviewed on 4/11/12 at 11:30 AM. The facility's internal incident reports indicated the following:</p> <p>-3/30/12 at 4:05 AM, "...[Client #1] went to the bathroom then his bedroom. Started pounding on door, walls & (and) fire alarm...."</p> <p>-3/29/12 "[Client #1] was pounding his fist on the walls, throwing items and yelling..." at 4:40 AM in the morning.</p> <p>-3/18/12 at 5:40 AM, "...[Client #1] was yelling and banging his fist on the walls and staff attempted to redirect him to his</p>			

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	<p>room to a calm area...."</p> <p>Client #1's record was reviewed on 4/12/12 at 11:40 AM. Client #1's Progress Notes indicated the following:</p> <p>-4/1/12 "[Client #1] stayed up watching TV all shift (12 AM to 6:00 AM)."</p> <p>-4/2/12 "[Client #1] up all night, had multiple BM's (bowel movements), 2nd (second) urination on floor...."</p> <p>-3/16/12 Client #1 was "up all night" making noise while other clients were trying to sleep.</p> <p>-3/13/12 Client #1 was awake all night.</p> <p>-3/8/12 Client #1 "...refused to go to bed and sat in chair all night turning on and off the TV for over 4 hours."</p> <p>Client #1's 2/24/12 IDT Meeting note indicated "Team met on [client #1] new admit...Behaviors were discussed also discussed was his insomnia and lack of sleep (sic). Ambian (sic) 10 mg (milligrams) was added...." The 2/24/12 IDT note indicated the Ambien would be administered at bedtime. The IDT also indicated client #1's guardian did not approve the medication. The 2/24/12 IDT and/or the client's 3/1/12 ISP did not</p>			

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	<p>address the client's identified need of staying up at night/lack of sleep.</p> <p>Interview with staff #2 on 4/12/12 at 7:30 AM stated "[Client #1] has insomnia and will not sleep at night. [Client #1] pounds on the wall at night and wakes [client #4]."</p> <p>Interview with the QDDP-D, LPN #1, administrative staff #2 and the BC on 4/13/12 at 8:21 AM indicated client #1 had been having difficulty sleeping. LPN #1 and the QDDP-D indicated client #1's behavior had improved over the past week. The QDDP-D indicated staff were to have the client clean at night, so client #1 would get tired and go to sleep. The QDDP-D indicated then the first shift staff would try and keep client #1 awake during the day so he would sleep at night. The QDDP-D indicated client #1's lack of sleep/being up at night had not been formally addressed.</p> <p>9-3-4(a)</p>				

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W0274	<p>483.450(b)(1) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The facility must develop and implement written policies and procedures that govern the management of inappropriate client behavior.</p> <p>Based on interview and record review for 2 of 2 sampled clients (#1 and #2), the facility failed to develop a policy and procedure which specifically addressed how the facility would manage clients' behaviors in their Extensive Support Needs group homes which addressed how often the Behavior Consultant/Clinician (BC) would be in the group home to provide direct monitoring, training, assessment and intervention of clients' behaviors, to ensure the BC's involvement with the interdisciplinary team, and when the BC was to be contacted in regard to clients' behaviors, and/or when specified behavior management techniques were used to ensure staff had 24 hour access to a BC who knew the specific needs of the clients.</p> <p>Findings include:</p> <p>1. The facility's internal incident reports and/or reportable incident reports were reviewed on 4/11/12 at 11:30 AM. The facility's internal and/or reportable incident reports indicated the following:</p>	W0274	<p>Corrective Action: (Specific) The facility will develop a policy and procedure that specifically addresses how often the Behavior Consultant/Clinician will be in the Extensive Support Needs group homes to provide direct monitoring, training, assessment and intervention of clients' behavior.</p> <p>How others will be identified: (Systemic) The Behavior Consultant/Clinician will be in the homes according to the policy and procedure that addresses how often the Behavior Consultant/Clinician will be in the homes.</p> <p>Measures to be put in place: Client #2's ISP /BSP will be revised to address his suicide attempts/ideation. Client #1's ISP/BSP will also be revised to identify and address the identified need in regard to not sleeping at night.</p> <p>Monitoring of Corrective Action: The Director of SGL will monitor the times that the Behavior Consultant/Clinician will be in the ESN homes to ensure the BC is in the home according to policy.</p>	05/19/2012	

