

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G197	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/10/2012
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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN 47448
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: December 3, 4, 5, 6, 7 and 10, 2012.</p> <p>Facility number: 000727 Provider number: 15G197 AIM number: 100239620</p> <p>Surveyor: Steven Schwing, Medical Surveyor III.</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/13/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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

TITLE

(X6) DATE

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

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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 1 of 3 clients in the sample (#1) and 1 of 3 non-sampled clients (#4), the facility failed to ensure the clients had the right to due process in regard to: 1) staff locking clients #1 and #4's personal cups in a cabinet and 2) staff prompting client #4 to complete a task in order for her to get a desired activity/reward.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 12/3/12 from 4:11 PM to 6:07 PM. At 4:27 PM, client #4 entered the living room area signing cup. Staff #1 unlocked a filing cabinet to give client #4 a cup.</p> <p>An interview with staff #1 was conducted on 12/3/12 at 4:27 PM. Staff #1 indicated client #4 stored her cups in the locked cabinet in order to keep other clients from taking the cups. Staff #1 indicated the staff have access to the cabinet but not the clients.</p>	W0125	<p>W125 QIDP has ensured that the cups noted in survey report have been returned to clients #1 and #4 and are not locked up. QIDP has retrained all staff on individual rights including but not exclusive to client's access to personal possessions and participation in or attainment of desired activity or reward. QIDP and/or designee will conduct random observations at the home and/or speak with individual clients weekly for one month and at least monthly thereafter to ensure compliance in this area. Responsible for QA: QIDP</p>	01/09/2013			

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	<p>An interview with client #1 was conducted on 12/5/12 at 11:32 AM. Client #1 stated staff #1 "hid" her Halloween cup in a locked cabinet drawer. Client #1 started crying during the interview. Client #1 stated staff #1 also "hid" her glass from a local restaurant in the cabinet. Client #1 indicated the staff took her cups and put them in a locked cabinet. Client #1 stated, "I want my cup and glass." Client #1 indicated the staff also lock client #4's cups.</p> <p>A review of client #1's record was conducted on 12/4/12 at 11:00 AM. There was no documentation in client #1's record indicating her cups needed to be locked.</p> <p>A review of client #4's record was conducted on 12/4/12 at 9:52 AM. There was no documentation in client #4's record indicating her cups needed to be locked.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/5/12 at 11:55 AM. The QMRP indicated there was no plan for clients #1 and #4 to lock their cups. The QMRP indicated client #4 would hoard cups however there was no plan for staff</p>			
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	<p>to lock her cups in a cabinet. The QMRP indicated client #1 had no plan and no reason to lock her cups. The QMRP indicated she had just discussed with the staff at a staff meeting about the staff not making their own rules. The QMRP stated staff #1 and #2 did not know how to keep control at the home "appropriately." The QMRP indicated she had discussed this with staff #1 and #2 several times already.</p> <p>2) An observation was conducted at the facility-operated workshop on 12/3/12 from 2:43 PM to 3:30 PM. At 3:18 PM, an interview with workshop supervisor (WS) #1 was conducted. WS #1 indicated the staff took away client #4's key to her lunchbox on 12/3/12 due to her behavior. WS #1 indicated he told client #4 he would throw the key away to her lunchbox if she did not comply with his requests.</p> <p>An observation was conducted at the group home on 12/4/12 from 5:52 AM to 8:05 AM. At 6:56 AM, client #4 sat in a chair in the med pass area. Client #4 sat on the curtain hanging down from a rod. Staff #6 asked client #4 to sit on the couch. Client #4 did not move. Staff #6 then told client #4 if she wanted to sit in the front seat of the group home vehicle she needed to move and take off her coat.</p>						

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	<p>At 7:14 AM, client #4 was told by staff #6 to take off her coat if she wanted to sit in the front seat on the way to the workshop.</p> <p>An interview with staff #3 was conducted on 12/4/12 at 7:30 AM. Staff #3 indicated other staff, particularly staff #1 and #2, tell client #4 she could not do certain things unless she complies with the staff's requests.</p> <p>An interview with the QMRP was conducted on 12/5/12 at 11:55 AM. The QMRP indicated she had just discussed with the staff at a staff meeting about the staff not making their own rules. The QMRP stated staff #1 and #2 did not know how to keep control at the home "appropriately." The QMRP indicated she had discussed this with staff #1 and #2 several times already. The QMRP indicated client #4 did not have a plan to comply with staff's requests before being allowed to do things she wanted to do. The QMRP indicated the staff were making their own plans to address client #4's behavior.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 12/5/12 at 1:07 PM. AS #1 indicated there was no plan for client #4 to comply with staff's requests in order to be able to do certain</p>						

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	<p>tasks/activities. AS #1 indicated client #4 had a plan however the interventions were not part of the plan and should not be used. On 12/6/12 at 11:36 AM, AS #1 indicated there was no plan or reason for staff to take client #4's key for any reason. AS #1 indicated client #4 should have access to her key.</p> <p>9-3-2(a)</p>				

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W0130	<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 2 of 5 clients (#2 and #6) observed to receive their medication on 12/3/12 during the morning observation at the group home, the facility failed to ensure the clients' privacy during the med pass.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 12/3/12 from 5:52 AM to 8:05 AM.</p> <p>At 6:27 AM when client #2 received her medications from staff #3, client #3 was sitting on the couch 3 feet away and client #4 was sitting on the arm of the couch 3 feet away. Clients #3 and #4 were not asked to leave the area to ensure client #2 had privacy during her med pass.</p> <p>At 6:38 AM when client #6 received her medications from staff #3, clients #3 and #4 were in the living room adjacent to the med pass area in the living room. Client #6 was asked to name her meds and purpose. Client #6 indicated she took Oyster Shell as a vitamin, Metformin and Calcitriol. Clients #3 and #4 were close</p>	W0130	<p>QIDP will retrain staff on the appropriate procedures for medication administration in regards to privacy during the med pass. QIDP or designee will observe in the home at least weekly for one month and monthly thereafter to ensure compliance in this area. Responsible for QA: QIDP</p>	01/09/2013			

