

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/20/2013
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 912 N PARKWAY DR ANDERSON, IN 46013
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: 12/10, 12/11, 12/12, 12/13, 12/17, 12/18, 12/19, and 12/20/13.</p> <p>Facility Number: 000923 Provider Number: 15G409 AIM Number: 100244490</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed January 2, 2013 by Dotty Walton, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, for 4 of 4 clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7) who lived in the group home, the governing body failed to exercise operating direction over the facility to complete maintenance and repairs at the group home for the chipped and worn</p>	W000104	W104-Facility staff will complete weekly physical plant inspections that will be reviewed by an administrator weekly. Further, a senior member of DSA management will complete a physical plant inspection a minimum of quarterly to maintain oversight. Maintenance concerns will be received and prioritized for	01/19/2014

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

TITLE

(X6) DATE

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

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	<p>dining room and kitchen floors and the chipped finish on the kitchen counter top.</p> <p>Findings include:</p> <p>On 12/10/13 from 3:30pm until 6:25pm, and on 12/11/13 from 5:00am until 7:06am, observations were conducted. During observation periods clients #1, #2, #3, #4, #5, #6, and #7 walked and/or used their wheelchairs to access the dining room and kitchen areas of the facility. The dining room and kitchen floor tile corners were worn, chipped and had exposed jagged edges. On 12/10/13 at 3:30pm, the RC (Residential Coordinator) indicated the dining room and kitchen tiles on the floors were worn and had jagged edges "throughout" the dining room and kitchen. The RC indicated the dining room floor was fifteen feet by sixteen feet. The RC stated maintenance requests had been submitted for the floors and she "was not sure how long" the floors had been in this condition but stated "years." The RC indicated the kitchen counter top had two chipped areas in the top of the counter top which were jagged. During both observation periods clients #1, #2, #3, #4, #5, #6, and #7 accessed the kitchen counter to obtain their snacks, make their lunches, and to assist in</p>		<p>action by the Area Director. In regard to the countertop in need of repair, the agency will initiate the process of replacement, to include getting estimates, on or before 1/19/14. The floor has been noted to need cosmetic repairs and the cosmetic repairs are listed on the capital projects maintenance list for 2014.</p>				

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W000120	<p>cooking meals.</p> <p>On 12/13/13 at 9:00am, an interview with the RC/QIDP (Residential Coordinator/Qualified Intellectual Disabilities Professional) and the SD (Site Director) was conducted. The SD indicated the group home maintenance requests had been submitted for the dining room and kitchen floors for repairs. The RC/QIDP indicated she would submit a request for the chipped kitchen counter top. The SD indicated clients #1, #2, #3, #4, #5, #6, and #7 lived in the group home and walked on the chipped dining room and kitchen floors.</p> <p>9-3-1(a)</p> <p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on observation, record review, and interview of 3 sampled clients (client #3), and 1 additional client (client #6), who attended an outside community workshop #2 for day services in the classroom facility failed to ensure the contracted workshop clients #3 and #6's identified dining supervisory</p> <p>Findings include:</p> <p>On 12/11/13 from 10:09am until</p>	W000120	<p>W120- Workshop staff will be provided with dining plans and training regarding dining plans for all clients. The QIDP will complete unannounced observations of the workshop lunches an average of weekly to assure that supervision levels remain appropriate for all clients ongoing and to be in place by 1/19/14.</p>	01/19/2014			

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	<p>11:55am, observation at the facility's contracted workshop #2 was conducted. From 10:09am until 11:15am, clients #3 and #6 were assisted and encouraged to go to the preset dining area of the classroom by WKS (Workshop Staff) #1. From 10:09am until 11:15am, WKS #1 was the one (1) workshop staff in the area to assist clients with dining and to monitor twenty-one (21) total number of clients including clients #3 and #6. The two other workshop staff were assisting other clients not within WKS #1's area of dining. From 10:09am until 11:15am, WKS #1 used a microwave across the room to heat each clients' individual meal. WKS #1 turned her back, was not within eye sight of clients eating, and was not accessible for clients to gain her attention during the lunch meal. At 10:45am, clients #3 and #6 were feeding themselves without staff sitting beside them and without staff within eyesight with seven (7) additional clients eating at the same time and at three (3) different pre-set tables. From 10:45am until 11:15am, client #6 fed herself jello with her fingers without redirection. Client #3 fed herself with a plastic spoon ground foods and placed her food onto the spoon with her fingers without redirection. At 10:45am, WKS #1 indicated clients #3 and #6 were to be supervised during dining within her</p>			

