

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G410	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/26/2013
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NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446
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W000000	<p>This visit was for the investigation of complaint #IN00134977.</p> <p>Complaint #IN00134977: Substantiated. Federal/state deficiencies related to the allegation are cited at W102, W104, W122, W149 and W154.</p> <p>Unrelated deficiencies cited.</p> <p>Survey Dates: September 23, 24, 25, and 26, 2013.</p> <p>Facility Number: 000924 Provider Number: 15G410 AIM Number: 100244510</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/2/13 by Ruth Shackelford, QIDP.</p>	W000000		

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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W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H). The governing body failed to ensure there was a policy/procedure in place addressing the staff securing their personal medications while at work. The governing body failed to ensure the facility conducted thorough investigations of abuse and neglect. The governing body failed to ensure the rights of all clients to be free of abuse and neglect. The governing body failed to ensure client C's guardian was notified of incidents. The governing body failed to ensure corrective actions were taken following incidents of neglect.</p> <p>Findings include:</p> <p>1) Please refer to W122. For 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the governing body failed to meet the Condition of Participation: Client Protections. The governing body failed to ensure the rights of all clients to be free of abuse and neglect by failing to implement its policies and procedures prohibiting client</p>	W000102	<p>A procedure for staff to keep personal medications and other items secure while at work was developed and all staff will be trained on it by 10/26/13. This procedure will be monitored by the Home Manager and Program Director at least weekly by observation to ensure it is being implemented correctly when staff are at work. A re-training will be completed with all Program Directors to ensure that guardians are notified of incidents and investigations involving their client by 10/26/13. The Area Director will review all incident reports to ensure guardian notification has been completed timely. All Program Directors will be retrained on the Abuse and Neglect Policy and the prevention for clients by 10/26/13. All staff will be retrained on preventing abuse and neglect by 10/26/13. All Program Directors will be retrained on the components of a thorough investigation, how to complete one, and ensuring the results of the investigation are reported to the administrator within five working days of the incidents by 10/26/13. The Area Director will review all investigations and ensure they are reported within five working days of the incident or will</p>	10/26/2013			

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	<p>abuse and neglect by failing to ensure: 1) there was a policy or procedure in place addressing staff securing their personal medications while working directly with the clients, 2) client C's guardian was notified of incidents and investigations involving client C, 3) abuse and neglect of the clients was prevented, 4) thorough investigations were conducted, 5) the results of an investigation were reported to the administrator within five working days of the incident, 6) corrective actions were taken following incidents of neglect and 7) sufficient staff were provided to manage and supervise the clients in accordance with their individual program plans.</p> <p>2) Please refer to W104. For 8 of 8 clients living at the group home (A, B, C, D, E, F, G and H), the governing body failed to ensure there was a policy or procedure in place addressing staff securing their personal medications while working directly with the clients. The governing body failed to ensure the results of investigations were reported to the administrator within 5 working days.</p> <p>This federal tag relates to complaint #IN00134977.</p> <p>9-3-1(a)</p>		<p>complete corrective action as needed. All Program Directors will be trained on completing corrective actions for staff as needed following incidents of neglect by 10/26/13. The Area Director and Quality Assurance Specialist will monitor that corrective actions are completed as needed for incidents of abuse and neglect. Staffing ratios have been increased in the home to sufficiently provide management and supervision of clients in accordance with their individual program plans. The Home Manager and Program Director will review schedules at least weekly to ensure sufficient staffing is in place. The Area Director will be notified in writing each week, that schedules have been reviewed for sufficient staffing. Persons Responsible: Home Manager, Program Director, Area Director, Quality Assurance Specialist Addendum: An extra key will be made for the van to ensure the van is safely secured during transports. Staff will have this key on them so the van can be locked whenever staff are out of the van. This includes transition times of picking up or dropping off clients during transport, while using the lift, or anytime staff are assisting clients outside the van. Staff will be trained on following this procedure on</p>				

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 8 of 8 clients living at the group home (A, B, C, D, E, F, G and H), the governing body failed to exercise operating direction over the facility by not ensuring there was a policy or procedure in place addressing staff securing their personal medications while working directly with the clients.</p> <p>Findings include:</p> <p>1) A review of the facility's incident/investigative reports was conducted on 9/23/13 at 1:58 PM.</p> <p>On 8/19/13 at 8:45 PM, client C went out to the parking lot at the facility-operated day program and got into the group home van which was running. The Bureau of Developmental Disabilities Services (BDDS) report, dated 8/20/13, indicated client C locked all the doors. Client C grabbed the fire extinguisher and was attempting to spray it inside her mouth but was not successful. Client C moved to the driver's seat and attempted to release the parking brake but she was not successful. Staff opened the hood and removed the battery cables causing the van to shut off. Client C looked around</p>	W000104	<p>A procedure for staff to keep personal medications and other items secure while at work was developed and all staff will be trained on it by 10/26/13. This procedure will be monitored by the Home Manager and Program Director by observation at least weekly to ensure it is being implemented correctly when staff are at work. Persons Responsible: Home Manager, Program Director Addendum: An extra key will be made for the van to ensure the van is safely secured during transports. Staff will have this key on them so the van can be locked whenever staff are out of the van. This includes transition times of picking up or dropping off clients during transport, while using the lift, or anytime staff are assisting clients outside the van. Staff will be trained on following this procedure on 10/24/2013.</p>	10/26/2013			

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	<p>the van and found the staff's purse. Client C found a bottle of prescription pills, opened them, and poured some into her hand (report indicated not sure how many). Client C put the pills into her mouth. Staff used a rock and broke a window of the van to gain access. The police arrived and "took over client." Client C was transported to the emergency room. She was admitted to the crisis care unit. The facility did not have documentation the incident was investigated. There was no documentation the facility implemented measures to ensure an incident such as this did not occur again. This affected clients A, B, D, E, F, G and H.</p> <p>On 9/24/13 at 3:16 PM, the facility was unable to provide a policy or procedure addressing the security of staff bringing their personal medications to work.</p> <p>On 9/24/13 at 2:47 PM, the Program Director (PD) for the day program indicated he was not formally aware of a policy addressing staff bringing their medications to work. The PD indicated the day program staff keep their medications with their personal possessions.</p> <p>On 9/23/13 at 2:30 PM the Area Director (AD) indicated there was no policy in</p>				

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	<p>particular for staff's medications. The AD stated, "I guess if we don't, we should have something." On 9/24/13 at 3:12 PM, the AD indicated he searched for a policy with the assistance of the Human Resources staff and was unable to locate a policy addressing staff securing their medications while at work.</p> <p>2) Please refer to W148. For 2 of 5 incident/investigative reports reviewed affecting client C, the facility failed to ensure client C's guardian was notified of incidents and investigations involving client C.</p> <p>3) Please refer to W149. For 6 of 6 incident/investigative reports reviewed affecting clients A, C and H, the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients, conduct thorough investigations into incidents and ensure investigations were completed within 5 working days.</p> <p>4) Please refer to W154. For 4 of 5 incident/investigative reports reviewed affecting clients A, C and H, the facility failed to conduct thorough investigations.</p> <p>5) Please refer to W156. For 1 of 5 incident/investigative reports reviewed affecting client C, the facility failed to</p>			

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	<p>report the results of an investigation to the administrator within five working days of the incident.</p> <p>6) Please refer to W157. For 1 of 5 incident/investigative reports reviewed affecting client C, the facility failed to ensure corrective actions were implemented.</p> <p>This federal tag relates to complaint #IN00134977.</p> <p>9-3-1(a)</p>						