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	<p>-2/24/12 "[Client #2] became agitated and started having behaviors. He proceeded to make inappropriate comments to staff members, tried to pull the fire alarm, and attempted to elope the property. [Client #2] was administered his PRN (as needed) Haldol, 5 mg. (milligrams) to calm his behaviors.</p> <p>-2/23/12 "[Client #2] became agitated and started huffing and puffing. He began verbally threatening other clients and attempting to elope from the home. The PRN Haldol, 5mg. was administered to calm [client #2] down...."</p> <p>-2/20/12 "[Client #2] became agitated and started obsessing over staff. He became red in the face and neck. He was cussing and staff and was unable to calm down (sic). To prevent the behaviors from escalating, staff got the approval to administer his PRN Haldol, 5 mg...."</p> <p>-2/16/12 "The PC (program coordinator) was working with [client #2] to sign some paperwork. He (client #2) began talking about missing his mom and friend and became agitated. He became red in the face and neck and stated that no one will do anything for him. He was saying he didn't want to go to work and that he hated everyone. Staff was unable to redirect him and calm him so the approval</p>						

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	<p>for his PRN Haldol, 5 mg. was given...."</p> <p>The facility's internal incident report indicated client #2 required 3 staff to perform the YSIS (Your Safe, I'm Safe-behavioral technique/restraint) technique to a chair.</p> <p>-2/15/12 "[Client #2] became agitated and started having behaviors. He began pulling his own hair and attempting to tear the fire alarm off the wall. He became verbally and physically aggressive with staff. Staff was given approval to administer PRN, Haldol 5 mg....."</p> <p>-2/12/12 "[Client #2] became agitated and began having behaviors. He was wanting to pull the fire alarm and threatening to hurt others. Staff intervened and placed him in YSIS. Unable to get him to calm down, staff administered his PRN Haldol, 5 mg...."</p> <p>-2/11/12 "[Client #2] became aggressive and started having behaviors. Approval was given to administer his PRN Haldol, 5 mg...."</p> <p>-2/9/12 "[Client #2] began having behaviors and hit the mirror in the bathroom. Staff intervened and attempted to calm [client #2]. His behaviors continued to increase and he became very</p>			

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	<p>aggressive towards staff. He was placed in YSIS four times. Approval was given for [client #2] to take his PRN Haldol, 5 mg...."</p> <p>-2/6/12 "[Client #2] became agitated and started a behavior. He threatened to harm clients, staff, and himself. Staff intervened but [client #2] would not calm down. He was administered PRN Zyprexa (behavior) 10 mg. at 1:20 PM...."</p> <p>-2/4/12 "After multiple behaviors of attacking staff, [client #2] calms down for a brief second then jumps up (sic) flips over couch in LR (living room) #1. YSIS w/ (with) 3 people, leaving clients locked in office for their safety. Got [client #1] to go to his room shut door (sic). Redirect didn't work, Protocol on PRN was approved, but [client #2] refusing to take. Would not go to his room." A second internal incident report indicated client #2 started "...putting his fingers into his eyes trying to pop out his eyes...."</p> <p>-2/3/12 at 10:00 PM, "[Client #2] had been having behaviors all day, attacking staff and property destruction. Staff tried to verbally redirect [client #2] and tried to place him YSIS, when that wouldn't work staff called the nurse and she instructed them to administer the Haldol PRN...."</p>			

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	<p>-2/3/12 at 2:50 PM, "[Client #2] started to attack staff and threatening his housemates, staff tried to place him in YSIS and that wouldn't work called 911. When the police showed up to the house [client #2] calmed down and was administered a PRN, Zyprexa 10 mg...."</p> <p>The reportable incident report indicated client #2's behavior lasted 4 hours.</p> <p>The facility's 2/3/12 internal incident report indicated "Xtra (sic) staff from (group home) #2 came to help..." with client #2's behaviors. The internal incident report indicated client #2 required 3 staff to implement YSIS techniques. Another 2/3/12 internal incident report indicated client #2 indicated he would "...throw himself thru (sic) window to get 911 called...."</p> <p>-2/1/12 "Staff was showering [client #2] and he began making suicidal threats and threatening to beat and kill another consumer. Staff was given approval to administer [client #2's] PRN, Zyprexa 10 mg. It was given at 3:00 PM. There was no improvement after administration of the PRN and he would not calm down. 911 was called...."</p> <p>-2/1/12 at 3:00 PM, "[Client #2] began having a behavior and started getting aggressive. He was attempting to tear the</p>						