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W000130	<p>eyesight. No dining plans for clients #3 and #6 were available for review.</p> <p>On 12/13/13 at 9:25am, client #3's record was reviewed. Client #3's 12/3/13 ISP (Individual Support Plan) indicated client #3 could use a spoon, needed supervision to cut her food into smaller portions, and to use a napkin.</p> <p>On 12/19/13 at 2:00pm, an interview with the Site Director (SD) was conducted. The SD indicated clients #3 and #6 had the identified need to have staff within eyesight supervision during meals. The SD indicated clients #3 and #6 required redirection and assistance to cut their foods up into bite sized pieces, to not eat with their fingers, and to supervise the clients for dining. The SD indicated the workshop services did not meet the needs of clients #3 and #6.</p> <p>9-3-1(a)</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, for 5 of 7 clients (clients #1, #2, #4, #5, and #7), the facility failed to encourage and teach personal privacy during client #1,</p>	W000130	W130-Staff will receive additional training regarding ensuring privacy during treatment and care of personal needs. The QIDP will review goals of consumers that	01/19/2014			

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	<p>#5, and #7's medication administration and for clients #2 and #4 when opportunities existed.</p> <p>Findings include:</p> <p>1. On 12/10/13 from 4:15pm until 4:45pm, clients #1, #5, and #7 had their evening medications administered by GHS (Group Home Staff) #1 at the back hallway of the group home with the door to the kitchen/dining room and the second door to the back hallway bedrooms open. From 4:15pm until 4:45pm, the other group home staff assisted other clients from the group home to walk through the medication area while medications were named out loud verbally, reasons for the medications, and medications administered without privacy of personal information taught and/or encouraged. During the medication administration time clients #1, #2, #3, #4, #5, #6, and #7 sat at the dining room table and/or sat within feet of the doorway in wheelchairs, and watched medications administered by GHS #1 to the other clients without redirection. At 4:45pm, the RC/QIDP (Residential Coordinator/Qualified Intellectual Disabilities Professional) entered the medication room from the dining/kitchen door and closed both</p>		<p>privacy training needs are addressed, making changes as necessary. The QIDP will complete routine observations weekly to assure that privacy is respected and maintained. All responses to be implemented on or before 1/19/14.</p>				

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	<p>doorways, then left the area.</p> <p>On 12/19/13 at 2:00pm, an interview with the SD (Site Director) was conducted. The SD indicated clients #1, #5, and #7 should have privacy and be taught personal privacy during their medication administration.</p> <p>2. On 12/11/13 from 5:00am until 7:06am, clients #2 and #4 were observed at the group home. At 5:00am, client #2 was in the bathroom, the bathroom door was open to the hallway, and client #4 walked into the bathroom in his underwear, while client #2 was urinating in the stool, to brush client #4's teeth. At 5:15am, client #4 walked from his bedroom into the bathroom, left the door open to the hallway, and urinated into the toilet. From 5:00am until 5:15am, GHS #1 walked into and out of the hallway where the bathroom was located.</p> <p>On 12/19/13 at 2:00pm, an interview with the SD was conducted. The SD indicated clients #2 and #4 should have been taught personal privacy during each opportunity.</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 record review and interview, for 3 of 5 BDDS (Bureau of Developmental Disabilities Services) reports for allegations of abuse, neglect, and/or mistreatment reviewed (clients #1 and #3), the facility neglected to implement their policy and procedure to immediately report allegations to BDDS and to the administrator in accordance with state law (client #1), neglected to secure medications (for clients #1 and #3), and neglected to supervise client #3 during medication administration.</p> <p>Findings include:</p> <p>1(a). On 12/10/13 at 1:30pm, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #1. -A 1/23/13 BDDS report for client #1's 1/20/13 at 8:00am incident indicated "An allegation of possible abuse was reported to the [Residential Coordinator (RC)] on 1/23/13 from [GHS #2]. The incident was to have occurred on Sunday 1/20/13. The allegation is that [GHS #3] told [client #1] that if she hit [GHS #3], [GHS #3] would hit [client #1] back." The report indicated the staff</p>	W000149	W149-Staff will receive additional training regarding the requirement to report any alleged or suspected abuse immediately to the administrator, that medications are to be secured in a locked cabinet at all times unless they are specifically in use, and regarding the prohibition and prevention of abuse and neglect. The QIDP will complete routine weekly observations to assure that staff interactions remain appropriate and respectful for all consumers. All corrections to be in place on or before 1/19/14.	01/19/2014			

