

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/30/2011
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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1413 DARBY KOKOMO, IN46904
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W0000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: September 27, 28, 29, and 30, 2011</p> <p>Facility number: 001100 Provider number: 15G586 AIM number: 100240050</p> <p>Surveyors: Tracy Brumbaugh, Medical Surveyor III-Team Leader Kathy Craig, Medical Surveyor III</p> <p>These deficiencies also reflect state findings under 460 IAC 9. Quality Review completed 10/12/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0149	<p>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, the facility failed to implement their abuse/neglect policy by: not reporting 1 of 2 unknown injuries to BDDS (Bureau of Developmental Disabilities Services), not</p>	W0149	<p>The agency will follow abuse/neglect policy. The QDDP will investigate all injuries of unknown origin within 24 hours. Once the injury has been deemed "unknown", the QDDP will notify BDDS within 24 hours.</p>	10/28/2011

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>investigating thoroughly 1 of 2 unknown injuries; and not providing sufficient corrective action to prevent client #8 from being physically aggressive to other clients.</p> <p>Findings include:</p> <p>1. Review on 9/27/11 at 2:50 PM of the facility's accident/incident reports was conducted. An accident/incident report dated 4/15/11 indicated client #8 had an injury of unknown origin which was a quarter-sized bruise on the top of her left shoulder. Review on 9/27/11 at 9:50 AM of the facility's BDDS incident reports was conducted and there was no report for client #8's injury of unknown origin.</p> <p>Interview on 9/30/11 at 9:45 AM with the QMRP (Qualified Mental Retardation Professional) was conducted. She indicated injuries of unknown origin should be reported to BDDS when the source of the injury was not witnessed by any person, when the source of the injury could not be explained by the client, and after investigation the injury remains unknown.</p> <p>2. Review on 9/27/11 at 2:50 PM of the facility's accident/incident reports was conducted. An accident/incident report dated 4/15/11 indicated client #8 had an</p>		<p>The QDDP will notify the VP of Residential Services of injuries of unknown origin. We have developed a new form in which the QDDP will use to thoroughly investigate and document all injuries of unknown origin. The "investigation" form will be attached to the accident/incident and/or the BDDS report. All Residential QDDP's and day services staff were given the form on 9/29/11 and trained on the importance of thoroughly investigating and notifying the QDDP of all injuries. We track incidents for patterns and in this particular instance, Client #8 did not have one specific target. All staff are trained in CPI techniques. Staff are also trained in behavior plans. Staff are to redirect the acting out client to a quiet area to calm down or remove the other housemates to ensure everyone's safety when someone is acting out. When an incident of aggression occurs between 2 clients, we counsel both parties on appropriate interactions.</p>		

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	<p>injury of unknown origin which was a quarter-sized bruise on the top of her left shoulder. The investigation dated 4/18/11 did not include any client interviews or staff interviews regarding this injury of unknown origin.</p> <p>Interview on 9/28/11 at 2:10 PM with the QMRP #2 (Qualified Mental Retardation Professional) was conducted. He indicated injuries of unknown origin should be thoroughly investigated which would include to get specific people involved and to get any information that preceded the incident.</p> <p>3. Review on 9/27/11 at 9:50 AM of the facility's BDDS (Bureau of Developmental Disabilities Services) incident reports was conducted. The following incidents involved client #8 being physically aggressive towards other clients:</p> <p>1. 9/17/10: Client #8 poked client #7 in the left eye. No visible marks were noted.</p> <p>2. 11/22/10: Client #8 scratched a client from another group home at day program which produced scratches on the client.</p> <p>3. 12/9/10: Client #8 got angry and put her hand on client #1's head and dug her fingernails into his scalp, causing</p>				

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	<p>scratches. Skin was broken and a small amount of blood was present on his scalp.</p> <p>4. 5/11/11: Client #8 has a "history of physically violent behavior, often of unknown origin. She had been exhibiting signs of agitation since after breakfast on this day. Around 4:00 pm, [client #8] attacked a staff member and bit her on the arm and twisted her wrist. When other staff attempted to intervene, [client #8] became extremely combative. For the next (approx) 4 hours, [client #8] did not calm down and continued to attack any staff member in her vicinity. In addition to the above injury, two other staff were attacked, one by having her hair pulled with hair actually removed from her scalp, and one with a scratch on her eyeball and forehead. Staff also incurred various scratches on their hands and arms." Behaviors beginning on 5/11/11 continued throughout the day on 5/12/11. Client #8 was taken to the ER (Emergency Room) where the physician ordered an injection of Geodon in an attempt to calm client #8. At one point, client #8 became "so aggressive," hospital staff and group home staff that had accompanied her to the ER were employing physical restraint similar to that which was used on 5/11/11.</p> <p>5. 6/18/11: Client #8 "has a recent</p>				