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	<p>fire alarm off the wall and staff verbally redirected him several times. He was becoming more violent and the behaviors were increasing. YSIS was used two times. Staff administered his PRN, Zyprexa 10mg. at 2:50 PM...."</p> <p>-1/29/12 "[Client #2] started to have behaviors and telling staff that he was going to kill them and rape them. Staff tried to verbally redirect him but when that wouldn't work staff tried to place him in YSIS. When staff tried to place [client #2] in YSIS he ran into the office and started to tell staff that he was going to kill them and watch them bleed. When staff was not able to calm him down they called 911. When the police showed up [client #2] was attacking staff, when [client #2] saw the police he calmed down. [Client #2] was transported to [name of hospital] where he was admitted...."</p> <p>-1/16/12 "[Client #2] became red in the face and started talking under his breath and pacing back and forth. Staff were unable to calm him and they were approved to administer his PRN Zyprexa 10mg. at 3:00 PM...After administration of the med, behaviors did not improve. He was becoming physically aggressive and threatening suicide...." The reportable incident report indicated client</p>						

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	<p>#2's behavior lasted for 1 hour and resulted with 911 being called.</p> <p>-1/14/12 "[Client #2] suddenly got agitated and red in the face. He hit staff and they placed him in YSIS. Staff was given approval for his PRN medication Zyprexa 10mg. at 1:13 PM...."</p> <p>-1/5/12 "[Client #2] started running around the house and became agitated. He became red in the face and threatening to kill himself. Staff attempted to verbally redirect him. He was not calming down so staff administered his PRN, olanzapine (behavior) 10mg @ 2:50 PM...."</p> <p>-12/28/11 "[Client #2] woke around 7:30 AM and immediately was angry and agitated. He was threatening to kill staff as well as himself. Staff intervened and were unable to redirect him to calm down. The nurse was notified and she advised staff to give [client #2] his PRN Zyprexa 10mg...."</p> <p>A second 12/28/11 reportable incident report indicated client #2 had demonstrated behaviors "throughout the day" and had barricaded himself into a peer's bedroom which resulted in staff calling 911 for assistance.</p>				

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	<p>-12/27/11 "[Client #2] became agitated. He started pacing and throwing furniture. Staff intervened and redirected him. His behaviors were increasing and he began breaking plastic hangers threatening to hurt staff with them....Olanzapine 10 MG was administered at 1:10 PM...."</p> <p>A second 12/27/11 reportable incident report indicated client #2 began making suicidal threats and threatened staff. The reportable incident report indicated 911 was called and the client was transported to the hospital for evaluation.</p> <p>-12/22/11 "On December 21, 2011, [client #2's] Interdisciplinary Team met to discuss the severity of his behaviors and determined that a PRN medication should be explored with his consulting psychiatrist. [Name of psychiatrist] agreed with the team's recommendation and prescribed Olanzapine 10mg PRN...On 12/22/11, 12/24/11, and 12/26/11, [client #2] exhibited behaviors in which he attempted to attack staff and threatened to harm himself and others. The team administered the PRN on all occasions...."</p> <p>Client #2's record was reviewed on 4/12/12 at 9:55 AM. Client #2's Interdisciplinary Team (IDT) Meeting notes indicated the facility's BC was not</p>						

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	<p>present and/or did not provide input in regard to the client's behavior at the following IDT meetings which met in regard to the client's behaviors/approvals for PRNs:</p> <p>-2/26/12 -2/24/12 -2/23/12 -2/21/12 -2/20/12 -2/16/12 -2/14/12 -2/12/12 -2/11/12 -2/6/12 -2/4/12 -2/3/12 -2/1/12</p> <p>Client #2's record and/or 2012 monthly notes did not indicate the BC documented monthly notes/behavior data in the client's record since 1/12.</p> <p>2. The facility's internal incident reports, reportable incident reports and/or investigations were reviewed on 4/11/12 at 11:30 AM. The facility's internal incident reports indicated the following:</p> <p>-3/30/12 at 4:05 AM, "...[Client #1] went to the bathroom then his bedroom. Started pounding on door, walls & (and)</p>			