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	<p>enough to hear the client #6 and staff #3's interactions and training on client #6's medications. Clients #3 and #4 were not prompted to move or leave the area to ensure the clients' privacy.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/5/12 at 11:55 AM. The QMRP indicated the clients should be provided privacy during their med pass.</p> <p>9-3-2(a)</p>			

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W0149	<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 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility neglected to implement its policies and procedures to prevent client to client abuse, conduct thorough investigations and submit an incident report to the state within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/3/12 at 2:17 PM.</p> <p>1) On 11/19/12 at 12:45 PM, workshop staff discovered money missing from an unlocked desk drawer. Clients #1, #2, #3, #4, #5 and #6 were each missing \$10.00. The facility did not have documentation an investigation was conducted. The facility did not have witness statements, a report indicating who conducted the investigation, the dates of the investigation, the outcome of the investigation, and information related to when the money was last accounted for. The documentation the facility had included Bureau of Developmental</p>	W0149	<p>W149 Agency policy and procedures on prohibiting mistreatment, neglect, or abuse of clients, reporting of incidents to the state, and investigations were reviewed and determined appropriate. Investigation of the missing money on 11/19/12 has been completed and documented and a BDDS report has been filed for the missing money of client #5 which was inadvertently missed initially. SGL manager will retrain QIDP's on timely reporting of incidents and completing investigations per agency policy. SGL manager will review internal incident reports to ensure state reports and investigations are completed as required. Responsible for QA: SGL Manager, QIDP</p>	01/09/2013			

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	<p>Disabilities Services initial and follow-up reports and an email related to the incident.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 12/4/12 at 10:22 AM. AS #1 indicated the facility did not have documentation an investigation was conducted. AS #1 indicated an investigation should have been conducted.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/5/12 at 11:55 AM. The QMRP indicated an investigation should have been conducted.</p> <p>2) On 6/21/12 at 6:30 PM, client #6 inappropriately hugged a woman at church. The report indicated client #6 was sucking on a water bottle at church when a woman at the church commented client #6 was drinking the water like a baby and asked her if she needed a pacifier. The report indicated client #6 "got very excited about being called a baby by this woman and began hugging her 'obbsevely' (sic) and trying to hug sexually." The report indicated the woman moved away from client #6. Client #6 then sat too close to staff and purposely touched staff's breast. The report indicated reactive strategies were</p>						

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	<p>used from client #6's behavior plan. There was no documentation an investigation was conducted.</p> <p>A review of client #6's record was conducted on 12/5/12 at 10:43 AM. Client #6's record did not include a behavior plan. The Individual Program Plan, dated 9/12 to 9/13, indicated, "Client does not have a behavior plan as her behaviors are minor and generally infrequent."</p> <p>An interview with AS #1 was conducted on 12/5/12 at 1:07 PM. AS #1 indicated there was no documentation an investigation was conducted. AS #1 indicated the QMRP interviewed client #6 however there was no documentation of the interview.</p> <p>3) On 6/6/12 at 5:00 PM, client #1 informed staff she had bruising on her right breast. Client #1 initially informed staff she did not know where the bruising came from but later indicated it may have been from heavy water stream in the shower. The bruise was 1 inch wide by 4 inches long. The report indicated the bruising looked like, "small dots like some poked her with a marker." There was no documentation an investigation was conducted.</p>			

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	<p>An interview with AS #1 was conducted on 12/5/12 at 1:07 PM. AS #1 indicated the facility should investigate injuries of unknown origin.</p> <p>4) On 3/14/12 at 7:30 AM, client #1 "attacked" client #6. Client #6 pushed client #1 away. The report indicated client #1 kicked client #6 in the bottom then attacked her (tried to hit and scratch her). The report indicated one of the clients (report was not clear who was injured) had a scrape on her right arm. There was no documentation an investigation was conducted.</p> <p>An interview with AS #1 was conducted on 12/5/12 at 1:07 PM. AS #1 indicated the facility should investigate client to client aggression.</p> <p>5) On 1/31/12 at 3:30 PM, client #1 was asked to put her lunchbox in the back of the truck. Client #1 hit client #3 (report did not indicate location) and pulled another housemate's arm (report did not indicate who). Client #1 hit client #4 with a pillow. The QMRP and AS #1 signed off on the report. There was no investigation conducted.</p> <p>An interview with AS #1 was conducted on 12/5/12 at 1:07 PM. AS #1 indicated the facility should investigate client to</p>				

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	<p>client aggression.</p> <p>6) On 11/19/12 at 12:45 PM, workshop staff discovered money missing from an unlocked desk drawer. Client #5 was missing \$10.00 from her workshop money. The facility failed to report the incident to BDDS.</p> <p>An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 12/5/12 at 11:55 AM. The QMRP indicated the facility failed to submit a BDDS report for client #5 within 24 hours. The QMRP indicated the BDDS report was submitted on 12/4/12.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 12/4/12 at 10:22 AM. AS #1 indicated the facility failed to report to BDDS for client #5 when her money was discovered missing at the facility-operated workshop. AS #1 indicated there should have been a report submitted for client #5.</p> <p>A review of the facility's policy and procedure for Identifying and Reporting Violations of Client Rights, dated 4/12/06, was reviewed on 12/3/12 at 2:45 PM. The policy indicated rights violations included abuse, neglect, exploitation and mistreatment. Abuse</p>			