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview for 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to ensure the rights of all clients to be free of abuse and neglect by failing to implement its policies and procedures prohibiting client abuse and neglect by failing to ensure: 1) there was a policy or procedure in place addressing staff securing their personal medications while working directly with the clients, 2) client C's guardian was notified of incidents and investigations involving client C, 3) abuse and neglect of the clients was prevented, 4) thorough investigations were conducted, 5) the results of an investigation were reported to the administrator within five working days of the incident, 6) corrective actions were taken following incidents of neglect and 7) sufficient staff were provided to manage and supervise the clients in accordance with their individual program plans.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 6 of 6 incident/investigative reports reviewed</p>	W000122	A procedure for staff to keep personal medications and other items secure while at work was developed and all staff will be trained on it by 10/26/13. This procedure will be monitored by the Home Manager and Program Director at least weekly by observation to ensure it is being implemented correctly when staff are at work. A re-training will be completed with all Program Directors to ensure that guardians are notified of incidents and investigations involving their client by 10/26/13. The Area Director will review all incident reports to ensure guardian notification has been completed timely. All Program Directors will be retrained on the Abuse and Neglect Policy and the prevention for clients by 10/26/13. All staff will be retrained on preventing abuse and neglect by 10/26/13. All Program Directors will be retrained on the components of a thorough investigation, how to complete one, and ensuring the results of the investigation are reported to the administrator within five working days of the incidents by 10/26/13. The Area Director will review all investigations and ensure they are reported within five working days of the incident or will complete corrective action as	10/26/2013			

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	<p>affecting clients A, C and H, the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients, conduct thorough investigations into incidents and ensure investigations were completed within 5 working days.</p> <p>2) Please refer to W148. For 2 of 5 incident/investigative reports reviewed affecting client C, the facility failed to ensure client C's guardian was notified of incidents and investigations involving client C.</p> <p>3) Please refer to W154. For 4 of 5 incident/investigative reports reviewed affecting clients A, C and H, the facility failed to conduct thorough investigations.</p> <p>4) Please refer to W156. For 1 of 5 incident/investigative reports reviewed affecting client C, the facility failed to report the results of an investigation to the administrator within five working days of the incident.</p> <p>5) Please refer to W157. For 1 of 5 incident/investigative reports reviewed affecting client C, the facility failed to ensure corrective actions were implemented.</p> <p>6) Please refer to W186. for 1 of 5</p>		<p>needed. All Program Directors will be trained on completing corrective actions for staff as needed following incidents of neglect by 10/26/13. The Area Director and Quality Assurance Specialist will monitor that corrective actions are completed as needed for incidents of abuse and neglect. Staffing ratios have been increased in the home to sufficiently provide management and supervision of clients in accordance with their individual program plans. The Home Manager and Program Director will review schedules at least weekly to ensure sufficient staffing is in place. The Area Director will be notified in writing each week, that schedules have been reviewed for sufficient staffing. Persons Responsible: Home Manager, Program Director, Area Director, Quality Assurance Specialist Addendum: An extra key will be made for the van to ensure the van is safely secured during transports. Staff will have this key on them so the van can be locked whenever staff are out of the van. This includes transition times of picking up or dropping off clients during transport, while using the lift, or anytime staff are assisting clients outside the van. Staff will be trained on following this procedure on 10/24/2013.</p>				

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	<p>incident/investigative reports reviewed affecting clients A, B, C, D, E, F and G, the facility failed to provide sufficient staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>This federal tag relates to complaint #IN00134977.</p> <p>9-3-2(a)</p>			

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W000148	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &amp;</p> <p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview for 2 of 5 incident/investigative reports reviewed affecting client C, the facility failed to ensure client C's guardian was notified of incidents and investigations involving client C.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 9/23/13 at 1:58 PM.</p> <p>On 8/18/13 at 10:06 AM, clients C and H eloped from the group home. The police found them near the post office sitting on someone's porch. After looking at the group home, the staff noticed the door alarms had been unplugged and put under the end table. The BDDS report, dated 8/19/13, indicated "N/A" for legal guardian notification for client C. The facility did not have documentation indicating client C's guardian was notified.</p> <p>On 8/19/13 at 8:45 PM, client C went out</p>	W000148	<p>A re-training will be completed with all Program Directors to ensure that guardians are notified of incidents and investigations involving their client by 10/26/13. The Area Director will review all incident reports to ensure guardian notification has been completed timely. Persons Responsible: Program Director, Area Director</p>	10/26/2013

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	<p>to the parking lot at the facility-operated day program and got into the group home van which was running. Client C locked all the doors. Client C grabbed the fire extinguisher and was attempting to spray it inside her mouth but was not successful. Client C moved to the driver's seat and attempted to release the parking brake but she was not successful. Staff opened the hood and removed the battery cables causing the van to shut off. Client C looked around the van and found the staff's purse. Client C found a bottle of prescription pills, opened them, and poured some into her hand (report indicated not sure how many). Client C put the pills into her mouth. Staff used a rock and broke a window of the van to gain access. The police arrived and "took over client." Client C was transported to the emergency room. She was admitted to the crisis care unit. The BDDS report, dated 8/20/13, indicated "N/A" for legal guardian notification for client C. The facility did not have documentation indicating client C's guardian was notified.</p> <p>A review of client C's record was conducted on 9/24/13 at 11:00 AM. Client C's 8/1/12 Individual Support Plan (ISP) indicated she had a guardian.</p> <p>On 9/23/13 at 2:34 PM, the Area Director</p>			

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	<p>(AD) stated client C's guardian "definitely" should have been notified. The AD indicated client C's guardian recently had a concern about not being notified soon enough after an incident however the AD could not recall which incident it was.</p> <p>9-3-2(a)</p>			

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 6 of 6 incident/investigative reports reviewed affecting clients A, C and H, the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients, conduct thorough investigations into incidents and complete investigations within 5 working days.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 9/23/13 at 1:58 PM.</p> <p>1) On 8/18/13 at 10:06 AM, clients C and H eloped from the group home. The police found them near the post office sitting on someone's porch. After looking at the group home, the staff noticed the door alarms had been unplugged and put under the end table. The investigation, dated 8/22/13, indicated the incident date was 8/16/13 (incident date was 8/18/13). The investigation indicated the clients were reported missing by another client (A) living at the group home. The report indicated the clients were found 5 blocks away from the group home sitting on the</p>	W000149	<p>Program Directors will be retrained on the Abuse and Neglect Policy and the prevention for clients by 10/26/13. All staff will be retrained on preventing abuse and neglect by 10/26/13. All Program Directors will be retrained on the components of a thorough investigation, how to complete one, and ensuring the results of the investigation are reported to the administrator within five working days of the incidents by 10/26/13. The Area Director will review all investigations and ensure they are reported within five working days of the incident or will complete corrective action as needed. Persons Responsible: Program Director, Area Director Addendum: An extra key will be made for the van to ensure the van is safely secured during transports. Staff will have this key on them so the van can be locked whenever staff are out of the van. This includes transition times of picking up or dropping off clients during transport, while using the lift, or anytime staff are assisting clients outside the van. Staff will be trained on following this procedure on 10/24/2013.</p>	10/26/2013			

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	<p>porch of the Post Office after "approximately one hour." The Conclusion of the investigation indicated, "Evidence supports that the alarms had been turned off by [client C], before eloping. Evidence supports that [staff #6] followed the Behavior Support Plans and missing persons protocol appropriately." The investigation did not indicate whether or not neglect was substantiated. The investigation did not indicate client H used a wheelchair and was pushed out of the home, down the gravel driveway and up the road by client C.</p> <p>A review of client C's record was conducted on 9/24/13 at 11:00 AM. Her Behavioral Support Plan, dated 6/11/13, indicated she had a targeted behavior of elopement. Elopement was defined as leaving an area without staff or without permission. The plan indicated in the Reactive Strategies section for elopement, in part, "If [client C] leaves anyway, the staff member responsible for her program must exit with her and stay with her to protect her from danger. Do not chase [client C]; shadow her from behind." Her Individual Support Plan (ISP), dated 8/1/12, indicated, in part, "[Client C] requires 24/7 supervision and continuous line-of-sight except when at day program and when in bedroom or bathroom."</p>			