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	<p>history of aggressive behavior, believed to be triggered by a recurring urinary tract infection, and the associated discomfort. As she was waking up on 6/18 and being accompanied to the bathroom by staff, she became aggressive towards [client #6] as she passed her in the hall. [Client #8] grabbed [client #6] by the hair, and then hit her once in the upper chest and once in the arm, causing client #6 to fall backwards and land on her bottom in the bathroom." There were no signs of bruising or other marks.</p> <p>6. 7/22/11: "Without warning, or any known provocation, [client #8] lunged across the table at breakfast time and grabbed [client #2] by the hair. Staff had to physically remove [client #8's] hand from [client #2's] hair. This left a scratch on [client #2's] forehead, and removed some hair from her scalp. Staff applied first aid, but no other treatment needed. [Client #8] attempted to get at another consumer, but was stopped by staff."</p> <p>7. 8/5/11: "[Client #1] was in the kitchen preparing his lunch to take with him to work. [Client #8] entered kitchen and without warning or provocation attacked [client #1], causing a 2 inch scratch on the top of his head. A second scratch, on [client #1's] right wrist was observed." The report indicated client #8 has a</p>				

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	<p>history of "indiscriminately attacking consumers", but has targeted client #1 on numerous occasions. Staff will closely monitor client #8 when in the presence of client #1 at all times.</p> <p>8. 8/7/11: "[Client #8] was agitated and went to her bedroom. Her roommate [client #7] was laying in her bed. [Client #7] screamed out. [Client #8] smacked [client #7] on the mouth when she screamed. [Client #8] went over to her bed and laid down." Staff checked client #7's lip and applied a cold wet cloth.</p> <p>9. 8/28/11: Client #8 scratched at client #3. Client #3 had scratches on her leg.</p> <p>Interview on 9/27/11 at 3:10 PM with client #1 was conducted. Client #1 indicated he was scared of client #8 when she gets mad. Client #1 indicated client #8 has scratched his head when she got mad.</p> <p>Interview on 9/28/11 at 2:50 PM with the QMRP (Qualified Mental Retardation Professional) was conducted. She indicated client #8's BSP (behavior support plan) was just updated September, 2011 and it spells out proactive measures.</p> <p>Review on 9/27/11 at 9:45 AM of the facility's abuse/neglect policy dated 5/11</p>				

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W0153	<p>indicated the following: "In order to protect the general welfare of persons served, Bona Vista Programs strictly prohibits the abuse of any form, neglect, exploitation or mistreatment of an individual or violation of an individual's rights by employees or agents delivering services on behalf of the agency." The policy on investigations dated 3/08 indicated "Investigation of an alleged case of neglect, battery, exploitation of a person, injuries of unknown origin or psychological abuse shall include, but not be limited to, a statement from the complainant, a statement from the alleged violator, and any and all witnesses to the alleged incident. . . ." This policy indicated injuries of unknown origin, after an investigation, must make a report to BDDS and APS (Adult Protective Services).</p> <p>9-3-2(a)</p> <p>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.</p> <p>Based on record review and interview, the facility failed for 1 of 2 injuries of unknown origin to immediately report the unknown injury to BDDS (Bureau of</p>	W0153	Direct care staff were retrained on 10/12/11 that they are to notify a supervisor immediately when an injury is discovered. Staff will complete the accident form	10/12/2011	