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	<p>was defined as, "the intentional or willful infliction of physical injury, the unnecessary use of physical or chemical restraints or isolation, punishment that results in physical harm or pain." Verbal/Emotional Abuse was defined as "includes oral, written, and/or gestured language that includes disparaging or derogatory remarks. Also includes demeaning tones or harsh language. Includes unreasonable confinements, intimidation or humiliation." Neglect was defined as, "Placing an individual in a situation that may endanger his or her life or health; includes failure to provide appropriate care, food, medical care, shelter, or supervision."  9-3-2(a)</p>				

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W0153	<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 12 incident/investigative reports reviewed affecting client #5, the facility failed to report to the Bureau of Developmental Disabilities Services (BDDS) an incident of missing money from the facility-operated workshop, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/3/12 at 2:17 PM. On 11/19/12 at 12:45 PM, workshop staff discovered money missing from an unlocked desk drawer. Client #5 was missing \$10.00 from her workshop money. The facility failed to report the incident to BDDS.</p> <p>An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 12/5/12 at 11:55 AM. The QMRP indicated the facility failed to submit a BDDS report for client #5 within 24 hours. The QMRP indicated</p>	W0153	<p>w153 Agency policy and procedures on prohibiting mistreatment, neglect, or abuse of clients, reporting of incidents to the state, and investigations were reviewed and determined appropriate. Investigation of the missing money on 11/19/12 has been completed and documented and a BDDS report has been filed for the missing money of client #5 which was inadvertently missed initially. SGL manager will retrain QIDP's on timely reporting of incidents and completing investigations per agency policy. SGL manager will review internal incident reports to ensure state reports and investigations are completed as required. Responsible for QA: SGL Manager, QIDP</p>	01/09/2013

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	<p>the BDDS report was submitted on 12/4/12.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 12/4/12 at 10:22 AM. AS #1 indicated the facility failed to report to BDDS for client #5 when her money was discovered missing at the facility-operated workshop. AS #1 indicated there should have been a report submitted for client #5.</p> <p>9-3-2(a)</p>			

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 5 of 12 incident/investigative reports reviewed affecting 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to conduct thorough investigations of clients' missing money at the facility-operated workshop, client to client abuse and an injury of unknown origin.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/3/12 at 2:17 PM.</p> <p>1) On 11/19/12 at 12:45 PM, workshop staff discovered money missing from an unlocked desk drawer. Clients #1, #2, #3, #4, #5 and #6 were each missing \$10.00. The facility did not have documentation an investigation was conducted. The facility did not have witness statements, a report indicating who conducted the investigation, the dates of the investigation, the outcome of the investigation, and information related to when the money was last accounted for. The documentation the facility had included Bureau of Developmental</p>	W0154	<p>w154 Agency policy and procedures on prohibiting mistreatment, neglect, or abuse of clients, reporting of incidents to the state, and investigations were reviewed and determined appropriate. Investigation of the missing money on 11/19/12 has been completed and documented and a BDDS report has been filed for the missing money of client #5 which was inadvertently missed initially. SGL manager will retrain QIDP's on timely reporting of incidents and completing investigations per agency policy. SGL manager will review internal incident reports to ensure state reports and investigations are completed as required. Responsible for QA: SGL Manager, QIDP</p>	01/09/2013			

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	<p>Disabilities Services initial and follow-up reports and an email related to the incident.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 12/4/12 at 10:22 AM. AS #1 indicated the facility did not have documentation an investigation was conducted. AS #1 indicated an investigation should have been conducted.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/5/12 at 11:55 AM. The QMRP indicated an investigation should have been conducted.</p> <p>2) On 6/21/12 at 6:30 PM, client #6 inappropriately hugged a woman at church. The report indicated client #6 was sucking on a water bottle at church when a woman at the church commented client #6 was drinking the water like a baby and asked her if she needed a pacifier. The report indicated client #6 "got very excited about being called a baby by this woman and began hugging her 'obbsevely' (sic) and trying to hug sexually." The report indicated the woman moved away from client #6. Client #6 then sat too close to staff and purposely touched staff's breast. The report indicated reactive strategies were</p>						

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	<p>used from client #6's behavior plan. There was no documentation an investigation was conducted.</p> <p>A review of client #6's record was conducted on 12/5/12 at 10:43 AM. Client #6's record did not include a behavior plan. The Individual Program Plan, dated 9/12 to 9/13, indicated, "Client does not have a behavior plan as her behaviors are minor and generally infrequent."</p> <p>An interview with AS #1 was conducted on 12/5/12 at 1:07 PM. AS #1 indicated there was no documentation an investigation was conducted. AS #1 indicated the QMRP interviewed client #6 however there was no documentation of the interview.</p> <p>3) On 6/6/12 at 5:00 PM, client #1 informed staff she had bruising on her right breast. Client #1 initially informed staff she did not know where the bruising came from but later indicated may have been from heavy water stream in the shower. The bruise was 1 inch wide by 4 inches long. The report indicated the bruising looked like, "small dots like some poked her with a marker." There was no documentation an investigation was conducted.</p>			

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	<p>An interview with AS #1 was conducted on 12/5/12 at 1:07 PM. AS #1 indicated the facility should investigate injuries of unknown origin.</p> <p>4) On 3/14/12 at 7:30 AM, client #1 "attacked" client #6. Client #6 pushed client #1 away. The report indicated client #1 kicked client #6 in the bottom then attacked her (tried to hit and scratch her). The report indicated one of the clients (report was not clear who was injured) had a scrape on her right arm. There was no documentation an investigation was conducted.</p> <p>An interview with AS #1 was conducted on 12/5/12 at 1:07 PM. AS #1 indicated the facility should investigate client to client aggression.</p> <p>5) On 1/31/12 at 3:30 PM, client #1 was asked to put her lunchbox in the back of the truck. Client #1 hit client #3 (report did not indicate location) and pulled another housemate's arm (report did not indicate who). Client #1 hit client #4 with a pillow. The QMRP and AS #1 signed off on the report. There was no investigation conducted.</p> <p>An interview with AS #1 was conducted on 12/5/12 at 1:07 PM. AS #1 indicated the facility should investigate client to</p>						