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	<p>A review of client H's record was conducted on 9/24/13 at 12:31 PM. Client H's ISP, dated 8/12/12, indicated the following for "Assessment of her ability to ambulate: Requires a wheelchair and has only 1 leg." Client H's ISP indicated, in part, "Due to recent incidents of vacating that caused endangerment, the alarms that were in place on the front and back door of the group home for another client's safety, are now also being used for [client H's] safety beginning 11/16/11."</p> <p>On 9/24/13 at 11:52 AM, the Program Director (PD) indicated there was one staff on duty at the time of the incident. The PD indicated the clients were out of the home unsupervised for 15-20 minutes. The PD stated, "I don't believe so" when asked if client H had a plan for elopement. The PD indicated client C's plan for elopement was implemented. The PD, when asked how the clients whose rooms were on opposite sides of the group home were able to get out without staff's knowledge stated, "I'm with you." The PD stated "Evidently the staff on duty had to be in the office longer than the 15 minute checks."</p> <p>On 9/23/13 at 1:30 PM, the Area Director (AD) indicated clients C and H unplugged the alarm when they eloped. The AD indicated the staff on duty (#6) was</p>						

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	<p>suspended. The AD indicated he called the home after the incident and asked staff #6 to open the back door. The AD indicated the alarm did not sound. The AD indicated client C unplugged the alarm prior to eloping. On 9/23/13 at 2:34 PM, the AD indicated both clients had plans in place to address elopement. The AD indicated staff #6 was not aware the clients were gone until client A asked where they were. The AD indicated the clients left together out the back door after client C unplugged the alarm. The AD stated client C was "pretty clever" for unplugging the alarms. The AD indicated client H was pushed in her wheelchair by client C to get to the Post Office.</p> <p>2) On 8/19/13 at 8:45 PM, client C went out to the parking lot at the facility-operated day program and got into the group home van which was running. The Bureau of Developmental Disabilities Services (BDDS) report, dated 8/20/13, indicated client C locked all the doors. Client C grabbed the fire extinguisher and was attempting to spray it inside her mouth but was not successful. Client C moved to the driver's seat and attempted to release the parking brake but she was not successful. Staff opened the hood and removed the battery cables causing the van to shut off. Client C looked around the van and found the staff's purse. Client</p>				

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	<p>C found a bottle of prescription pills, opened them, and poured some into her hand (report indicated not sure how many). Client C put the pills into her mouth. Staff used a rock and broke a window of the van to gain access. The police arrived and "took over client." Client C was transported to the emergency room. She was admitted to the crisis care unit. The facility did not have documentation the incident was investigated. There was no documentation the facility implemented measures to ensure an incident such as this did not occur again.</p> <p>A review of client C's record was conducted on 9/24/13 at 11:00 AM. Her ISP, dated 8/1/12, indicated, in part, "[Client C] requires 24/7 supervision and continuous line-of-sight except when at day program and when in bedroom or bathroom."</p> <p>On 9/23/13 at 2:34 PM the AD stated the incident was not investigated due to "[Name of day program PD] and everybody was there and observed what happened." The AD indicated client C ran out right after the staff closed the back doors and jumped into the van and locked the doors. The AD indicated in order for the lift to work, the van must be running with the parking brake on. The AD</p>			

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	<p>indicated staff #7 left her purse on the van with three prescription pills (either two allergy pills and one pain pill or the other way around). The AD indicated there was no policy addressing the security of staff having medications in the van or the group home. The AD indicated he spoke to staff about supervising the clients once at the day program. The AD indicated no additional action was taken. On 9/24/13 at 2:30 PM, the AD initially stated, "I didn't implement anything" following the incident. The AD then indicated he told staff to stay by the van while it was running.</p> <p>On 9/24/13 at 11:52 AM, the Program Director (PD) for the group home stated "I have no idea" when asked why the incident was not investigated. The PD indicated the incident should have been investigated.</p> <p>On 9/24/13 at 2:47 PM, the PD for the day program indicated the van needed to be running in order for the wheelchair lift to operate. The PD indicated he had been informed of the incident on 9/23/13 after a two week vacation. The PD stated he needed to "research" whether or not protective measures were implemented to ensure an incident such as this would not occur again. The PD indicated he was not aware of protective measures being</p>						

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	<p>implemented.</p> <p>3) A BDDS report indicated on 8/29/13 at 11:15 AM at the facility-operated day program, client C "had gone out back door." Staff followed client C. Client C "started cursing [staff] and saying that she was doing heroin." Staff talked to client C and she reentered the building and went to the restroom. When client C exited the restroom, staff observed her put something into the trash. When staff looked into the trash can, staff found two syringes. Staff questioned client C about the discarded syringes but client C "became upset and refused to answer." A second staff arrived and spoke to client C. Client C told the second staff "she had taken syringes from med room and had tried to inject herself with water while in the bathroom." Client C showed the second staff a "very small" puncture wound on her right thigh. Client C indicated, after calming down, she needed to use the restroom. While on the way to the restroom she "had somehow taken phone to bathroom with her." Client C had called the police. Client C was taken to the emergency room where she was admitted on a 72 hour hold to the crisis care unit. The investigation, dated 9/13/13, indicated the following, "Several extra syringes had been sent in prior to this incident and they had not yet been</p>			

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	<p>returned to [name of nursing home]. There syringes are kept in the medication room. They are to be locked up. The syringes that [client C] took were new and still in their packaging. It is likely that she took them when she went to a program room to get her lunch box as confirmed by [day program staff #1]. No information was found to determine who failed to lock up the new syringes in the medication room." The report did not indicate whether or not neglect was substantiated.</p> <p>A review of client C's record was conducted on 9/24/13 at 11:00 AM. Her ISP, dated 8/1/12, indicated, in part, "[Client C] requires 24/7 supervision and continuous line-of-sight except when at day program and when in bedroom or bathroom."</p> <p>On 9/24/13 at 11:52 AM, the Program Director (PD) indicated the syringes should be locked up.</p> <p>On 9/24/13 at 10:22 AM, the nurse indicated the syringes should have been locked with the medications.</p> <p>On 9/23/13 at 2:34 PM, the Area Director (AD) indicated there were syringes at the day program due to having clients who attended requiring insulin. The AD</p>				

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	<p>indicated new syringes were dropped off at the day program and not locked up. The AD indicated the day program staff were aware there were syringes in the building and should have locked them up.</p> <p>4) On 8/30/13 at 5:20 PM, client C alleged the Home Manager (HM) told her she would never see her family again due to her behaviors. The investigation, dated 9/4/13, indicated, "Interviews with staff and clients, provide no evidence supporting claim against staff member." The investigation included an interview with client C, the HM, client C's social worker at the crisis care unit and one direct care staff (#4). There were no interviews conducted with clients A, B, D, E, F and G. There were no interviews conducted with additional direct care staff.</p> <p>On 9/24/13 at 11:52 AM, the PD indicated she conducted the investigation. The PD indicated she did not conduct additional interviews with additional clients or staff. The PD indicated she thought she interviewed the people she needed to interview for a thorough investigation.</p> <p>5) On 9/21/13 at 11:20 PM, client C eloped from the group home. The BDDS report, dated 9/21/13, indicated, in part,</p>			

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	<p>"Staff reported that, following [client C's] elopement protocol, they had begun to search for [client C] and had also called police to aid in the search. Midnight staff had also been called in early to help locate [client C]. [Client C] was located and 'brought back to the group home approximately 30 minutes after she vacated the home.'" Client C "was very agitated upon returning and the police called an ambulance to take her to [name of hospital] for evaluation." Client C was transferred to another hospital for further evaluation. She was released at approximately 4:00 AM. During the survey, the facility indicated the investigation was on-going.</p> <p>A review of client C's record was conducted on 9/24/13 at 11:00 AM. Her Behavioral Support Plan, dated 6/11/13, indicated she had a targeted behavior of elopement. Elopement was defined as leaving an area without staff or without permission. The plan indicated in the Reactive Strategies section for elopement, in part, "If [client C] leaves anyway, the staff member responsible for her program must exit with her and stay with her to protect her from danger. Do not chase [client C]; shadow her from behind."</p> <p>An interview with the Program Director (PD) was conducted on 9/24/13 at 11:52</p>				