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W0154	<p>Developmental Disabilities Services) regarding 1 additional client (client #8) in accordance with state law.</p> <p>Findings include:</p> <p>Review on 9/27/11 at 2:50 PM of the facility's accident/incident reports was conducted. An accident/incident report dated 4/15/11 indicated client #8 had an injury of unknown origin which was a quarter-sized bruise on the top of her left shoulder. Review on 9/27/11 at 9:50 AM of the facility's BDDS incident reports was conducted and there was no report for client #8's injury of unknown origin.</p> <p>Interview on 9/30/11 at 9:45 AM with the QMRP (Qualified Mental Retardation Professional) was conducted. She indicated injuries of unknown origin should be reported to BDDS when the source of the injury was not witnessed by any person, when the source of the injury could not be explained by the client, and after investigation the injury remains unknown.</p> <p>9-3-2(a)</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, the facility failed for 1 of 2 injuries of</p>	W0154	<p>indicating the location, size, etc of the injury. The QDDP will investigate all injuries of unknown origin within 24 hours. Once the injury has been deemed "unknown", the QDDP will notify BDDS within 24 hours. The QDDP will notify the VP of Residential Services of injuries of unknown origin. We have developed a new form in which the QDDP will use to thoroughly investigate and document all injuries of unknown origin. The "investigation" form will be attached to the accident/incident and/or the BDDS report. All Residential QDDP's and day services staff were given the form on 9/29/11 and trained on the importance of thoroughly investigating and notifying the QDDP of all injuries.</p> <p>The QDDP will investigate all injuries of unknown origin within 24 hours. Once the injury has</p>	10/03/2011	

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W0157	<p>unknown origin to investigate the unknown injury thoroughly regarding 1 additional client (client #8).</p> <p>Findings include:</p> <p>Review on 9/27/11 at 2:50 PM of the facility's accident/incident reports was conducted. An accident/incident report dated 4/15/11 indicated client #8 had an injury of unknown origin which was a quarter-sized bruise on the top of her left shoulder. The investigation dated 4/18/11 did not include any client interviews or staff interviews regarding this injury of unknown origin.</p> <p>Interview on 9/28/11 at 2:10 PM with the QMRP #2 (Qualified Mental Retardation Professional) was conducted. He indicated injuries of unknown origin should be thoroughly investigated which would include to get specific people involved and to get any information that preceded the incident.</p> <p>9-3-2(a)</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to implement sufficient corrective action in 9 of 9 incidents of</p>	W0157	<p>been deemed "unknown", the QDDP will notify BDDS within 24 hours. The QDDP will notify the VP of Residential Services of injuries of unknown origin. We have developed anew form in which the QDDP will use to thoroughly investigate and document all injuries of unknown origin. The "investigation" form will be attached to the accident/incident and/or the BDDS report. All Residential QDDP's and day services staff were given the form on 9/29/11 and trained on the importance of thoroughly investigating and notifying the QDDP of all injuries.</p> <p>Client #8's behavior plan had been revised throughout the year with the last revision on 9/11 to</p>	10/12/2011	

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	<p>client to client abuse in the past year (September 2010 to September 2011) regarding client #8.</p> <p>Findings include:</p> <p>Review on 9/27/11 at 9:50 AM of the facility's BDDS (Bureau of Developmental Disabilities Services) incident reports was conducted. The following incidents involved client #8 being physically aggressive toward other clients:</p> <ol style="list-style-type: none"> <li>9/17/10: Client #8 poked client #7 in the left eye. No visible marks were noted.</li> <li>11/22/10: Client #8 scratched a client from another group home at day program which produced scratches on the client.</li> <li>12/9/10: Client #8 got angry and put her hand on client #1's head and dug her fingernails into his scalp, causing scratches. Skin was broken and a small amount of blood was present on his scalp.</li> <li>5/11/11: Client #8 has a "history of physically violent behavior, often of unknown origin. She had been exhibiting signs of agitation since after breakfast on this day. Around 4:00 pm, [client #8] attacked a staff member and bit her on the arm and twisted her wrist. When other</li> </ol>		<p>assist staff with interventions for aggressive outbursts. Client #8 has been undergoing medical testing/evaluation due to her increase in behaviors which is an indication of medical issues. We have changed/introduced some systems with her Primary Care Physician to immediately evaluate her when we see an increase in behaviors. We have standing orders for Urine specimens since this is a regular issue and is a known cause of agitation/increased behaviors. We have introduced some new medication to assist with allergies and migraines to be preventative instead of waiting until she indicates pain or is acting out. Staff were re- trained on her support plan to remove clients in the area or protect them if she is acting out and to use the least restrictive measures in which to keep everyone safe. Staff have been trained on Client #8's behavior plan. We have implemented new strategies to deal with client #8 when she is acting out. Staff are to either redirect her to another area where there are items that are soothing to client #8, move the vulnerable (immobile) clients out of the area where client #8 is, shield the clients with their bodies if not able to move to another location (van). Staff are to use techniques taught in CPI to redirect and de-escalate the situation. Staff talk calmly to the</p>		