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	client aggression.  9-3-2(a)				

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W0249	<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 observation, record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the staff implemented the clients' program plans as written.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/3/12 from 4:11 PM to 6:07 PM and 12/4/12 from 5:52 AM to 8:05 AM.</p> <p>1) During the observation on 12/4/12 from 5:52 AM to 8:05 AM, the clients' lunchboxes were sitting on the kitchen counter. At 6:12 AM, client #4 put a cereal bar into her lunchbox as staff was attempting to have her put it back into the container. Staff #6 indicated to staff #3 she would remove the cereal bar from client #4's lunchbox in a minute. At 6:15 AM, staff #6 indicated to staff #3 she would remove the cereal bar from client #4's lunchbox later.</p>	W0249	<p>W249</p> <p>Staff will be retrained on implementation of each client's individual program plans. Specific training will include but not be limited to plans in addressing lunchboxes, the use of the communication device, and appropriate response to obsessive behavior for client #4, the implementation of medication training objectives during each med pass for each client, the laundry training objective for client #2, and training objectives for client #1 for exercising and wearing her eyeglasses. QIDP will review with workshop staff the need for downtime activity during periods of no work. QIDP or designee will observe at least weekly for one month then monthly thereafter in the home and at the workshop to ensure compliance in these areas. Responsible for QA: QIDP</p>	01/09/2013			

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	<p>A review of client #4's record was conducted on 12/4/12 at 9:52 AM. Her Individual Program Plan (IPP), dated 9/12 - 9/13, indicated in the Behavioral section, "She seems to want to monitor others' behavior more in the mornings as she attempts to waken housemates and monitor their lunch contents. Currently lunch boxes are put away once they're packed until everyone is ready to leave for workshop." There was no documentation in client #4's plan for staff to remove items from her lunchbox.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/5/12 at 11:55 AM. The QMRP indicated the lunchboxes should be put away behind the staff desk in the living room in the morning. The QMRP indicated this was part of client #4's plan and should have been implemented. The QMRP indicated there was no plan for staff to remove items from client #4's lunchbox.</p> <p>2) Observations were conducted at the group home on 12/3/12 from 4:11 PM to 6:07 PM and 12/4/12 from 5:52 AM to 8:05 AM. During the observations, client #4 was not prompted to use her communication device, sign language or PEC (picture exchange communication</p>						

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	<p>system) communication system.</p> <p>A review of client #4's record was conducted on 12/4/12 at 9:52 AM. Her IPP, dated 9/12 - 9/13, indicated in the Communication section, "[Client #4] is non-verbal but is able to make her wants known through gestures or showing you or taking you to what she wants. She also uses sign language or her communication board/book or her Alt-Chat machine." The IPP indicated client #4 had a goal to use her Alt-chat device. Client #4's Behavior Support Plan (BSP), dated 9/11/12, indicated in the Proactive Strategies/Basic Ideas for Prevention section, in part, "Encourage [client #4] to communicate her wants and needs using PECS (communication pictures), sign language, and/or gestures."</p> <p>An interview with the QMRP was conducted on 12/5/12 at 11:55 AM. The QMRP indicated the former behaviorist put the system in place. The QMRP indicated client #4 did not like or use the system from day one. The QMRP indicated the system should be removed from her plan. The QMRP indicated since the plan indicated the PEC system should be used, staff should implement the system until it was removed from the plan. The QMRP indicated client #4 had a augmentative communication device</p>			

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	<p>and staff should prompt client #4 to use the device.</p> <p>3) An observation was conducted at the facility-operated workshop on 12/3/12 from 2:43 PM to 3:30 PM. During the observation, client #4 was yelling, screaming, attempting to put her hands in the surveyor's pants pockets, invading the surveyor's space, pulling on the surveyor and signing soda repeatedly. The workshop initially did not intervene. The workshop staff took 5 minutes prior to intervening in client #4's behaviors.</p> <p>An observation was conducted at the group home on 12/3/12 from 4:11 PM to 6:07 PM. On 12/3/12 at 4:11 PM upon arrival to the group home, client #4 attempted to enter the surveyor's locked car. At 4:15 PM, client #4 was grunting, groaning, yelling and signing soda repeatedly. At 4:32 PM, client #4 grunted and groaned while signing money. Client #4 wanted a cup like client #1 had (a Halloween themed plastic cup with a lid and straw). At 4:34 PM through 4:42 PM, client #4 was grunting and picked up the phone repeatedly for staff to contact the QMRP assistant to get permission for client #4 to spend money on a cup. At 4:48 PM, client #4 pulled staff #1 over to staff #2 to talk about client #4 getting a soda. At 4:50 PM, client #4 attempted to</p>			

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	<p>get into staff #2's bag. Client #4 then attempted to access a locked filing drawer cabinet. At 4:55 PM, client #4 attempted to access the locked filing drawer cabinet. Staff #2 opened the cabinet and took out client #4's money to use while shopping. Client #4 went to the recycle container to get an empty soda can to communicate she wanted a soda. Staff #2 told client #4 they were not getting soda. Client #4 belched and then moaned. Client #4 did something (did not observe) to staff #2. Staff #2 stated, "You are hurting me" two times. Client #4 attempted to push past staff #2 to get to staff #2's bag. During the observations, staff at the workshop and the group home staff did not redirect client #4 to another activity, redirect her to another area, or count to 3 to possibly give her a time out using a timer.</p> <p>A review of client #4's record was conducted on 12/4/12 at 9:52 AM. Her BSP, dated 9/11/12, indicated the following for obsessive behavior, "Verbally redirect by offering her another activity of interest to her. Ignore the behavior, reminding [client #4] that her request/need has been addressed and you will interact with her when she is ready to move on to the next activity. If she follows you and pulls on you, redirect her to another area and calmly remind her that you will talk to her when she stops</p>				