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	<p>AM. The PD indicated the staff followed the plan and then could not leave the group home since there was only one staff working at the time of the incident. The PD indicated the staff stayed at the home with clients A, B, D, E, F and G and contacted the on-call staff and the police. The PD indicated there was sufficient staff.</p> <p>An interview with the Area Director (AD) was conducted on 9/24/13 at 11:52 AM. The AD indicated the group home had enough staff based on the current incidents (no incidents of elopement after 12:00 AM). The AD indicated a second staff was added to stay until 12:00 AM. The AD indicated from 12:00 AM to 6:00 AM there was one staff at the group home. The AD indicated there had been no elopement incidents involving client C after 12:00 AM.</p> <p>6) An observation was conducted at the group home on 9/23/13 from 4:06 PM to 6:09 PM. At 5:57 PM, client C yelled at client A after client A made a statement about wanting to go to bed. Client A walked away from client C. Client C jumped up out of the recliner she was sitting in and ran after client A. Due to the surveyor's positioning in the home as well as the layout of the home, the surveyor was unable to observe the</p>						

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	<p>physical aggression that took place. After the incident, client A indicated client C hit her. Client C indicated she was hit by client A. The BDDS report, dated 9/24/13, indicated the following, "both hit each other." Neither client was injured.</p> <p>On 9/24/13 at 11:52 AM, the AD stated "99.9% of the time it should be prevented" when asked about the incident on 9/23/13. The AD indicated the staff should have prevented the incident by separating the clients when client C yelled at client A.</p> <p>On 9/24/13 at 11:52 AM, the PD indicated she observed client C hit client A first. The PD indicated client A indicated client C hit her but client C denied hitting her. The PD indicated client C was attention seeking at the time of the behavior. The PD stated, "Maybe the staff should have intervened sooner."</p> <p>A review of the facility's abuse and neglect policy, dated April 2011, was conducted on 9/25/13 at 11:24 AM. The policy indicated the following, "Any allegation of abuse or human rights violation is thoroughly investigated by the Area Director in consultation with Human Resources Department and/or Quality Assurance/Risk Management Department." The policy indicated,</p>				

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	<p>"Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: e. Ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment... o. The following actions are prohibited by employees of Indiana MENTOR: 1) abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds. 2) violation of an individual's rights."</p> <p>This federal tag relates to complaint #IN00134977.</p> <p>9-3-2(a)</p>			

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W000154	<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 observation, record review and interview for 4 of 5 incident/investigative reports reviewed affecting clients A, C and H, the facility failed to conduct thorough investigations.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 9/23/13 at 1:58 PM.</p> <p>1) On 8/18/13 at 10:06 AM, clients C and H eloped from the group home. The police found them near the post office sitting on someone's porch. After looking at the group home, the staff noticed the door alarms had been unplugged and put under the end table. The investigation, dated 8/22/13, indicated the incident date was 8/16/13 (incident date was 8/18/13). The investigation indicated the clients were reported missing by another client (A) living at the group home. The report indicated the clients were found 5 blocks away from the group home sitting on the porch of the Post Office after "approximately one hour." The Conclusion of the investigation indicated, "Evidence supports that the alarms had</p>	W000154	All Program Directors will be retrained on the components of a thorough investigation, how to complete one, and ensuring the results of the investigation are reported to the administrator within five working days of the incidents by 10/26/13. The Area Director will review all investigations and ensure they are reported within five working days of the incident or will complete corrective action as needed. Persons Responsible: Program Director, Area Director	10/26/2013
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	<p>been turned off by [client C], before eloping. Evidence supports that [staff #6] followed the Behavior Support Plans and missing persons (sic) protocol appropriately." The investigation did not indicate whether or not neglect was substantiated. The investigation did not indicate client H used a wheelchair and was pushed out of the home, down the gravel driveway and up the road by client C.</p> <p>On 9/24/13 at 11:52 AM, the Program Director (PD) indicated there was one staff on duty at the time of the incident. The PD indicated the clients were out of the home unsupervised for 15-20 minutes. The PD stated, "I don't believe so" when asked if client H had a plan for elopement. The PD indicated client C's plan for elopement was implemented. The PD, when asked how the clients whose rooms were on opposite sides of the group home were able to get out without staff's knowledge stated, "I'm with you." The PD stated "Evidently the staff on duty had to be in the office longer than the 15 minute checks."</p> <p>On 9/23/13 at 1:30 PM, the Area Director (AD) indicated clients C and H unplugged the alarm when they eloped. The AD indicated the staff on duty (#6) was suspended. The AD indicated he called</p>						

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	<p>the home after the incident and asked staff #6 to open the back door. The AD indicated the alarm did not sound. The AD indicated client C unplugged the alarm prior to eloping. On 9/23/13 at 2:34 PM, the AD indicated both clients had plans in place to address elopement. The AD indicated staff #6 was not aware the clients were gone until client A asked where they were. The AD indicated the clients left together out the back door after client C unplugged the alarm. The AD stated client C was "pretty clever" for unplugging the alarms. The AD indicated client H was pushed in her wheelchair by client C to get to the Post Office.</p> <p>2) On 8/19/13 at 8:45 PM, client C went out to the parking lot at the facility-operated day program and got into the group home van which was running. The Bureau of Developmental Disabilities Services (BDDS) report, dated 8/20/13, indicated client C locked all the doors. Client C grabbed the fire extinguisher and was attempting to spray it inside her mouth but was not successful. Client C moved to the driver's seat and attempted to release the parking brake but she was not successful. Staff opened the hood and removed the battery cables causing the van to shut off. Client C looked around the van and found the staff's purse. Client C found a bottle of prescription pills,</p>				

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	<p>opened them, and poured some into her hand (report indicated not sure how many). Client C put the pills into her mouth. Staff used a rock and broke a window of the van to gain access. The police arrived and "took over client." Client C was transported to the emergency room. She was admitted to the crisis care unit. The facility did not have documentation the incident was investigated.</p> <p>On 9/23/13 at 2:34 PM the AD stated the incident was not investigated due to "[Name of day program PD] and everybody was there and observed what happened." The AD indicated client C ran out right after the staff closed the back doors and jumped into the van and locked the doors. The AD indicated in order for the lift to work, the van must be running with the parking brake on. The AD indicated staff #7 left her purse on the van with three prescription pills (either two allergy pills and one pain pill or the other way around).</p> <p>On 9/24/13 at 11:52 AM, the Program Director (PD) for the group home stated "I have no idea" when asked why the incident was not investigated. The PD indicated the incident should have been investigated.</p>						

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	<p>3) A BDDS report indicated on 8/29/13 at 11:15 AM at the facility-operated day program, client C "had gone out back door." Staff followed client C. Client C "started cursing [staff] and saying that she was doing heroin." Staff talked to client C and she reentered the building and went to the restroom. When client C exited the restroom, staff observed her put something into the trash. When staff looked into the trash can, staff found two syringes. Staff questioned client C about the discarded syringes but client C "became upset and refused to answer." A second staff arrived and spoke to client C. Client C told the second staff "she had taken syringes from med room and had tried to inject herself with water while in the bathroom." Client C showed the second staff a "very small" puncture wound on her right thigh. Client C indicated, after calming down, she needed to use the restroom. While on the way to the restroom she "had somehow taken phone to bathroom with her." Client C had called the police. Client C was taken to the emergency room where she was admitted on a 72 hour hold to the crisis care unit. The investigation, dated 9/13/13, indicated the following, "Several extra syringes had been sent in prior to this incident and they had not yet been returned to [name of nursing home]. There syringes are kept in the medication</p>						