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	<p>fire alarm...."</p> <p>-3/29/12 "[Client #1] was pounding his fist on the walls, throwing items and yelling..." at 4:40 AM in the morning.</p> <p>-3/18/12 at 5:40 AM, "...[Client #1] was yelling and banging his fist on the walls and staff attempted to redirect him to his room to a calm area...."</p> <p>Client #1's record was reviewed on 4/12/12 at 11:40 AM. Client #1's IDT meeting notes indicated the following:</p> <p>-4/3/12 "[Client #1] became upset for no apparent reason when he left the bathroom and went into his bedroom. He began hitting the walls, doors, and fire alarm. When the staff attempted to verbally re-direct him he became more agitated and physically aggressive towards the other staff. The staff implemented 2 man YSIS....."</p> <p>-3/29/12 "[Client #1] became upset for an unapparent reason. When staff tried to verbally redirect him from hitting the walls and throwing items. (sic) He (sic) attempted to try to hit the staff. He then began throwing items at the staff. Staff were unable to get him calm. Staff implemented YSIS...."</p>			

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	<p>-3/20/12 "[Client #1] became upset for an unapparent reason. He began hitting the walls and yelling. Staff attempted verbal redirection to his room. [Client #1] then came back into the living room throwing his toy and the T.V. remote. He then tried hitting and biting staff. Staff implemented YSIS...."</p> <p>Client #1's above mentioned IDT notes indicated the facility's BC was not involved and/or participated in the mentioned IDTs regarding client #1's behavior.</p> <p>The facility's policy and procedures were reviewed on 4/16/12 at 5:19 PM. The facility's 4/1/12 policy entitled Behavior Support Services Policy and Procedures indicated the facility's policy which addressed behavior management programs did not specifically address and/or include how the facility would manage clients' behaviors in their Extensive Support Needs group homes. The 4/1/12 policy did not specifically address how often the BC would be in the group home to provide direct monitoring, training, assessment and intervention of clients' behaviors, did not indicate how the BC should be involved with the interdisciplinary team, and did not indicate when the BC should be contacted in regard to clients' behaviors/usage of</p>						

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	<p>specified behavior management techniques to ensure staff had 24 hour access to a BC who knew the specific needs of the clients.</p> <p>Interview with LPN #1 and the Qualified Developmental Disability Professional-Designee (QDDP-D) on 4/12/12 at 1:45 PM indicated they did not know how often the BC visited the group home.</p> <p>Interview with the BC on 4/13/12 at 8:21 AM when asked how often he was present in the group home, the BC stated "As often as I can." The BC indicated he was present for client #2's IDTs. The BC could not explain why his signature was not on the above mentioned IDT notes and/or why the IDT notes did not indicate the BC was present by phone. The BC indicated he was to be present in the home for 10 hours a week.</p> <p>9-3-5(a)</p>			

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W0289	<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 interview and record review for 1 of 2 sampled clients (#2), the client's Individual Support Plan (ISP) and/or Behavior Support Plan (BSP) failed to include the use of calling 911 when the client demonstrated behaviors that could not be controlled by staff. The client's ISP/BSP also failed to indicate and/or include a protocol when the client's PRN (as needed) Haldol Intramuscular (IM) injection should be utilized to control the client's aggression toward others and/or self.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or internal incident reports were reviewed on 4/11/12 at 11:30 AM. The facility's reportable incident reports indicated the following:</p> <p>-2/3/12 at 3:45 PM, client #2 was attempting to leave the house and "attacking staff." The internal incident report indicated additional staff were called from group home #2 to come and</p>	W0289	<p>Corrective Action: (Specific) Client #2's ISP/BSP will be revised to include the use of calling 911 when Client #2's behaviors cannot be controlled by staff. Client's #2's Haldol IM injection will be discontinued.</p> <p>How others will be identified: (Systemic) All client ISPs/BSPs will address all specific behaviors.</p> <p>Measures to be put in place: Client #2's ISP/BSP will be revised to include the use of calling 911 when Client #2's behaviors cannot be controlled by staff. Client's #2's Haldol IM injection will be discontinued.</p> <p>Monitoring of Corrective Action: The Operations Manager or the Director of SGL will monitor all ISPs/BSPs to ensure all needs of the clients' are addressed.</p>	05/19/2012			