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	<p>yelling. If needed, ask another staff for assistance with redirecting [client #4] away from you and to another area. Count to 3, and let [client #4] know that if you get to 3 she will have a 'time out.'" If you get to 3, set a timer and redirect [client #4] to another area, away from her peers, for 5 minutes."</p> <p>An interview with the QMRP was conducted on 12/5/12 at 11:55 AM. The QMRP stated in regard to staff implementing client #4's BSP, as written, "I'm sure it's not being implemented the way it's written."</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 12/5/12 at 1:07 PM. AS #1 indicated the staff at the workshop and the group home should implement client #4's plan as written.</p> <p>4a) Observations were conducted at the group home on 12/3/12 from 4:11 PM to 6:07 PM and 12/4/12 from 5:52 AM to 8:05 AM. On 12/3/12 at 4:25 PM, client #2 received her medications (Phenytoin and Quetiapine) from staff #1. Staff #1 did not implement client #2's medication administration training objectives. On 12/4/12 at 6:27 AM, client #2 received her medications (Clobetasol, Petroleum jelly, Divalproex, Loratadine, Phenytoin, Quetiapine, Ranitidine, and tab-a-vite)</p>			

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	<p>from staff #3. Staff #3 did not implement client #2's medication administration training objectives.</p> <p>A review of client #2's record was conducted on 12/4/12 at 12:21 PM. Client #2's IPP, dated 5/12 - 5/13, indicated she had a medication training objectives to identify her medication, medication times and possible side effects of her medications.</p> <p>An interview with the QMRP was conducted on 12/5/12 at 11:55 AM. The QMRP indicated client #2's medication training objectives should be implemented at every med pass.</p> <p>4b) An observation was conducted at the group home on 12/4/12 from 5:52 AM to 8:05 AM. At 6:05 AM, client #4 received her medications (Nitrofurantoin, Docusate Sodium, Invega, Quetiapine, and Sertraline) from staff #3. Staff #1 did not inform client #4 the names of the medications, purpose and side effects. There was no discernible medication training objective implemented.</p> <p>A review of client #4's record was conducted on 12/4/12 at 9:52 AM. Her IPP, dated 9/12 - 9/13, indicated she had a training objective to learn the side effects of her medications.</p>						

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	<p>An interview with the QMRP was conducted on 12/5/12 at 11:55 AM. The QMRP indicated the staff should implement client #4's medication training objectives during each med pass.</p> <p>4c) An observation was conducted at the group home on 12/4/12 from 5:52 AM to 8:05 AM. At 6:47 AM, client #5 received her medications (Symbicort, Levothyroxine, Benztropine, Glipizide, Risperidone, tab-a-vite and Lantus) from staff #3. Staff #3 did not ask or inform client #5 the names, purpose and side effects of her medications.</p> <p>A review of client #5's record was conducted on 12/4/12 at 10:01 AM. Client #5's IPP, dated 9/12 - 9/13, indicated client #5 had medication training objectives to identify her medications and the purpose of her medications.</p> <p>An interview with the QMRP was conducted on 12/5/12 at 11:55 AM. The QMRP indicated the staff should implement client #5's medication training objectives during each med pass.</p> <p>5) An observation was conducted at the group home on 12/4/12 from 5:52 AM to 8:05 AM. At 7:16 AM, staff #3 indicated</p>			

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	<p>to staff #6 she was going downstairs to start client #2's laundry. Client #2 was sitting in the living room and available to assist staff #3. Staff #3 did not prompt client #2 to assist her.</p> <p>A review of client #2's record was conducted on 12/4/12 at 12:21 PM. Client #2's IPP, dated 5/12 - 5/13, indicated she had a laundry training objective to sort her laundry and measure detergent.</p> <p>An interview with the QMRP was conducted on 12/5/12 at 11:55 AM. The QMRP indicated the staff should not have been doing client #2's laundry. The QMRP indicated the staff should prompt client #2 to do her laundry. The QMRP indicated the staff should implement client #2's IPP as written.</p> <p>6) An observation was conducted at the group home on 12/3/12 from 4:11 PM to 6:07 PM. At 5:08 PM, staff #1 asked client #1 if she was going to exercise. Client #1 indicated she was not going to exercise. At 5:10 PM, staff #1 prompted client #1 to get her glasses out to clean them. After client #1 cleaned her glasses, staff #1 asked her if she was going to wear them. Client #1 indicated she was not going to wear them. Staff #1 asked client #1 one time (initial prompt) to wear</p>			

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	<p>her glasses and to exercise. Staff #1 did not provide additional prompts, encouragement, training, and education regarding the benefits of client #1 wearing her glasses and exercising.</p> <p>A review of client #1's record was conducted on 12/4/12 at 11:00 AM. Client #1's IPP, dated 8/12 - 8/13, indicated she had a training objective to wear her glasses and exercise.</p> <p>An interview with the QMRP was conducted on 12/5/12 at 11:55 AM. The QMRP indicated the staff did not implement the training objective as intended. The QMRP indicated staff #1 should have encouraged and trained the client to participate in her program objectives.</p> <p>7) An observation was conducted at the facility-operated workshop on 12/3/12 from 2:43 PM to 3:30 PM. During the observation, clients #1, #2, #3, #4, #5 and #6 were not engaged in activities. The clients were sitting at tables or walking around the workshop area. There were no formal or informal activities being implemented for the clients to participate in. There was no work being conducted in the workshop. The clients did not receive instruction from the staff in the workshop.</p>				

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	An interview with the QMRP was conducted on 12/5/12 at 11:55 AM. The QMRP indicated there were supposed to be activities and instruction for the clients during down-time (no work) in the workshop.  9-3-4(a)			