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	<p>room. They are to be locked up. The syringes that [client C] took were new and still in their packaging. It is likely that she took them when she went to a program room to get her lunch box as confirmed by [day program staff #1]. No information was found to determine who failed to lock up the new syringes in the medication room." The report did not indicate whether or not neglect was substantiated.</p> <p>On 9/24/13 at 11:52 AM, the Program Director (PD) indicated the syringes should be locked up.</p> <p>On 9/24/13 at 10:22 AM, the nurse indicated the syringes should have been locked with the medications.</p> <p>On 9/23/13 at 2:34 PM, the Area Director (AD) indicated there were syringes at the day program due to having clients who attended requiring insulin. The AD indicated new syringes were dropped off at the day program and not locked up. The AD indicated the day program staff were aware there were syringes in the building and should have locked them up.</p> <p>4) On 8/30/13 at 5:20 PM, client C alleged the Home Manager (HM) told her she would never see her family again due to her behaviors. The investigation, dated</p>						

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	<p>9/4/13, indicated, "Interviews with staff and clients, provide no evidence supporting claim against staff member." The investigation included an interview with client C, the HM, client C's social worker at the crisis care unit and one direct care staff (#4). There were no interviews conducted with clients A, B, D, E, F and G. There were no interviews conducted with additional direct care staff.</p> <p>On 9/24/13 at 11:52 AM, the PD indicated she conducted the investigation. The PD indicated she did not conduct additional interviews with additional clients or staff. The PD indicated she thought she interviewed the people she needed to interview for a thorough investigation.</p> <p>This federal tag relates to complaint #IN00134977.</p> <p>9-3-2(a)</p>						

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W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 5 incident/investigative reports reviewed affecting client C, the facility failed to report the results of an investigation to the administrator within five working days of the incident.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 9/23/13 at 1:58 PM.</p> <p>A BDDS report indicated on 8/29/13 at 11:15 AM at the facility-operated day program, client C "had gone out back door." Staff followed client C. Client C "started cursing [staff] and saying that she was doing heroin." Staff talked to client C and she reentered the building and went to the restroom. When client C exited the restroom, staff observed her put something into the trash. When staff looked into the trash can, staff found two syringes. Staff questioned client C about the discarded syringes but client C "became upset and refused to answer." A second staff arrived and spoke to client C.</p>	W000156	All Program Directors will be retrained on the components of a thorough investigation, how to complete one, and ensuring the results of the investigation are reported to the administrator within five working days of the incidents by 10/26/13. The Area Director will review all investigations and ensure they are reported within five working days of the incident or will complete corrective action as needed. Persons Responsible: Program Director, Area Director	10/26/2013

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	<p>Client C told the second staff "she had taken syringes from med room and had tried to inject herself with water while in the bathroom." Client C showed the second staff a "very small" puncture wound on her right thigh. Client C indicated, after calming down, she needed to use the restroom. While on the way to the restroom she "had somehow taken phone to bathroom with her." Client C had called the police. Client C was taken to the emergency room where she was admitted on a 72 hour hold to the crisis care unit. The investigation, dated 9/13/13, indicated the following, "Several extra syringes had been sent in prior to this incident and they had not yet been returned to [name of nursing home]. There syringes are kept in the medication room. They are to be locked up. The syringes that [client C] took were new and still in their packaging. It is likely that she took them when she went to a program room to get her lunch box as confirmed by [day program staff #1]. No information was found to determine who failed to lock up the new syringes in the medication room." The report did not indicate whether or not neglect was substantiated.</p> <p>On 9/24/13 at 11:52 AM, the Program Director (PD) indicated the syringes should be locked up. On 9/25/13 at 1:10</p>			

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	<p>PM, the PD indicated the results of investigations should be reported to the administrator within 5 days.</p> <p>On 9/24/13 at 10:22 AM, the nurse indicated the syringes should have been locked with the medications.</p> <p>On 9/23/13 at 2:34 PM, the Area Director (AD) indicated there were syringes at the day program due to having clients who attended requiring insulin. The AD indicated new syringes were dropped off at the day program and not locked up. The AD indicated the day program staff were aware there were syringes in the building and should have locked them up. On 9/25/13 at 1:29 PM, the AD indicated in an email the investigation should have been conducted within 5 working days.</p> <p>9-3-2(a)</p>				

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 2 of 5 incident/investigative reports reviewed affecting client C, the facility failed to ensure corrective actions were implemented.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 9/23/13 at 1:58 PM.</p> <p>1) On 8/19/13 at 8:45 PM, client C went out to the parking lot at the facility-operated day program and got into the group home van which was running. The Bureau of Developmental Disabilities Services (BDDS) report, dated 8/20/13, indicated client C locked all the doors. Client C grabbed the fire extinguisher and was attempting to spray it inside her mouth but was not successful. Client C moved to the driver's seat and attempted to release the parking brake but she was not successful. Staff opened the hood and removed the battery cables causing the van to shut off. Client C looked around the van and found the staff's purse. Client C found a bottle of prescription pills, opened them, and poured some into her hand (report indicated not sure how</p>	W000157	All Program Directors will be trained on completing corrective actions for staff as needed following incidents of neglect by 10/26/13. The Area Director and Quality Assurance Specialist will monitor that corrective actions are completed as needed for incidents of abuse and neglect. Persons Responsible: Program Director, Area Director, Quality Assurance Specialist	10/26/2013			

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	<p>many). Client C put the pills into her mouth. Staff used a rock and broke a window of the van to gain access. The police arrived and "took over client." Client C was transported to the emergency room. She was admitted to the crisis care unit. There was no documentation the facility implemented measures to ensure an incident such as this did not occur again.</p> <p>On 9/23/13 at 2:34 PM the AD stated the incident was not investigated due to "[Name of day program PD] and everybody was there and observed what happened." The AD indicated client C ran out right after the staff closed the back doors and jumped into the van and locked the doors. The AD indicated in order for the lift to work, the van must be running with the parking brake on. The AD indicated staff #7 left her purse on the van with three prescription pills (either two allergy pills and one pain pill or the other way around). The AD indicated there was no policy addressing the security of staff having medications in the van or the group home. The AD indicated he spoke to staff about supervising the clients once at the day program. The AD indicated no additional action was taken. On 9/24/13 at 2:30 PM, the AD indicated in order for the group home van's lift to operate, the van must be running. The AD initially</p>			

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	<p>stated, "I didn't implement anything" following the incident. The AD then indicated he told staff to stay by the van while it was running.</p> <p>On 9/24/13 at 2:47 PM, the PD for the day program indicated the van needed to be running in order for the wheelchair lift to operate. The PD indicated he had been informed of the incident on 9/23/13 after a two week vacation. The PD stated he needed to "research" whether or not protective measures were implemented to ensure an incident such as this would not occur again. The PD indicated he was not aware of protective measures being implemented.</p> <p>2) On 9/21/13 at 11:20 PM, client C eloped from the group home. The BDDS report, dated 9/21/13, indicated, in part, "Staff reported that, following [client C's] elopement protocol, they had begun to search for [client C] and had also called police to aid in the search. Midnight staff had also been called in early to help locate [client C]. [Client C] was located and 'brought back to the group home approximately 30 minutes after she vacated the home.'" Client C "was very agitated upon returning and the police called an ambulance to take her to [name of hospital] for evaluation." Client C was transferred to another hospital for further</p>			