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	<p>was suspended pending an investigation.</p> <p>-Client #1's 1/30/13 BDDS Follow up report indicated "The investigation was completed and the allegation substantiated as the alleged perpetrator admitted to the offense." The report indicated GHS #3 was terminated from employment.</p> <p>On 12/19/13 at 2:00pm, an interview with the SD (Site Director) was conducted. The SD indicated staff did not immediately report client #1's allegation but it should have been. The SD indicated client #1's allegation was substantiated physical abuse.</p> <p>1(b). On 12/10/13 at 1:30pm, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #1.</p> <p>-A 2/1/13 BDDS report for client #1's 2/1/13 at 6:30am medication incident indicated the House Manager (HM) "discovered that [client #1's] February (2013) Clonazepam (for behavior) medication was unavailable to administer this morning and could not be located in the home." The report indicated client #1 did not miss any medication as there was back up medication available and an investigation into client #1's missing</p>						

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	<p>controlled medication was initiated.</p> <p>-Client #1's 2/7/13 BDDS Follow up report indicated "the investigation was unable to determine the whereabouts of the medication. [GHS #4] was suspended as she acknowledged receipt of the medication" with the pharmacy delivery ticket. The report indicated GHS #4 acknowledges "that she did not follow agency protocol in reporting the delivery of medications to the nurse or signing in and storing the medications. Further, [GHS #4] failed a drug screen. Police have been apprised of all information."</p> <p>On 12/12/20/13 at 9:02am, an interview the agency Registered Nurse (RN) was conducted. The RN indicated staff did not follow the facility's policy and procedure to ensure controlled medications were secure when not being administered. The RN indicated the facility followed Core A/Core B Living in the Community training for medication administration.</p> <p>2. On 12/10/13 at 1:30pm, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #3.</p> <p>-A 2/4/13 BDDS report for an incident on 2/3/13 at 5:30pm, indicated staff</p>			

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	<p>were "passing medications on 2/3/13 at which time [client #3] came up and picked up the med (medication) cup with another consumers (sic) medications in it and took them. [Client #3] took the following medications: Calcium w/(with) vitamin D, Docusate Sodium 100mg (milligrams), Oxybutynin 5mg (for incontinence), Risperidone (for behaviors) 2mg, and Tiagabine (for seizures) 8mg. The agency nurse on call directed that [client #3] be closely monitored and that vitals be taken every 30 minutes over the next 6 hours." The report indicated client #3's vitals were within normal limits and client #3 was "drowsy."</p> <p>-A 2/5/13 BDDS report for an incident on 2/4/13 at 5:00pm, indicated client #3's personal physician requested client #3 be seen at the ER (Emergency Room) due to receiving medications on 2/3/13. The report indicated client #3 had no treatment required and she was released.</p> <p>On 12/10/13 at 1:30pm, the facility's Investigation Summary was reviewed for client #3 and indicated the following: -Client #3's 2/7/13 Investigation for client #3's 2/3/13 medication error indicated GHS #5 "allowed [client #3] to take [client #7's] medications. [GHS #5] stated that she [GHS #5] prepared</p>						