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	<p>staff attempted to intervene, [client #8] became extremely combative. For the next (approx) 4 hours, [client #8] did not calm down and continued to attack any staff member in her vicinity. In addition to the above injury, two other staff were attacked, one by having her hair pulled with hair actually removed from her scalp, and one with a scratch on her eyeball and forehead. Staff also incurred various scratches on their hands and arms."</p> <p>Behaviors beginning on 5/11/11 continued throughout the day on 5/12/11. Client #8 was taken to the ER (Emergency Room) where the physician ordered an injection of Geodon in an attempt to calm client #8. At one point, client #8 became "so aggressive," hospital staff and group home staff that had accompanied her to the ER were employing physical restraint similar to that which was used on 5/11/11.</p> <p>5. 6/18/11: Client #8 "has a recent history of aggressive behavior, believed to be triggered by a recurring urinary tract infection, and the associated discomfort. As she was waking up on 6/18 and being accompanied to the bathroom by staff, she became aggressive towards [client #6] as she passed her in the hall. [Client #8] grabbed [client #6] by the hair, and then hit her once in the upper chest and once in the arm, causing client #6 to fall</p>		<p>other clients and reassure them that they are safe. We track the behaviors and have eliminated as many irritants for Client #8 as possible. Because of her serious heart condition, she is not a candidate for most behavior medication which she has been on all of her life. Because we know Client #8 acts out when she has medical issues, the Dr has prescribed a low dose daily antibiotic for UTI's and this is monitored by a monthly urine sample. Client #8 sees a psychiatrist, neurologist, PCP, oral surgeon and heart specialist who all work in conjunction to provide her medical care.</p>	

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	<p>backwards and land on her bottom in the bathroom." There were no signs of bruising or other marks.</p> <p>6. 7/22/11: "Without warning, or any known provocation, [client #8] lunged across the table at breakfast time and grabbed [client #2] by the hair. Staff had to physically remove [client #8's] hand from [client #2's] hair. This left a scratch on [client #2's] forehead, and removed some hair from her scalp. Staff applied first aid, but no other treatment needed. [Client #8] attempted to get at another consumer, but was stopped by staff."</p> <p>7. 8/5/11: "[Client #1] was in the kitchen preparing his lunch to take with him to work. [Client #8] entered kitchen and without warning or provocation attacked [client #1], causing a 2 inch scratch on the top of his head. A second scratch, on [client #1's] right wrist was observed." The report indicated client #8 has a history of "indiscriminately attacking consumers", but has targeted client #1 on numerous occasions. Staff will closely monitor client #8 when in the presence of client #1 at all times.</p> <p>8. 8/7/11: "[Client #8] was agitated and went to her bedroom. Her roommate [client #7] was laying in her bed. [Client #7] screamed out. [Client #8] smacked</p>				

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W0229	<p>[client #7] on the mouth when she screamed. [Client #8] went over to her bed and laid down." Staff checked client #7's lip and applied a cold wet cloth.</p> <p>9. 8/28/11: Client #8 scratched at client #3. Client #3 had scratches on her leg.</p> <p>Interview on 9/27/11 at 3:10 PM with client #1 was conducted. Client #1 indicated he was scared of client #8 when she gets mad. Client #1 indicated client #8 has scratched his head when she got mad.</p> <p>Interview on 9/28/11 at 2:50 PM with the QMRP (Qualified Mental Retardation Professional) was conducted. She indicated client #8's BSP (behavior support plan) was just updated September, 2011 and it spells out proactive measures.</p> <p>9-3-2(a)</p> <p>The objectives of the individual program plan must be stated separately, in terms of a single behavioral outcome.</p> <p>Based on record review and interview, the facility failed for 3 of 4 sampled clients (clients #1, #2, and #3) by not ensuring their IPP (Individual Program Plan) objectives were stated separately with a single behavioral outcome.</p>	W0229	<p>Staff have been trained on the consumers new single objective goals as they are completed by the QDDP. The QDDP is replacing the current goals with single objective goals and will be completed by 11/11/11. All QDDP's have been retrained on</p>	11/11/2011	