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	<p>assist with client #2. The internal incident report indicated 911 was eventually called and client #2 was in YSIS (Your Safe, I'm Safe-restraint/physical behavior management technique) when the police arrived.</p> <p>-2/3/12 at 2:50 PM, "[Client #2] started to attack staff and threatening his housemates, staff tried to place him YSIS and when that wouldn't work called 911...."</p> <p>-1/29/12 at 5:00 PM, "[Client #2] started to have behaviors and telling staff that he was going to kill them and rape them. Staff tried to verbally redirect him but that wouldn't work staff tried to place him YSIS. When staff tried to place [client #2] in YSIS he ran into the office and started to tell staff that he was going to kill them and watch them bleed. When staff was not able to calm him down they called 911...."</p> <p>-1/16/12 at 12:30 PM, 911 was called after client #2 was administered PRN Zyprexa for his behaviors. The reportable incident report indicated client #2 "...behaviors did not improve. He was becoming physically aggressive and threatening suicide...."</p>			

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	<p>-12/28/11 at 8:30 PM, "[Client #2] had been having behaviors throughout the day and received a PRN of Olanzapine at 1:10 PM. His behaviors continued to escalate to the point where [client #2] locked himself in a peer's room and barricaded the door. At this point staff determined that 911 needed to be called to take him to the ER (emergency room) for evaluation...."</p> <p>-12/27/11 at 10:10 PM, client #2 became upset and started having behaviors of aggression toward staff. The reportable incident report indicated client #2 "...continued to become more agitated and could not calm down...it was determined a PRN (as needed) medication should be given. Staff administered Olanzipine (sic) (behavior) 10 mg (milligrams) @ (at) 10:37 PM. The behaviors continued to increase and he began threatening and making suicidal threats. 911 was called...."</p> <p>Client #2's record was reviewed on 4/12/12 at 9:55 AM. Client #2's 3/5/12 BSP indicated client #2 demonstrated physical aggression, self injury behavior, property destruction and "leaving assigned areas." Client #2's 3/5/12 BSP did not indicate 911 was to be utilized and/or incorporated into the client's BSP.</p>						

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	<p>Interview with staff #2 on 4/12/12 at 7:30 AM indicated the police had been called to the group home due to client #2's behavior. Staff #2 indicated the police no longer wanted to come to the home to deal with client #2 and/or to take the client to the hospital.</p> <p>Interview with the Behavior Consultant/Clinician (BC), the Qualified Developmental Disability Professional-Designee (QDDP-D), administrative staff #2 and LPN #1 on 4/13/12 at 8:21 AM indicated 911 had been called in the past to assist with client #2's behavior. The BC indicated staff were only calling 911 to provide transport to a hospital for evaluation. The BC and QDDP-D indicated the use of 911 had not been incorporated into client #2's BSP.</p> <p>2. Client #2's record was reviewed on 4/12/12 at 9:55 AM. Client #2's 3/26/12 physician's order indicated client #2 had an order for Haloperidol Lactate Intramuscular (IM) Injection 5 milligrams/milliliters every 6 hours PRN (as needed) due to the client's physical aggression related to the client's Intermittent Explosive Disorder. Client #2's 3/26/12 physician's order indicated the PRN injection was started on 2/5/12.</p> <p>Client #2's 3/5/12 BSP indicated the</p>			

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	<p>client did not have a protocol in place for the use of the PRN Haloperidol injection.</p> <p>Interview with LPN #1 and the QDDP-D on 4/12/12 at 1:45 PM indicated client #2 did not receive any Haldol IM injections since the doctor wrote the order. When asked who was to administer the medications, LPN #1 stated "The nurse." LPN #1 and the QDDP-D could not locate a protocol for the use of the PRN Haldol injection.</p> <p>Interview with the BC, the QDDP-D and the Director of Nursing Services (DNS) on 4/13/12 at 8:21 AM indicated client #2 had not received the PRN Haldol injection. The DNS, LPN #1, the BC and the QDDP-D indicated client #2's PRN Haldol injection was not part of the client's 3/5/12 BSP as the BSP did not include a protocol on when and/or how the Haldol IM injection was to be used.</p> <p>9-3-5(a)</p>			