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	<p>[client #7's] medications for [client #7] to take but [client #7] refused to take them. [GHS #5] stated that she placed [client #7's] medications in the souffle cup on top of the cleaning wipes on the medication counter. [Client #3] came to get her medications and reached up taking the cup off the cleaning wipes and swallowing the medications." The investigation indicated "Findings: [GHS #5] failed to secure medications in a locked cabinet that were refused by [client #7] allowing [client #3] access to them. [Client #3] did not understand that these medications were not hers and was asked to come to the medication area, saw the medication cup, and took those pills. Recommendations: [GHS #5] should receive corrective action for failure to secure medications in a safe place so as not to allow access by any consumers."</p> <p>On 12/12/20/13 at 9:02am, an interview with the agency Registered Nurse (RN) was conducted. The RN indicated staff did not follow the facility's policy and procedure to ensure medications were secure when not being administered. The RN indicated the facility followed Core A/Core B Living in the Community training for medication administration.</p>						

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	<p>On 12/19/13 at 2:00pm, an interview with the SD was conducted. The SD indicated staff were inattentive when client #3 took client #7's medication. When asked if it was neglectful? The SD indicated the staff's inattentiveness met the criteria for neglect.</p> <p>On 12/20/13 at 8:30am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated "Core Lesson 3: Principles of Administering Medication" indicated medications should be secured.</p> <p>On 12/18/13 at 12:00noon, a review was completed of the 10/2005 "Bureau of Developmental Disabilities Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse or exploitation by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in</p>				

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	<p>physical or psychological harm to the individual." The BDDS policy indicated each allegation of abuse, neglect, and/or mistreatment should be immediately reported.</p> <p>On 12/10/13 at 12:45pm, the facility's 10/13 "Preventing Abuse and Neglect" policy and procedure indicated "Abuse means the following: 1. Intentional or willful infliction of physical injury...3. Punishment with resulting physical harm or pain...7. Corporal Punishment which includes forced physical (sic), hitting, pinching, application of painful or noxious stimuli, use of electric shock, and the infliction of physical pain...9. Violation of individual rights....Neglect means failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual." The policy and procedure indicated "all" allegations of abuse and/or neglect should be immediately reported to the administrator and to BDDS in accordance with State Law and should be thoroughly investigated.</p> <p>9-3-2(a)</p>				

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, for 1 of 3 BDDS (Bureau of Developmental Disabilities Services) reports for allegations of abuse, neglect, and/or mistreatment reviewed (client #1), the facility failed to implement their policy and procedure to immediately report to BDDS and to the administrator in accordance with state law (client #1).</p> <p>Findings include:</p> <p>On 12/10/13 at 1:30pm, the facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed for client #1. -A 1/23/13 BDDS report for client #1's 1/20/13 at 8:00am incident indicated "An allegation of possible abuse was reported to the [Residential Coordinator (RC)] on 1/23/13 from [GHS #2]. The incident was to have occurred on Sunday 1/20/13. The allegation is that [GHS #3] told [client #1] that if she hit [GHS #3], [GHS #3] would hit [client #1] back."</p>	W000153	W153-Staff will receive additional training regarding the requirement to report any alleged or suspected abuse immediately to the administrator as well as regarding the prevention of abuse and neglect. The QIDP will complete weekly observations to include quizzing the staff intermittently regarding the reporting requirement. All corrections to be in place on or before 1/19/14.	01/19/2014			