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W0262	<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 observation, record review and interview for 1 of 3 clients in the sample (#1), the facility failed to ensure the specially constituted committee (HRC) reviewed, approved and monitored the use of a restrictive behavior plan (#1).</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 12/4/12 at 11:00 AM. Client #1's behavior plan (BSP), dated 8/11/12, included the use of psychotropic medications (Zoloft for depression, Lamictal for depressive symptoms and mood stabilization, Seroquel for Schizo-affective disorder and Risperdal for Schizo-affective disorder), line of sight supervision due to polydipsia (excessive thirst), locking of her bathroom door due to polydipsia and dietary restrictions due to her PKU (Phenylketonuria) diet. There was no documentation in her record or provided by the facility indicating the HRC reviewed, approved and monitored client #1's restrictive BSP.</p>	W0262	<p>w262 HRC review and consent for client #1's BSP will be obtained. QIDP's will be retrained on agency policy and state requirements for HRC approval for any restrictive behavior plan. QIDP will obtain at least annually and as needed HRC approval on every BSP involving restrictions. QIDP will review each BSP at least annually and as needed to ensure HRC approval is obtained as needed. Responsible for QA: QIDP</p>	01/09/2013

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	An interview with the QMRP was conducted on 12/10/12 at 9:26 AM. The QMRP indicated the facility should have HRC consent for client #1's BSP. 9-3-4(a)				

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W0263	<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 observation, record review and interview for 3 of 3 clients in the sample (#1, #2 and #6), the facility's specially constituted committee failed to ensure restrictive interventions were conducted with written informed consent from the clients' legal representative.</p> <p>Findings include:</p> <p>1) A review of client #1's record was conducted on 12/4/12 at 11:00 AM. Client #1's Individual Program Plan (IPP), dated 8/12 - 8/13, indicated client #1 had a Health Care Representative. Client #1's behavior plan (BSP), dated 8/11/12, included the use of psychotropic medications (Zoloft for depression, Lamictal for depressive symptoms and mood stabilization, Seroquel for Schizo-affective disorder and Risperdal for Schizo-affective disorder), line of sight supervision due to polydipsia (excessive thirst), locking of her bathroom door due to polydipsia and dietary restrictions due to her PKU (Phenylketonuria) diet. There was no</p>	W0263	<p>W263 QIDP's will be retrained on agency policy and state requirement to obtain approval from any legal representative or the client themselves where appropriate for restrictive interventions. Appropriate consent will be obtained for client #1's BSP, client's #2 and #6's IPP's and the use of cameras in the home. SGL manager will review plans monthly to ensure appropriate consent has been obtained. Responsible for QA: QIDP, SGL manager</p>	01/09/2013
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	<p>documentation in her record or provided by the facility indicating client #1 or her Health Care Representative consented to the restrictive BSP.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/10/12 at 9:26 AM. The QMRP indicated the facility attempted to obtain consent from client #1's health care representative however the facility did not receive the consent. The QMRP indicated consent should have been obtained from client #1 and/or the health care representative.</p> <p>2) Observations were conducted at the group home on 12/3/12 from 4:11 PM to 6:07 PM and 12/4/12 from 5:52 AM to 8:05 AM. During the observations, cameras were in use and displayed on a computer screen on a desk located in the living room of the group home. The cameras showed the kitchen,dining room, living room, upstairs living room and the perimeter of the outside of the group home. This affected client #2.</p> <p>A review of client #2's record was conducted on 12/4/12 at 12:21 PM. Client 2's Individual Program Plan (IPP), dated 5/12 - 5/13, indicated client #2 had a guardian. The IPP did not contain written informed consent from client #2's</p>			

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	<p>guardian for the implementation of the plan. The IPP included the need for 24 hour supervision and a door alarm on her bedroom door due to a peer's past behavior of unwelcome touch. There was no documentation in client #2's record indicating her guardian gave written informed consent for the use of the cameras.</p> <p>An interview with the QMRP was conducted on 12/10/12 at 9:26 AM. The QMRP indicated consent from client #2's guardian should have been obtained.</p> <p>3) Observations were conducted at the group home on 12/3/12 from 4:11 PM to 6:07 PM and 12/4/12 from 5:52 AM to 8:05 AM. During the observations, cameras were in use and displayed on a computer screen on a desk located in the living room of the group home. The cameras showed the kitchen,dining room, living room, upstairs living room and the perimeter of the outside of the group home. This affected client #6. During the observations, when the outside door to the home was opened, there was an audible alert. This affected client #6.</p> <p>A review of client #6's record was conducted on 12/5/12 at 10:43 AM. Client #6's IPP, dated 9/12 - 9/13, indicated client #6 had a guardian. Client</p>			

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	<p>#6's record did not contain documentation and the facility was unable to provide documentation indicating the guardian gave written informed consent for the use of door alarms and cameras. There was no documentation in client #6's record indicating her guardian gave written informed consent for her IPP. Client #6's IPP included the restriction to water, soda and other liquids due to a housemate's polydipsia and 24 hour supervision.</p> <p>An interview with the QMRP was conducted on 12/10/12 at 9:26 AM. The QMRP indicated consent should have been obtained for client #6's plan.</p> <p>9-3-4(a)</p>			

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W0264	<p>483.440(f)(3)(iii) PROGRAM MONITORING &amp; CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, record review and interview for 1 of 3 clients in the sample (#6), the specially constituted committee (HRC) failed to review, approve and monitor the facility practice of using audible door alarms on the exit doors of the group home.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/3/12 from 4:11 PM to 6:07 PM and 12/4/12 from 5:52 AM to 8:05 AM. During the observations, when the door to the home was opened, there was an audible alert. This affected client #6.</p> <p>A review of client #6's record was conducted on 12/5/12 at 10:43 AM. Client #6's record did not contain documentation and the facility was unable to provide documentation indicating the HRC reviewed, approved and monitored the use of door alarms for client #6. There was no documentation in client #6's</p>	W0264	<p>W264 HRC review and consent for the use of audible door alarms on exit doors will be obtained now and annually thereafter. QIDP's will be retrained on agency policy on the HRC and the need for the review and consent of this committee of any restrictive practice that affects the clients. QIDP's will review current plans and any use of restrictive practices to ensure review and consent by the HRC. Responsible for QA: QIDP</p>	01/09/2013			