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W0295	<p>483.450(d)(1)(i) PHYSICAL RESTRAINTS</p> <p>The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.</p> <p>Based on interview and record review for 1 of 2 sampled clients (#2), the client's Individual Support Plan (ISP) and/or Behavior Support Plan (BSP) failed to include the specific behavioral management techniques/restraints which could be utilized when the client demonstrated physical aggression and/or property destruction.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 4/12/12 at 9:55 AM. Client #2's 3/5/12 BSP indicated client #2 demonstrated physical aggression which was defined as "hits, bites, lunges at staff or peers, any time he makes contact with staff or peers and there is the potential for the contact to cause injury or redness...." Client #2's 3/5/12 BSP also indicated client #2 demonstrated property destruction which was defined as "anytime he breaks his property or the property of others...." Client #2's 3/5/12 BSP indicated facility staff could utilize "Your Safe I am Safe procedures (physical behavior management technique/restraint)" with</p>	W0295	<p>Corrective Action: (Specific) Client #2's ISP/BSP will be revised to include specific techniques/restraints that are to be utilized when the client demonstrates physical aggression and/or property destruction.</p> <p>How others will be identified: All client's ISPs/BSPs if needed will include appropriate intervention techniques/restraints to address specific behavior concerns.</p> <p>Measures to be put in place: Client #2's ISP/BSP will be revised to include specific techniques/restraints that are to be utilized when the client demonstrates physical aggression and/or property destruction.</p> <p>Monitoring of Corrective Action: The Operations Manager or the Director of SGL will monitor all ISPs/BSPs to ensure all needs of the clients' are addressed.</p>	05/19/2012			

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	<p>client #2 when he continued to demonstrate physical aggression and/or property destruction. Client #2's 3/5/12 BSP and/or 6/30/11 ISP did not include the specific behavioral/restraint techniques staff could utilize when client #2 continued property destruction and/or aggression toward others.</p> <p>Interview with the Behavior Consultant/Clinician (BC) on 4/13/12 at 8:21 AM indicated client #2's 3/5/12 BSP should include the specific techniques/restraints which could be utilized with the client.</p> <p>9-3-5(a)</p>			

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on interview and record review for 1 of 2 sampled clients (#2), the facility's nursing services failed to ensure a protocol was put in place for the use of an as needed behavioral Intramuscular medication injection. The facility's nursing services failed to obtain an order to discontinue the PRN (as needed) behavioral medication injection as it was not being used.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 4/12/12 at 9:55 AM. Client #2's 3/26/12 physician's order indicated client #2 had an order for Haloperidol Lactate Intramuscular (IM) Injection 5 milligrams/milliliters every 6 hours PRN due to the client's physical aggression related to the client's Intermittent Explosive Disorder. Client #2's 3/26/12 physician's order indicated the PRN injection was started on 2/5/12.</p> <p>Client #2's 3/5/12 BSP (Behavior Support Plan) and/or 6/30/11 Individual Support Plan (ISP) indicated the client did not have a protocol in place for the use of the PRN Haloperidol injection. Review of</p>	W0331	<p>Corrective Action: (Specific) The nurse will be retrained that all protocol must be in place for the use of an as needed behavioral intramuscular medication injection, The nurse will also be retrained that all medications and the discontinuance of all medications need an order.</p> <p>How others will be identified: (Systemic) All homes will have medication orders that appropriately address their needs. Appropriate protocols will be put in place to address specific medical concerns.</p> <p>Measures to be put in place: The nurse will be retrained that all protocol must be in place for the use of an as needed behavioral intramuscular medication injection, The nurse will also be retrained that all medications and the discontinuance of all medications need an order.</p> <p>Monitoring of Corrective Action: The Director of Nursing will ensure that all medications are obtained and protocols are followed when administering medications.</p>	05/19/2012			