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W000225	<p>-Client #1's 1/30/13 BDDS Follow up report indicated "The investigation was completed and the allegation substantiated as the alleged perpetrator admitted to the offense." The report indicated GHS #3 was terminated from employment.</p> <p>On 12/19/13 at 2:00pm, an interview with the SD (Site Director) was conducted. The SD indicated staff did not immediately report client #1's allegation and should have been. The SD indicated client #1's allegation was substantiated physical abuse.</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on interview and record review, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), the facility failed to include in the assessment of client #1, #2, #3, and #4's active treatment needs for vocational skills, their individual work history, work skills, and work interests.</p> <p>Findings include:</p> <p>On 12/12/13 at 1:45pm, client #1's record was reviewed. Client #1's 3/20/13 ISP and 3/20/13 "Vocational</p>	W000225	W225-The Vocational Assessment will be revised to capture information regarding the client's work history and/or work interests. The revised assessments will be completed for all consumers living in the home. The ISP's for Clients 1, 2, 3 and 4 did include a vocational goal/objective and are included as an attachment. All corrections to be in place on or before 1/19/14.	01/19/2014			

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	<p>Assessment" did not include a vocational goal/objective. Client #1's 3/20/13 "Vocational Assessment" did not include her work history and/or work interests.</p> <p>On 12/13/13 at 11:05am, client #2's record was reviewed. Client #2's 12/5/13 ISP did not include a vocational goal/objective. Client #2's 12/5/13 "Vocational Assessment" did not include his work history and/or work interests.</p> <p>On 12/13/13 at 9:25am, client #3's record was reviewed. Client #3's 12/5/13 ISP did not include a vocational goal/objective. Client #3's 12/5/12 "Vocational Assessment" did not include her work history and/or work interests.</p> <p>On 12/13/13 at 8:05am, client #4's record was reviewed. Client #4's 10/30/13 ISP (Individual Support Plan) did not include a vocational goal/objective. Client #4's 10/30/13 "Vocational Assessment" did not include his work history and/or work interests.</p> <p>On 12/20/13 at 8:30am, an interview with the Site Director (SD) and the QIDP (Qualified Intellectual Disabilities</p>			

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W000249	<p>Professional) was conducted. The SD and the QIDP indicated clients #1, #2, #3, and #4 did not have an identified goal/objective for their vocational skills. Both professional staff indicated client #1, #2, #3, and #4's vocational assessments did not include a work history, work skills, and/or their work interests.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview, and record review, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), the facility failed to have available and teach clients #1, #2, #3, and #4 cooking skills with the use of picture book recipes to prepare their meals at the group home when opportunities existed.</p> <p>Findings include: On 12/10/13 from 3:30pm until 6:25pm and on 12/11/13 from 5:00am until 7:06am, clients #1, #2, #3, and #4 were</p>	W000249	W249-Staff will receive additional training regarding program implementation to include use of picture recipes when opportunities exist. The QIDP will complete weekly observations to assure that training occurs as is appropriate and recommended by the IST. All corrections will be in place on or before 1/19/14.	01/19/2014

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	<p>observed at the group home. During both observation periods clients #1, #2, #3, and #4 assisted the facility staff with cooking the evening and/or breakfast meals and snacks. During both observation periods no picture book recipes were used to teach the clients regarding cooking including popcorn in the microwave, and/or meal preparation.</p> <p>On 12/12/13 at 1:45pm, client #1's record was reviewed. Client #1's 3/20/13 ISP indicated a goal/objective to identify foods high in fat and to prepare a food using a picture book recipe.</p> <p>On 12/13/13 at 11:05am, client #2's record was reviewed. Client #2's 12/5/13 ISP indicated a goal/objective to prepare a food using a picture book recipe and to prepare his popcorn in the microwave.</p> <p>On 12/13/13 at 9:25am, client #3's record was reviewed. Client #3's 12/5/13 ISP indicated a goal/objective to use a picture book to communicate her wants/needs and to prepare a food using a picture book recipe.</p> <p>On 12/13/13 at 8:05am, client #4's record was reviewed. Client #4's 10/30/13 ISP indicated a goal/objective to prepare microwave popcorn and to</p>						