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	<p>evaluation. She was released at approximately 4:00 AM. During the survey, the facility indicated the investigation was on-going.</p> <p>A review of client C's record was conducted on 9/24/13 at 11:00 AM. Her Behavioral Support Plan, dated 6/11/13, indicated she had a targeted behavior of elopement. Elopement was defined as leaving an area without staff or without permission. The plan indicated in the Reactive Strategies section for elopement, in part, "If [client C] leaves anyway, the staff member responsible for her program must exit with her and stay with her to protect her from danger. Do not chase [client C]; shadow her from behind."</p> <p>An interview with the Program Director (PD) was conducted on 9/24/13 at 11:52 AM. The PD indicated the staff followed the plan and then could not leave the group home since there was only one staff working at the time of the incident. The PD indicated the staff stayed at the home with clients A, B, D, E, F and G and contacted the on-call staff and the police. The PD indicated there was sufficient staff.</p> <p>An interview with the Area Director (AD) was conducted on 9/24/13 at 11:52 AM. The AD indicated the group home had</p>						

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	<p>enough staff based on the current incidents (no incidents of elopement after 12:00 AM). The AD indicated a second staff was added to stay until 12:00 AM. The AD indicated from 12:00 AM to 6:00 AM there was one staff at the group home. The AD indicated there had been no elopement incidents involving client C after 12:00 AM.</p> <p>9-3-2(a)</p>			

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W000159	<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. Based on record review and interview for 3 of 4 clients in the sample (A, C and H), the Qualified Intellectual Disabilities Professional (QIDP) failed to ensure: 1) client A, C and H's monthly reviews of progress toward completing their training objectives were completed, 2) an accurate assessment or reassessment was conducted for client C within 30 days after admission, 3) client C's team prepared an individual program plan (IPP) within 30 days of admission, 4) client C's behavior support plan (BSP) was available to all relevant staff, 5) client A and H's functional assessments were reviewed annually by the team and updated as needed and 6) client H's individual program plan was revised at least annually.</p> <p>Findings include:</p> <p>1) A review of client A's record was conducted on 9/24/13 at 12:26 PM. Client A's record did not contain documentation the QIDP completed the monthly reviews tracking progress on her training objectives for the past 12 months. On 9/25/13 at 9:08 AM, the facility</p>	W000159	All Program Directors will be retrained on completing thorough monthly reviews to include progress toward completing training objectives, completing assessments or reassessments within 30 days of admissions, preparing an individual program plan within 30 days of admission and at least annually after that, ensuring the behavior support plan (BSP) is available to all relevant staff, and functional assessments are reviewed annually by the team and updated as needed by 10/26/13. The Area Director will review all new admission plans and ensure 30 day assessments/reassessments are completed and an individual program plan is developed for all new clients. The Area Director will follow up monthly to ensure all monthly reviews have pertinent information and progress on training objectives, that BSPs are in the homes and available for relevant staff, functional assessments are updated and reviewed as required and individual program plans are revised at least annually. The Area Director will complete corrective action as needed for items out of compliance. Persons Responsible: Program Director,	10/26/2013			

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	<p>provided documentation indicating the monthlies were completed in all months except September, October and November 2012.</p> <p>A review of client C's record was conducted on 9/24/13 at 11:00 AM. Client C's record did not contain documentation the QIDP completed the monthly reviews tracking progress on her training objectives since 3/1/13 (date of admission to the group home). On 9/25/13 at 9:08 AM, the facility provided documentation indicating the monthlies were completed in April, May, June, July and August 2013. Each monthly indicated, "NO GOAL SHEETS." There was no documentation indicating the QIDP addressed this issue.</p> <p>A review of client H's record was conducted on 9/24/13 at 12:31 PM. Client H's record did not contain documentation the QIDP completed the monthly reviews tracking progress on her training objectives since October 2012. On 9/25/13 at 9:08 AM, the facility provided documentation indicating the monthlies were completed in all months except September, October and November 2012.</p> <p>An interview with the Program Director (PD) was conducted on 9/24/13 at 11:39</p>		Area Director				

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	<p>AM. The PD indicated she started in her position in August 2013 and had not completed the monthly reviews for the clients since she started. The PD indicated she was not aware of the monthlies being completed prior to her starting in her position.</p> <p>2) Please refer to W210. For 1 of 1 client in the sample who moved into the home within the past 12 months (C), the facility failed to ensure an accurate assessment or reassessment was conducted within 30 days after admission.</p> <p>3) Please refer to W226. For 1 of 1 client who was admitted to the group home in the past 12 months (C), the facility failed to ensure client C's team prepared an individual program plan (IPP) within 30 days of admission.</p> <p>4) Please refer to W248. For 1 of 4 clients in the sample (C), the facility failed to ensure client C's behavior support plan (BSP) was available to all relevant staff.</p> <p>5) Please refer to W259. For 2 of 3 clients in the sample (A and H), the facility failed to ensure the clients' functional assessments were reviewed annually by the team and updated as needed.</p>						

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	<p>6) Please refer to W260. For 1 of 4 clients in the sample (H), the facility failed to ensure client H's individual program plan was revised at least annually.</p> <p>9-3-3(a)</p>			

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W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 1 of 5 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the facility failed to provide sufficient staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 9/23/13 at 1:58 PM. On 9/21/13 at 11:20 PM, client C eloped from the group home. The Bureau of Developmental Disabilities Services (BDDS) report, dated 9/21/13, indicated, in part, "Staff reported that, following [client C's] elopement protocol, they had begun to search for [client C] and had also called police to aid in the search. Midnight staff had also been called in early to help locate [client C]. [Client C] was located and "brought back to the group home approximately 30 minutes</p>	W000186	<p>Staffing ratios have been increased in the home to sufficiently provide management and supervision of clients in accordance with their individual program plans. The Home Manager and Program Director will review schedules at least weekly to ensure sufficient staffing is in place. The Area Director will be notified in writing each week, that schedules have been reviewed for sufficient staffing. Persons Responsible: Home Manager, Program Director, Area Director</p>	10/26/2013	

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	<p>after she vacated the home." This incident also potentially affected clients A, B, D, E, F, G and H due to the group home not having sufficient staff to manage and supervise the clients.</p> <p>A review of client C's record was conducted on 9/24/13 at 11:00 AM. Her Behavioral Support Plan, dated 6/11/13, indicated she had a targeted behavior of elopement. Elopement was defined as leaving an area without staff or without permission. The plan indicated in the Reactive Strategies section for elopement, in part, "If [client C] leaves anyway, the staff member responsible for her program must exit with her and stay with her to protect her from danger. Do not chase [client C]; shadow her from behind." Her ISP, dated 8/1/12, indicated, in part, "[Client C] requires 24/7 supervision and continuous line-of-sight except when at day program and when in bedroom or bathroom."</p> <p>An interview with the Program Director (PD) was conducted on 9/24/13 at 11:52 AM. The PD indicated the staff followed the plan and then could not leave the group home since there was only one staff working at the time of the incident. The PD indicated the staff stayed at the home with clients A, B, D, E, F and G and contacted the on-call staff and the police.</p>			

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	<p>The PD indicated there was sufficient staff. On 9/25/13 at 1:10 PM, the PD indicated it was not possible for staff to implement client C's plan when one staff was on duty and she eloped during that time when one staff was working. The PD indicated one staff would not be able to stay with client C due to not being able to leave the other 7 clients unsupervised. The PD initially indicated there was one staff working at the group home from 12:00 AM to 8:00 AM. The PD then stated, "I honestly don't know" the hours when one staff was working at the home. The PD indicated the Home Manager was in charge of the staff's schedules. On 9/25/13 at 1:34 PM, the PD sent a text message indicating there was one staff at the group home from 12:00 AM to 6:00 AM.</p> <p>An interview with the Area Director (AD) was conducted on 9/24/13 at 11:52 AM. The AD indicated the group home had enough staff based on the current incidents (no incidents of elopement after 12:00 AM). The AD indicated a second staff was added to stay until 12:00 AM. The AD indicated from 12:00 AM to 6:00 AM there was one staff at the group home. The AD indicated there had been no elopement incidents involving client C after 12:00 AM.</p>			