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	<p>client #2's 4/12, 3/12 and 2/12 Medication Administration Records (MARs) indicated client #2's Haldol PRN injection had not been used since it was ordered. Client #2's record and/or 3/26/12 physician's order indicated the medication had not been discontinued.</p> <p>Interview with LPN #1 and the QDDP-D on 4/12/12 at 1:45 PM indicated client #2 did not receive any Haldol IM injections since the doctor wrote the order. When asked who was to administer the medications, LPN #1 stated "The nurse." LPN #1 and the QDDP-D could not locate a protocol for the use of the PRN Haldol injection.</p> <p>Interview with the BC, the QDDP-D and the Director of Nursing Services (DNS) on 4/13/12 at 8:21 AM indicated client #2 had not received the PRN Haldol injection. The DNS, LPN #1, the BC and the QDDP-D indicated client #2's PRN Haldol injection was not part of the client's 3/5/12 BSP as the BSP did not include a protocol on when and/or how the Haldol IM injection was to be used. The DNS indicated she thought client #2's PRN Haldol IM injection had been discontinued. The DNS and LPN #1 indicated an order should have been obtained to discontinue the order.</p>			

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W0454	<p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation and interview for 1 additional client (#4), the facility failed to ensure facility staff did not allow the client to sit on the kitchen counter while dinner was being prepared and/or cleaned off the counter afterwards to ensure sanitary conditions.</p> <p>Findings include:</p> <p>During the 4/11/12 observation period between 4:30 PM and 6:45 PM, at the group home, client #4 hopped up on the counter, between the sink and the stove, and sat on his bottom where dinner was being prepared. At 5:16 PM, staff #3 left the kitchen and staff #2 entered the kitchen and saw client #4 sitting on the counter. Staff #2 did not encourage the client to get down off the counter where the dinner meal was being prepared. A few minutes later, client #4 independently got down off the counter on his own. Staff #2 did not wash down and/or clean the counter where client #4 sat. Staff #3 returned to the kitchen and started placing food items into the serving bowl where client #4 had sat.</p> <p>Interview with the Qualified</p>	W0454	<p>Corrective Action: (Specific) All staff will be retrained that sanitary methods will be used to avoid sources and transmission of infections. Counters will be sanitized when needed to prevent transmission of infections.</p> <p>How others will be identified: (Systemic) Sanitary methods will be used to avoid sources and transmission of infections in all the homes.</p> <p>Measures to be put in place: The nurse will be retrained that all protocol must be in place for the use of an as needed behavioral intramuscular medication injection, The nurse will also be retrained that all medications and the discontinuance of all medications need an order,</p> <p>Monitoring of Corrective Action: The Director of Nursing will ensure that sanitary methods are used to prevent sources and transmission of infections.</p>	05/19/2012			

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	<p>Developmental Disability Professional-Designee (QDDP-D) on 4/12/12 at 1:45 PM indicated client #4 would sit on the kitchen counter. The QDDP-D indicated facility staff should have cleaned the kitchen counter after the client sat on the counter to maintain sanitary conditions.</p> <p>9-3-7(a)</p>			

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W0484	<p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2), the facility failed to have a sufficient supply of butter knives to allow clients to cut up their food when needed.</p> <p>Findings include:</p> <p>During the 4/11/12 observation period between 4:30 PM and 6:45 PM at the group home, clients #1 and #2 had green beans, cornbread, baked chicken and salad for dinner. At 5:38 PM, client #2 placed forks and spoons on the table. Staff #2, #3 and the QDDP-D did not prompt client #2 to put butter knives on the table. At 5:57 PM, client #2 was prompted to cut up his chicken. Staff #4 assisted client #2 to cut up his chicken into pieces with a fork. No knife was used and/or provided.</p> <p>Client #2's record was reviewed on 4/12/12 at 9:55 AM. Client #2's 6/30/11 Individual Support Plan (ISP) indicated sharps/knives were locked due to the clients' behaviors in the group home. The ISP did not indicate client #2 should not have access to a butter knife to cut up his</p>	W0484	<p>Corrective Action: (Specific) The Program Coordinator will be retrained that all clients will have needed equipment according to their developmental needs. Butter knives will be obtained to cut up food items that are on the menu.</p> <p>How others will be identified: (Systemic) All homes will have needed equipment according to their developmental needs, especially at meal times.</p> <p>Measures to be put in place: The Program Coordinator will be retrained that all clients will have needed equipment according to their developmental needs. Butter knives will be obtained to cut up food items that are on the menu.</p> <p>Monitoring of Corrective Action: The Operations Manager for SGL will ensure that all needed equipment will be obtained for each client according to their developmental needs.</p>	05/19/2012			