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W000268	<p>prepare a food using a picture book recipe.</p> <p>On 12/19/13 at 2:00pm, an interview with the Site Director (SD) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The SD and the QIDP indicated clients #1, #2, #3, and #4 should use picture book recipes to assist to prepare and cook meals at the group home. The SD indicated facility staff should have used formal and informal opportunities to teach clients #1, #2, #3, and #4 to use picture book recipes.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, record review, and interview, for 1 of 4 sampled client (client #4) and for 1 additional client (client #5), the facility staff failed to interact with clients #4 and #5 to promote individual development and respect when opportunities existed.</p> <p>Findings include: On 12/11/13 from 5:00am until 5:30am,</p>	W000268	W268- Staff will receive additional training regarding respectful interactions with consumers and that they should promote individual development and treat consumers in full recognition of their dignity. The QIDP will complete weekly observations to assure that staff interactions are in full recognition of consumer dignity and respectful.	01/19/2014			

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	<p>Group Home Staff (GHS) was observed the one (1) staff on duty at the group home with clients #1, #2, #3, #4, #5, #6, and #7. From 5:00am until 5:30am, clients #2 and #4 entered and exited their shared bedroom, the hallway bathroom, and began to dress themselves. At 5:22am, client #5 began yelling at client #2 who was in the hallway door way to the living room. GHS #1 said to client #5 in a loud tone of voice "you'll go to time out if you don't stop it" (the yelling). Client #5 sat down on the sofa in the living room and did not say or yell any additional verbalizations. At 5:30am, GHS #1 entered client #4's bedroom, began to clap her hands together and a loud smack could be heard out into the hallway and GHS #1 stated in a loud tone of voice "Let's Go, Let's Go, Let's Go." GHS #1 indicated that was how she encouraged client #4 in the morning. GHS #1 walked out of client #4's bedroom. Client #4's head was facing downward, he stood in the same position from 5:30am with no movement, and had stopped dressing. When asked if he was upset. Client #4 stated after several moments "Yes." At 5:55am, client #4 stood in the same position inside his room, with his head facing downward, and had not moved or dressed for the day. At 6:15am, GHS #1 entered client</p>						

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	<p>#4's shared bedroom again, clapping her hands together to make a cracking noise, and stating "Let's Go, Let's Go, Let's Go." Client #4 had not moved from the same spot from 5:30am until 6:15am in the center of the bedroom.</p> <p>On 12/19/13 at 2:00pm, an interview with the Site Director (SD) was conducted. The SD indicated the facility did not use time out for behavior management and client #5 should not have been told she would had to go to time out if she did not stop her behavior. The SD indicated GHS #1 was inappropriate with client #4 when she clapped her hands and repeated "Let's Go, Let's Go, Let's Go" to prompt client #4 to get dressed and start his day. When asked if the staff interactions with clients #4 and #5 were done with respect and dignity? The SD stated "probably not" when asked if GHS #1's best choice of words were used to teach and train clients #4 and #5 how to start their day.</p> <p>On 12/19/13 at 2:00pm, a review of the undated facility's Clients Rights policy and procedure was conducted. The policy and procedure indicated clients had the right to be treated with respect and dignity.</p> <p>9-3-5(a)</p>						

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #2 and #4) and 1 additional client (client #6) with adaptive equipment, the facility failed to teach and encourage clients #2 and #4 to have their identification available, failed to have available client #2's communication book and/or augmented device to use for communication, and failed to ensure client #2 and #6's wheelchairs were clean.</p> <p>Findings include:</p> <p>1. On 12/10/13 from 3:30pm until 6:25pm and on 12/11/13 from 5:00am until 7:06am, clients #2 and #4 were observed at the group home and did not carry their identification in their wallets and/or on their persons. On 12/11/13 at 6:15am, client #4 showed his wallet and no identification was inside. Client #4 accessed his drawer and showed an</p>	W000436	<p>W436-The QIDP will assure that clients have access to communication devices in all service settings and that all applicable staff are trained in their use. Additionally, the QIDP will assure that all clients have current identification and are taught to use it as applicable. The job list for the overnight staff will be updated to include that the wheelchairs are cleaned on a nightly basis. Staff will receive additional training that the wheelchairs are to be cleaned nightly and/or more frequently as needed. The QIDP will complete routine observations across all service settings an average of weekly to assure that: communication devices and ID cards are available and in use and that adaptive equipment is clean and in good working order. All corrections will be in place on or before 1/19/14.</p>	01/19/2014	