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W000210	<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 record review and interview for 1 of 1 client in the sample who moved into the home within the past 12 months (C), the facility failed to ensure an accurate assessment or reassessment was conducted within 30 days after admission.</p> <p>Findings include:</p> <p>A review of client C's record was conducted on 9/24/13 at 11:00 AM. Client C was admitted to the group home on 3/1/13. Client C's record did not contain a functional assessment.</p> <p>An interview with the Program Director (PD) was conducted on 9/24/13 at 11:39 AM. The PD indicated she did not do a functional assessment for client C.</p> <p>9-3-4(a)</p>	W000210	<p>All Program Directors will be retrained on completing thorough monthly reviews to include progress toward completing training objectives, completing assessments or reassessments within 30 days of admissions, preparing an individual program plan within 30 days of admission and at least annually after that, ensuring the behavior support plan (BSP) is available to all relevant staff, and functional assessments are reviewed annually by the team and updated as needed by 10/26/13. The Area Director will review all new admission plans and ensure 30 day assessments/reassessments are completed and an individual program plan is developed for all new clients. The Area Director will follow up monthly to ensure all monthly reviews have pertinent information and progress on training objectives, that BSPs are in the homes and available for relevant staff, functional assessments are updated and reviewed as required and individual program plans are revised at least annually. The Area Director will complete corrective action as needed for items out of compliance. Persons</p>	10/26/2013	

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			Responsible: Program Director, Area Director		

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W000226	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. Based on record review and interview for 1 of 1 client who was admitted to the group home in the past 12 months (C), the facility failed to ensure client C's team prepared an individual program plan (IPP) within 30 days of admission.</p> <p>Findings include:</p> <p>A review of client C's record was conducted on 9/24/13 at 11:00 AM. Client C was admitted to the group home on 3/1/13. Client C's record contained an IPP dated 8/1/12. There was no documentation in client C's record indicating the team reviewed and/or revised her IPP since her admission to the group home.</p> <p>On 9/24/13 at 11:39 AM, the Program Director (PD) indicated client C's meeting for her individual program plan had not been held. The PD indicated the meeting was overdue.</p> <p>9-3-4(a)</p>	W000226	<p>All Program Directors will be retrained on completing thorough monthly reviews to include progress toward completing training objectives, completing assessments or reassessments within 30 days of admissions, preparing an individual program plan within 30 days of admission and at least annually after that, ensuring the behavior support plan (BSP) is available to all relevant staff, and functional assessments are reviewed annually by the team and updated as needed by 10/26/13. The Area Director will review all new admission plans and ensure 30 day assessments/reassessments are completed and an individual program plan is developed for all new clients. The Area Director will follow up monthly to ensure all monthly reviews have pertinent information and progress on training objectives, that BSPs are in the homes and available for relevant staff, functional assessments are updated and reviewed as required and individual program plans are revised at least annually. The Area Director will complete corrective action as needed for items out of compliance. Persons Responsible: Program Director, Area Director</p>	10/26/2013			

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W000248	<p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 1 of 4 clients in the sample (C), the facility failed to ensure client C's behavior support plan (BSP) was available to all relevant staff.</p> <p>Findings include:</p> <p>A review of client C's record was conducted on 9/24/13 at 11:00 AM. Client C's record, available to relevant group home staff, contained client C's BSP dated 4/29/12. The facility provided the current BSP, dated 6/11/13, upon request. The BSP dated 6/11/13 was not available to the group home staff in client C's record (blue book).</p> <p>On 9/24/13 at 11:24 AM, the Area Director (AD) indicated the 4/29/12 BSP in client C's record was not the current plan. The AD left the interview and returned with a BSP dated 6/11/13. The AD indicated client C's 6/11/13 BSP should be in client C's record to be available to the group home staff.</p> <p>On 9/24/13 at 11:36 AM, the AD called</p>	W000248	All Program Directors will be retrained on completing thorough monthly reviews to include progress toward completing training objectives, completing assessments or reassessments within 30 days of admissions, preparing an individual program plan within 30 days of admission and at least annually after that, ensuring the behavior support plan (BSP) is available to all relevant staff, and functional assessments are reviewed annually by the team and updated as needed by 10/26/13. The Area Director will review all new admission plans and ensure 30 day assessments/reassessments are completed and an individual program plan is developed for all new clients. The Area Director will follow up monthly to ensure all monthly reviews have pertinent information and progress on training objectives, that BSPs are in the homes and available for relevant staff, functional assessments are updated and reviewed as required and individual program plans are revised at least annually. The Area Director will complete corrective action as needed for items out of compliance. Persons	10/26/2013			

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	<p>the group home and spoke to direct care staff #6. Staff #6 indicated if she needed to refer to a client's BSP, she would reference the client's blue book located in the cabinet at the group home.</p> <p>9-3-4(a)</p>		<p>Responsible: Program Director, Area Director</p>		

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview for 1 of 4 clients in the sample (C), the facility failed to implement client C's individual program plan as written.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 9/23/13 at 1:58 PM. On 9/21/13 at 11:20 PM, client C eloped from the group home. The Bureau of Developmental Disabilities Services (BDDS) report, dated 9/21/13, indicated, in part, "Staff reported that, following [client C's] elopement protocol, they had begun to search for [client C] and had also called police to aid in the search. Midnight staff had also been called in early to help locate [client C]. [Client C] was located and "brought back to the group home approximately 30 minutes after she vacated the home."</p> <p>A review of client C's record was conducted on 9/24/13 at 11:00 AM. Her</p>	W000249	<p>All Program Directors will be retrained on training direct support staff to implement individual program plans as written for all clients as soon as the team has developed the plan by 10/26/ 13. The Program Director will complete weekly observations of staff to monitor that individual program plans are being implemented correctly. The Area Director will review the weekly observations to ensure issues or concerns are being addressed as needed. Staffing ratios have been increased in the home to sufficiently provide management and supervision of clients in accordance with their individual program plans. The Home Manager and Program Director will review schedules at least weekly to ensure sufficient staffing is in place. The Area Director will be notified in writing each week, that schedules have been reviewed for sufficient staffing. Persons Responsible: Home Manager, Program Director, Area Director</p>	10/26/2013			

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	<p>Behavioral Support Plan, dated 6/11/13, indicated she had a targeted behavior of elopement. Elopement was defined as leaving an area without staff or without permission. The plan indicated in the Reactive Strategies section for elopement, in part, "If [client C] leaves anyway, the staff member responsible for her program must exit with her and stay with her to protect her from danger. Do not chase [client C]; shadow her from behind."</p> <p>An interview with the Program Director (PD) was conducted on 9/24/13 at 11:52 AM. The PD indicated the staff followed the plan and then could not leave the group home since there was only one staff working at the time of the incident. The PD indicated the staff stayed at the home with clients A, B, D, E, F, G and H and contacted the on-call staff and the police. The PD indicated there was sufficient staff. The PD then indicated client C's plan was not implemented as written. On 9/25/13 at 1:10 PM, the PD indicated it was not possible for staff to implement client C's plan when one staff was on duty and client C eloped during that time when one staff was working. The PD indicated one staff would not be able to stay with client C due to not being able to leave the other 7 clients unsupervised.</p> <p>9-3-4(a)</p>			