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	<p>record indicating she needed door alarms.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/10/12 at 9:26 AM. The QMRP indicated the facility should obtain HRC consent for the door alarms. The QMRP indicated the alarms were only to be used when the clients were not home and at night. The QMRP was unsure why the alarms were being used during the observations. The QMRP indicated the alarms were installed when there were issues in the past with prowlers seen around the home in the evening and at night.</p> <p>9-3-4(a)</p>				

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W0286	<p>483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used for disciplinary purposes. Based on observation, interview and record review for 1 of 6 clients living at the group home (#4), the facility failed to ensure staff did not implement techniques to manage inappropriate client behavior for disciplinary purposes.</p> <p>Findings include:</p> <p>An observation was conducted at the facility-operated workshop on 12/3/12 from 2:43 PM to 3:30 PM. At 3:18 PM, an interview with workshop supervisor (WS) #1 was conducted. WS #1 indicated the staff took away client #4's key to her lunchbox on 12/3/12 due to her behavior. WS #1 indicated he told client #4 he would throw the key away to her lunchbox if she did not comply with his requests.</p> <p>An observation was conducted at the group home on 12/4/12 from 5:52 AM to 8:05 AM. At 6:56 AM, client #4 sat in a chair in the med pass area. Client #4 sat on the curtain hanging down from a rod. Staff #6 asked client #4 to sit on the couch. Client #4 did not move. Staff #6 then told client #4 if she wanted to sit in</p>	W0286	<p>W286 QIDP will retrain staff on appropriate behavior management techniques for client #4. Training will also include general information regarding following behavior support plans as opposed to addressing client's behavioral issues in ways not identified in plan specifically ways that infringe on the client's rights. QIDP or designee will observe at least weekly for one month then monthly thereafter in the home and at the workshop to ensure compliance in these areas. Responsible for QA: QIDP</p>	01/09/2013			

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	<p>the front seat of the group home vehicle she needed to move and take off her coat. At 7:14 AM, client #4 was told by staff #6 to take off her coat if she wanted to sit in the front seat on the way to the workshop.</p> <p>An interview with staff #3 was conducted on 12/4/12 at 7:30 AM. Staff #3 indicated other staff, particularly staff #1 and #2, tell client #4 she could not do certain things unless she complies with the staff's requests.</p> <p>An interview with the QMRP was conducted on 12/5/12 at 11:55 AM. The QMRP indicated she had just discussed with the staff at a staff meeting about the staff not making their own rules. The QMRP stated staff #1 and #2 did not know how to keep control at the home "appropriately." The QMRP indicated she had discussed this with staff #1 and #2 several times already. The QMRP indicated client #4 did not have a plan to comply with staff's requests before being allowed to do things she wanted to do. The QMRP indicated the staff were making their own plans to address client #4's behavior.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 12/5/12 at 1:07 PM. AS #1 indicated there was no plan</p>						

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	<p>for client #4 to comply with staff's requests in order to be able to do certain tasks/activities. AS #1 indicated client #4 had a plan however the interventions were not part of the plan and should not be used. On 12/6/12 at 11:36 AM, AS #1 indicated there was no plan or reason for staff to take client #4's key for any reason. AS #1 indicated client #4 should have access to her key.</p> <p>9-3-5(a)</p>			

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W0356	<p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>Based on record review and interview for 2 of 3 clients in the sample (#1 and #6), the facility failed to ensure the clients received dental care in a timely manner.</p> <p>Findings include:</p> <p>1) A review of client #1's record was conducted on 12/4/12 at 11:00 AM. Client #1 was seen by her dentist on 8/30/11 and 9/19/12. The 8/30/11 dental form indicated the follow-up plan/appointment was a 4 month hygiene visit. There was no documentation this visit occurred. The 9/19/12 appointment form indicated, in part, "She had heavy plaque and tartar build-up. Generalized severe inflammation and heavy bleeding."</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 12/5/12 at 1:07 PM. AS #1 indicated client #1 should have had a follow-up appointment in December 2011, as recommended.</p> <p>2) A review of client #6's record was conducted on 12/5/12 at 10:43 AM. Client #6 was seen by her dentist on</p>	W0356	<p>W356 QIDP's will be retrained on requirements for timely medical and dental care for each client. Client #1 will receive routine dental treatment as recommended by her dentist. Client #6 was seen timely but documentation was not in the file. This documentation will be obtained and filed appropriately. QIDP and her assistant will review each client's record to ensure all medical/dental evals are timely. Responsible for QA: QIDP</p>	01/09/2013	

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	<p>4/25/11. There was no documentation client #6 had been seen by her dentist since 4/25/11.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/5/12 at 11:55 AM. The QMRP indicated there was a handwritten note indicating client #6 was seen on 2/27/12 by her dentist however there was no documentation to verify the appointment occurred.</p> <p>9-3-6(a)</p>			

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W0365	<p>483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. Based on observation and interview for 1 of 1 client (#2) observed to receive her medication during the evening med pass, the facility failed to ensure staff initialed the Medication Administration Record (MAR) after passing the client's medications.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 12/3/12 from 4:11 PM to 6:07 PM. At 4:25 PM, client #2 received her medications (Phenytoin and Quetiapine) from staff #1. Staff #1 initialed the MAR, dated December 2012, prior to administering client #2's medications.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/5/12 at 11:55 AM. The QMRP indicated the staff should initial the MAR after the medications were administered.</p> <p>9-3-6(a)</p>	W0365	<p>W365 Staff have been retrained on appropriate medication administration to include initialing of the MAR after passing the client's medications not before. QIDP or designee will observe at least weekly for one month then monthly thereafter in the home to ensure compliance in this area. Responsible for QA: QIDP</p>	01/09/2013	