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	<p>Findings include:</p> <p>On 9-28-11 at 10:30 a.m. a record review for client #1 was conducted. The IPP dated 7-28-11 included the following objectives:</p> <ol style="list-style-type: none"> <li>1. Showering program: will temper his water, will wash his face and body parts, and will not cover drain with foot.</li> <li>2. Tooth brushing: will get proper amount of toothpaste, brush upper teeth, brush lower teeth, brush back teeth for both AM and PM.</li> <li>3. Money program: identify coins, value, amount, and identify bills, value, dollar amount.</li> <li>4. Laundry program: sort laundry by colors, whites, bedding, load washer, fold clothes, put away in dresser hang clothes and put clothes away in closet.</li> <li>5. Cooking program: write down name of side item that is cooked, select proper method of cooking, select proper pan to use, prepare item, set dials, time or temperature, cook item, rinse dishes, and clean up area.</li> <li>6. Frustration program: handle 4 frustration situation, question #1, question #2, question #3, and question #4.</li> <li>7. Lunch making program: prepare entree, prepare fruit, prepare veggies, prepare drink, and prepare dessert.</li> </ol>		<p>having single outcome goals. The Social Service Coordinator and Residential Coordinator will review the consumers goals while completing the Periodic Service Review to ensure compliance.</p>		

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	<p>On 9-28-11 at 9:30 a.m. a record review for client #2 was conducted. The IPP dated 7-28-11 included the following objectives:</p> <ol style="list-style-type: none"> <li>1. Showering program: bring shower nozzle up to head and completely wet her hair.</li> <li>2. Tooth brushing: will get proper amount of toothpaste for both AM and PM.</li> <li>3. Dressing program: will choose weather appropriate clothing and will wear weather appropriate clothing;</li> <li>4. Handwashing program: wash hands after toileting, before preparing food, and before eating.</li> <li>5. Reality program: ask her what she dreamed about, discuss one thing that is fiction, discuss one thing that is true, have her tell you one thing that is true.</li> <li>6. Money program: state the name of a quarter, dime, penny, and nickel.</li> <li>7. Laundry program: sorts laundry light and darks, put laundry in washing machine, puts laundry in dryer, and puts clothing away.</li> <li>8. Lunch making program: prepare entree, prepare fruit, prepare veggies, prepare drink, and prepare dessert.</li> </ol> <p>Review on 9/28/11 at 9:50 AM of client #3's records was conducted. Client #3's IPP dated 1/20/11 included the following objectives:</p>				

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	<ol style="list-style-type: none"> <li>1. Showering program: will temper her water, will wash her face and body with separate washcloths.</li> <li>2. Tooth brushing: will get proper amount of toothpaste, brush upper teeth, brush lower teeth, brush back teeth for both AM and PM.</li> <li>3. Dressing program: will choose weather appropriate clothing and will wear weather appropriate clothing;</li> <li>4. Dishwasher Program: load top of dishwasher, load bottom of dishwasher, unload dishwasher, and put dishes away in correct places.</li> <li>5. Personal information program: correct number dialed, number that was called for phone program, initial, and traces her address.</li> <li>6. Money program: identify quarter, identify dime, identify penny, and identify nickel.</li> <li>7. Sheets program: take sheets off bed, take dirty sheets to laundry basket, get out a clean set of sheets, put clean sheets on bed, and finish making bed.</li> <li>8. Laundry program: puts socks away in correct drawer, hangs up pants, hangs up shirts, puts pajamas away in correct drawer, and puts undergarments away in correct drawer.</li> <li>9. Cooking program: write down name of side item that is cooked, select proper method of cooking, select proper pan to use, prepare item, set dials, time or</li> </ol>			

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	<p>temperature, cook item, rinse dishes, and clean up area.</p> <p>10. Serving program: pours drink, uses scoop to measure, and cuts meat up into pieces.</p> <p>11. Interacting program: respects her housemates and staff's personal space bubbles, does not touch anyone's personal belongings, even in a teasing manner, looks at the person she is speaking to and does not ignore them, refrains from any verbal abuse, and treats everyone with respect even during a frustrating situation.</p> <p>12. Frustration program: talks about a good thing that happened today, talks about a frustrating situation, ask what strategy did she use, and ask what strategy would work better the next time.</p> <p>13. Lunch making program: prepare entree, prepare fruit, prepare veggies, prepare drink, and prepare dessert.</p> <p>Interview on 9/28/11 at 2:45 PM with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated clients' objectives should be stated separately.</p> <p>9-3-4(a)</p>				