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	<p>food.</p> <p>Client #1's record was reviewed on 4/12/12 at 11:40 AM. Client #1's 3/1/12 ISP indicated sharps/knives were locked due to the clients' behaviors in the group home. The ISP did not indicate client #1 could not have access to a butter knife to cut up his food.</p> <p>Interview with the Qualified Developmental Professional-Designee (QDDP-D) on 4/13/12 at 8:21 AM indicated the group home had one butter knife in the home to use with clients #1 and #2.</p> <p>9-3-8(a)</p>			

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W0488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 2 of 2 sampled clients (#1 and #2) and for 1 additional client (#4), the facility failed to encourage and/or allow clients to be involved in all aspects of the meal preparation as their skills allowed.</p> <p>Findings include:</p> <p>During the 4/11/12 observation period between 4:30 PM and 6:45 PM, at the group home, client #4 was in the kitchen with staff #3. Client #4 stirred up corn bread mixture after staff #3 placed the mixture, eggs and milk into a bowl. Client #4 stood and watched staff #3 cut up lettuce with a knife after client #4 was able to retrieve the lettuce, carrots and cucumbers from the refrigerator. Staff #3 placed the cut lettuce into a bowl, cut the skin off the cucumbers and sliced and then grated the carrots without involving client #4. Client #4 spoke to staff #3 as the staff cut up tomatoes into a bowl. At 5:02 PM, staff #3 removed the corn bread from the oven and spread butter on top of the cornbread. Staff #3 did not involve and/or encourage client #4, who was in the kitchen, to participate in the task. After which, staff #3 told client #4 he</p>	W0488	<p>Corrective Action: (Specific) All staff will be retrained that all clients will prepare the meals to their developmental level.</p> <p>How others will be identified: The Program Coordinators in each home will monitor the preparation of the meals to ensure that all clients participate in meal prep according to their developmental level.</p> <p>Measures to be put in place: All staff will be retrained that all clients will prepare the meals to their developmental level.</p> <p>Monitoring of Corrective Action: The Program Coordinators in each home will monitor the preparation of the meals to ensure that all clients participate in meal prep according to their developmental level.</p>	05/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2012
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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN 47126
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	would need to wash his hands to touch the chicken. Client #4 washed his hands and stood and watched staff #3 cut up raw chicken into halves/pieces. Staff #3 handed client #4 the empty chicken bag to place into the trash. Staff #3 put seasoning on the chicken and placed the chicken on the cookie sheet without involving client #4. The staff then placed the chicken in the oven to cook. Client #4 sat on the counter top without being involved. At 5:30 PM, staff #3 placed water into a pitcher. Client #4 was able to independently stir the Koolaid mix into the water. Staff #3 also dished up the green beans into a serving bowl, placed the chicken into a serving dish and placed the cornbread onto a serving plate without involving client #4 who was the cook for the meal. Client #4 stood and watched staff complete these tasks. Client #4 had skills to carry the condiments, salad, green beans and cornbread to the table without staff assistance. Once at the table, staff #3 placed client #1's salad into client #1's bowl, placed ranch dressing on the client's salad and mixed the dressing up with the salad without involving client #1. Staff #3 also poured client #1's Koolaid into his cup without providing hand over hand assistance and/or allowing the client to do it himself. During the 4/11/12 dinner meal, staff #3 carried pre-measured pudding bowls to the table			

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	<p>for clients #1, #2 and #4 without encouraging the clients to carry the bowls of pudding to the table. At 6:20 PM, client #2's head was bent over his low to his plate when eating. Staff #1, #2, #3 and #4, who were at the dinner table, did not encourage client #2 to sit up to eat.</p> <p>Interview with the Qualified Developmental Disability Professional-Designee (QDDP-D) on 4/12/12 at 1:45 PM indicated client #4 should have participated in the meal/food preparation of the 4/11/12 dinner meal.</p> <p>9-3-8(a)</p>			