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W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 1 of 3 clients in the sample with adaptive equipment (#6), the facility failed to ensure the staff encouraged and prompted client #6 to wear her hearing aids.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 12/4/12 from 5:52 AM to 8:05 AM. At 6:38 AM during client #6's med pass, staff #3 asked client #6 if she was going to wear her hearing aids. Client #6 indicated she did not want to wear her hearing aids. Staff #3 did not provide training, education, encouragement or instruction to client #6 about the benefits of wearing her hearing aids.</p> <p>A review of client #6's record was conducted on 12/5/12 at 10:43 AM. Her Individual Program Plan (IPP), dated 9/12 to 9/13, indicated, "[Client #6] in the last year was fitted with hearing aids and wore them for a while. However, she now</p>	W0436	<p>W436</p> <p>QIDP will review client #6's plan and revise as needed to include information on use of hearing aid. Staff will be trained on any revisions to program plan. QIDP or designee will observe weekly for one month and at least monthly thereafter to ensure staff are encouraging client to use her hearing aid and educating her on reasons for this. Responsible for QA: QIDP</p>	01/09/2013

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	<p>refuses to wear them but has said she'd wear them when she would want to hear voices." Client #6 did not have a plan to wear her hearing aids in her record.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/10/12 at 9:26 AM. The QMRP indicated there was a training objective in place but not listed in client #6's IPP. The QMRP stated she thought it was "pointless" to list the hearing aid objective in the IPP since client #6 was refusing to wear her hearing aids daily. The QMRP indicated client #6 should be prompted, encouraged and provided training on the benefits of wearing her hearing aids. The QMRP indicated client #6 was supposed to wear her hearing aids daily.</p> <p>9-3-7(a)</p>						

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W0440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure evacuation drills were conducted quarterly for each shift.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 12/3/12 at 5:16 PM. On day shift (7:00 AM to 3:00 PM), there were no drills conducted from 3/18/12 to 7/28/12. On night shift (11:00 PM to 7:00 AM), there were no drills conducted from 6/27/12 to 10/28/12. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 12/4/12 at 10:22 AM. AS #1 indicated there should be one drill per shift per quarter.</p> <p>9-3-7(a)</p>	W0440	<p>W440 QIDP will retrain staff on the requirements for regular evacuation drills. A schedule of the drills will be posted in the home. Staff will turn in monthly documentation to the QIDP of the evacuation drills completed that month. QIDP will compare with the drill schedule to ensure compliance in this area. Responsible for QA: QIDP January 9, 2013</p>	01/09/2013	

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W0488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure: 1) clients #1, #2, #3, #4, #5 and #6 packed their own lunches and 2) client #3 prepared her own hot chocolate.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 12/4/12 from 5:52 AM to 8:05 AM. At 7:11 AM, client #5 indicated she did not like the drink and the bread in her lunch.</p> <p>An interview with client #6 was conducted on 12/4/12 at 7:25 AM. Client #6 indicated none of the clients (#1, #2, #3, #4, #5 and #6) packed their own lunches. Client #6 indicated the clients should pack their own lunches however the staff pack the lunches when the clients go to bed. On 12/5/12 at 11:09 AM, client #6 indicated the staff wait until the clients go to bed to make the lunches. Client #6 indicated staff #1 and #2 would not allow the clients to make their own lunches. Client #6 indicated the staff pack items she did not like.</p>	W0488	<p>W488 QIDP has retrained staff in how to support each client in the preparation and packing of their own lunches and beverages at the level of independence each client is capable of. The QIDP or designee will observe lunch prep and interview clients at least weekly for one month and at least monthly thereafter to ensure compliance in this area.</p> <p>Responsible for QA: QIDP</p>	01/09/2013			

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	<p>An interview with staff #3 was conducted on 12/4/12 at 7:26 AM. Staff #3 indicated at staff meetings, the staff had discussed who should be packing the lunches. Staff #3 indicated the clients were supposed to be packing their own lunches. Staff #3 stated, "the girls aren't going to learn unless you are teaching them." Staff #3 indicated the Qualified Mental Retardation Professional (QMRP) and the QMRP assistant were both aware the clients were not packing their lunches.</p> <p>An interview with client #5 was conducted on 12/4/12 at 9:28 AM. Client #5 indicated the staff would not allow the clients to pack their own lunches. Client #5 indicated she wanted to pack her own lunch. Client #5 indicated the staff told the clients the staff would pack the lunches after the clients go to bed.</p> <p>An interview with the QMRP was conducted on 12/5/12 at 11:55 AM. The QMRP indicated the clients should be packing their own lunches.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 12/5/12 at 1:07 PM. AS #1 indicated she was not aware the clients were not packing their own lunches. AS #1 indicated the clients should be packing their own lunches.</p>			

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	<p>2) An observation was conducted at the group home on 12/4/12 from 5:52 AM to 8:05 AM. At 6:53 AM, staff #6 prompted client #3 to sit at the table. Staff #6 indicated she would get her cocoa ready. At 6:56 AM, staff #6 was preparing client #3's cocoa while client #3 stood beside her. Staff #6 did not prompt client #3 to assist or participate in preparing her cocoa. Staff #6 carried client #3's cocoa to the table and then stirred the cocoa.</p> <p>An interview with the QMRP was conducted on 12/5/12 at 11:55 AM. The QMRP stated, "[Client #3] is perfectly capable of making her cocoa." The QMRP indicated client #3 should have made her own cocoa.</p> <p>9-3-8(a)</p>			