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W000259	<p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 2 of 3 clients in the sample (A and H), the facility failed to ensure the clients' functional assessments were reviewed annually by the team and updated as needed.</p> <p>Findings include:</p> <p>A review of client A's record was conducted on 9/24/13 at 12:26 PM. Client A's most recent functional assessment was dated 9/5/12. There was no documentation client A's team reviewed and updated her functional assessment since 9/5/12.</p> <p>A review of client H's record was conducted on 9/24/13 at 12:31 PM. Client H's most recent functional assessment was dated 7/16/12. There was no documentation client H's team reviewed and updated her functional assessment since 7/16/12.</p> <p>On 9/24/13 at 12:48 PM, the Area Director (AD) indicated the clients' functional assessments should be reviewed and updated at least annually.</p>	W000259	All Program Directors will be retrained on completing thorough monthly reviews to include progress toward completing training objectives, completing assessments or reassessments within 30 days of admissions, preparing an individual program plan within 30 days of admission and at least annually after that, ensuring the behavior support plan (BSP) is available to all relevant staff, and functional assessments are reviewed annually by the team and updated as needed by 10/26/13. The Area Director will review all new admission plans and ensure 30 day assessments/reassessments are completed and an individual program plan is developed for all new clients. The Area Director will follow up monthly to ensure all monthly reviews have pertinent information and progress on training objectives, that BSPs are in the homes and available for relevant staff, functional assessments are updated and reviewed as required and individual program plans are revised at least annually. The Area Director will complete corrective action as needed for items out of compliance. Persons Responsible: Program Director,	10/26/2013			

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	9-3-4(a)		Area Director		

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W000260	<p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview for 1 of 4 clients in the sample (H), the facility failed to ensure client H's individual program plan was revised at least annually.</p> <p>Findings include:</p> <p>A review of client H's record was conducted on 9/24/13 at 12:31 PM. Client H's most recent individual program plan (IPP) was dated 8/12/12. There was no documentation in client H's record indicating her IPP was revised since 8/12/12.</p> <p>On 9/24/13 at 12:48 PM, the Area Director (AD) indicated client H's IPP should be revised annually.</p> <p>9-3-4(a)</p>	W000260	<p>All Program Directors will be retrained on completing thorough monthly reviews to include progress toward completing training objectives, completing assessments or reassessments within 30 days of admissions, preparing an individual program plan within 30 days of admission and at least annually after that, ensuring the behavior support plan (BSP) is available to all relevant staff, and functional assessments are reviewed annually by the team and updated as needed by 10/26/13. The Area Director will review all new admission plans and ensure 30 day assessments/reassessments are completed and an individual program plan is developed for all new clients. The Area Director will follow up monthly to ensure all monthly reviews have pertinent information and progress on training objectives, that BSPs are in the homes and available for relevant staff, functional assessments are updated and reviewed as required and individual program plans are revised at least annually. The Area Director will complete corrective action as needed for items out of compliance. Persons Responsible: Program Director,</p>	10/26/2013	

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W000262	<p>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview for 2 of 4 clients in the sample (A and H), the facility failed to ensure the specially constituted committee (HRC - Human Rights Committee) reviewed, approved and monitored the clients' restrictive behavior support plans (BSPs).</p> <p>Findings include:</p> <p>A review of client A's record was conducted on 9/24/13 at 12:26 PM. Client A's BSP, dated 10/6/11, did not have written documentation the HRC reviewed, approved and monitored client A's plan. Client A's BSP included the use of psychotropic medications (mirtazapine, divalproex, quetiapine).</p> <p>A review of client H's record was conducted on 9/24/13 at 12:31 PM. Client H's BSP, dated 10/10/11, did not have written documentation the HRC reviewed, approved and monitored client H's plan. Client H's BSP included the use of psychotropic medications (buspirone, divalproex, topiramate, aripiprazole).</p>	W000262	The Program Director will be retrained on ensuring the client and the client's guardian, as applicable, have reviewed and approved all plans designed to manage inappropriate behavior prior to obtaining HRC approval by 10/26/13. Monthly, the Area Director will review, as applicable, individual program plans and BSPs to ensure client and guardian approvals are obtained prior to the HRC approving plans for implementation. Persons Responsible: Program Director, Area Director	10/26/2013	

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	<p>On 9/24/13 at 12:45 PM, the Area Director (AD) indicated he was unable to locate documentation indicating the facility's HRC reviewed, approved and monitored the clients' restrictive BSPs.</p> <p>9-3-4(a)</p>				

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W000263	<p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 3 of 4 clients in the sample (A, C and H), the facility's specially constituted committee (HRC - Human Rights Committee) failed to ensure the clients' programs were conducted with written informed consent of the client or the legal guardian.</p> <p>Findings include:</p> <p>A review of client A's record was conducted on 9/24/13 at 12:26 PM. Client A's 9/29/12 Individual Support Plan (ISP) indicated she had a guardian. Client A's BSP, dated 10/6/11, did not have written informed consent from her guardian. Client A's BSP included the use of psychotropic medications (mirtazapine, divalproex, quetiapine).</p> <p>A review of client C's record was conducted on 9/24/13 at 11:00 AM. Client C's 8/1/12 ISP indicated she had a guardian. Client C's BSP, dated 6/11/13, did not have written informed consent from her guardian. Client C's BSP included the use of door alarms,</p>	W000263	<p>The Program Director will be retrained on ensuring the client and the client's guardian, as applicable, have reviewed and approved all plans designed to manage inappropriate behavior prior to obtaining HRC approval by 10/26/13. Monthly, the Area Director will review, as applicable, individual program plans and BSPs to ensure client and guardian approvals are obtained prior to the HRC approving plans for implementation. Persons Responsible: Program Director, Area Director</p>	10/26/2013	

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	<p>psychotropic medications (Lithium Carbonate, Effexor, Seroquel, Klonopin, and Lamictal), restraints, smoking schedule, telephone schedule and increased supervision when outside the home.</p> <p>A review of client H's record was conducted on 9/24/13 at 12:31 PM. Client H's 8/12/12 ISP indicated she was emancipated. Client H's BSP, dated 10/10/11, did not have written informed consent from client H. Client H's BSP included the use of psychotropic medications (buspirone, divalproex, topiramate, aripiprazole).</p> <p>On 9/24/13 at 12:37 PM, the Area Director (AD) contacted the behavior clinician (BC) to obtain written informed consent for the client C's BSP. The BC indicated she did not obtain written informed consent.</p> <p>On 9/24/13 at 12:45 PM, the AD indicated he was unable to locate documentation the facility obtained written informed consent for the clients' restrictive BSPs.</p> <p>9-3-4(a)</p>				

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review for 1 of 4 clients in the sample with adaptive equipment (C), the facility failed to ensure client C had glasses to wear.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 9/23/13 from 4:06 PM to 6:09 PM. During the observation, client C was not observed to wear her glasses and staff did not prompt or encourage client C to wear her glasses.</p> <p>An interview with client C was conducted on 9/23/13 at 4:44 PM. Client C indicated she used to have glasses but she broke them. Client C stated she "should have glasses."</p> <p>A review of client C's record was conducted on 9/24/13 at 11:00 AM. Client C's most recent vision exam, dated 10/31/12, indicated, in part, "Replace broken glasses. Rx (prescription) full time." Client C's Individual Support Plan,</p>	W000436	<p>The Program Director will train staff in the home to ensure client adaptive equipment is available and in good repair by 10/26/13. Client C went to the eye doctor and was given a prescription for new glasses. As soon as the glasses arrive, staff will monitor, daily, the care and use of Client C's glasses to ensure they are available and in good repair and encourage her to wear them for her health and safety. The Home Manager and Program Director will review the daily tracking and will address any issues or concerns at least weekly. Persons Responsible: Home Manager, Program Director</p>	10/26/2013

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	<p>dated 8/1/12, indicated, "she wears glasses and is able to care for them independently."</p> <p>An interview with the nurse was conducted on 9/24/13 at 10:22 AM. The nurse indicated she had never seen client C wear glasses. The nurse reviewed client C's record and indicated client C was supposed to have glasses and wear full time. The nurse indicated client C's admission to the group home was on March 1, 2013 and she did not have glasses at the time. The nurse said client C's glasses, "fell through the crack."</p> <p>An interview with the Area Director (AD) was conducted on 9/24/13 at 10:22 AM. The AD indicated he had never observed client C wear her glasses. The AD indicated client C should have glasses and, if needed, a plan to wear her glasses.</p> <p>9-3-7(a)</p>			