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	<p>identification card dated 6/1999 and the picture on the identification showed a young client #4 with his group home placement address from three group homes before the current group home address.</p> <p>On 12/11/13 from 10:09am until 11:55am, client #2 was observed at the outside contracted workshop site #2 and client #2 indicated he did not have his identification in his wallet and/or on his person.</p> <p>On 12/13/13 at 11:05am, client #2's record was reviewed. Client #2's 12/5/13 ISP (Individual Support Plan) indicated a goal/objective to display his identification twice daily.</p> <p>On 12/13/13 at 8:05am, client #4's record was reviewed. Client #4's 10/30/13 ISP (Individual Support Plan) indicated a goal to identify community signs and dangers. Client #4's ISP indicated he rode the community church bus independently to church on Sundays.</p> <p>On 12/19/13 at 2:00pm, an interview with the Site Director (SD) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The SD and the QIDP indicated client #2 had an identification card in his wallet. When</p>			

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	<p>asked the last time client #2 had displayed his identification to the SD or QIDP. Both were unsure. The SD and QIDP indicated client #4 had a personal identification card he carried in his wallet. The QIDP indicated client #4's personal identification needed updating with his current picture, body type, and address. The SD indicated client #4 rode the church bus independently on Sundays and should have a personal identification on his person. The SD indicated clients #2 and #4 should have had a current identification card to carry in their wallets and did not.</p> <p>2. On 12/10/13 from 3:30pm until 6:25pm and on 12/11/13 from 5:00am until 7:06am, client #2 did not use a picture communication book to communicate.</p> <p>On 12/11/13 from 10:09am until 11:55am, client #2 was observed at the outside contracted workshop site #2 and client #2 indicated he did not have his picture communication book available for his use. At 11:45am, WKS #2 indicated client #2 did not have a communication book and/or an augmented device available for his use at the workshop. When asked if she had the skill to sign to communicate with deaf people. WKS #2 indicated she did</p>						

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	<p>sign "work" and could not sign to communicate with client #2 for other needs. WKS #2 indicated client #2 had the potential to benefit from a better communication system.</p> <p>On 12/13/13 at 11:05am, client #2's record was reviewed. Client #2's 12/5/13 ISP (Individual Support Plan) indicated a goal/objective to use sign language to indicate shave, bathe, toilet, and to communicate his wants/needs. Client #2's ISP indicated a goal/objective to display his identification card twice daily. Client #2's ISP indicated he was non-verbal and used sign language and picture communication books to communicate. Client #2's 2/19/13 and 7/3/12 Speech Therapy (ST) recommendations included the use picture communication books and an augmented device to communicate.</p> <p>On 12/20/13 at 8:30am, an interview with the Site Director (SD) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The SD and the QIDP indicated client #2 had a communication book he was to use when staff or people he wanted to communicate with did not have the skill to sign with him. The SD indicated she did not know the status of client #2's</p>						

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	<p>augmented device.</p> <p>3. On 12/10/13 from 3:30pm until 6:25pm and on 12/11/13 from 5:00am until 7:06am, client #2 and #6's wheelchairs had dried food debris on their seat belts, hand brakes, and seat cushions. On 12/11/13 at 5:30am, GHS #1 indicated clients #2 and #6's wheelchairs were in need of cleaning. When asked who cleaned the wheelchairs? GHS stated no one cleaned them "because (the wheelchairs) were pretty dirty." GHS #1 cleaned clients #2 and #6's wheelchairs at that time.</p> <p>On 12/20/13 at 8:30am, an interview with the SD was conducted. The SD indicated clients #2 and #6's wheelchairs should have been cleaned nightly and/or more often if needed.</p> <p>9-3-7(a)</p>						