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W0249	<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, the facility failed for 1 of 4 sampled clients (client #4) to ensure her medication goal was implemented per her Individualized Support Plan (ISP).</p> <p>Findings include:</p> <p>On 9-27-11 from 6:25 a.m. until 8:00 a.m. an observation at the home of client #4 was completed. At 6:30 a.m. direct care staff (DCS) #1 was observed to punch client #4's Baclofen (for spasticity) 10 mg into a souffle cup. DCS #1 then crushed the medication, added hot water, then went into client #4's bedroom. Client #4 was observed to be asleep in her bed when DCS #1 uncovered her, put gloves on, unhooked the nutritional supplement, and began to add the Baclofen into the G-tube. DCS #1 covered client #4 back up and left the room.</p> <p>On 9-28-11 at 10:15 a.m. a record review for client #4 was conducted. The ISP dated 3-15-11 indicated client #4 would respond to her medication administration</p>	W0249	<p>During a staff meeting on 10/12/11, staff were retrained on the importance of using med passes as a training opportunity and to follow the consumer's goals as written by the QDDP. The House Manager will review goals for completion. The QDDP will change goals based on progression/regression. The Nurse and House Manager will randomly observe various med passes to ensure staff are following the Med Core A&amp;B guidelines.</p>	10/28/2011	

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W0268	<p>by relaxing her muscles.</p> <p>On 9-28-11 at 12:30 p.m. an interview with the facility nurse indicated DCS #1 should have implemented the medication goal for client #4.</p> <p>9-3-4(a)</p> <p>These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation and interview, the facility failed for 1 of 4 clients (client #6) who was observed during medication administration, to ensure she wasn't given her medication while in the restroom to promote her dignity.</p> <p>Findings include:</p> <p>On 9-27-11 at 6:25 a.m. until 8:00 a.m. an observation at the group home of client #6 was conducted. At 6:48 a.m. direct care staff (DCS) #1 was observed to put client #6's Prilosec 20 mg (for acid reflux) in a souffle cup with applesauce. DCS #1 took the medication into the restroom and administered it to client #1 as she sat on</p>	W0268	<p>During a staff meeting on 10/12/11, staff were retrained on the importance of following the Med Core A&amp;B guidelines. This includes giving clients respect and dignity during med passes. The Nurse and House Manager will randomly observe various med passes to ensure staff are following the Med Core A&amp;B guidelines.</p>	11/11/2011	

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W0304	<p>the toilet. DCS #2 was also in the bathroom assisting client #6 with getting dressed.</p> <p>On 9-28-11 at 11:15 a.m. an interview with the facility nurse indicated client #6 should not be participating in a medication administration while sitting on the toilet.</p> <p>9-3-5(a)</p> <p>Restraints must be designed and used so as not to cause physical injury to the client. Based on record review and interview, the facility failed for 1 additional client (client #8) by not preventing injuries in restraint.</p> <p>Findings include:</p> <p>Review on 9/27/11 at 9:50 AM of the facility's BDDS (Bureau of Developmental Disabilities Services) incident reports was conducted. The following incident resulted in client #8 receiving injuries after being placed in a restraint during a behavior:</p> <p>BDDS dated 5/12/11 for an incident dated 5/11/11: client #8 has a "history of physically violent behavior, often of</p>	W0304	<p>Client #8's behavior was found to be caused by a UTI. The House Manager that directed staff to restrain client #8 is no longer employed here. After this incident, we updated her plan on several occasions with the last revision on 9/11 to assist staff with interventions for aggressive outbursts. We have changed/introduced some systems with her PCP to immediately evaluate her when we see an increase in behaviors. We have standing orders for Urine specimens since this is a regular issue and is a known cause of agitation/increased behaviors. We have introduced some new medication to assist with allergies and migraines to be</p>	10/12/2011	

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	unknown origin. She had been exhibiting signs of agitation since after breakfast on this day. Around 4:00 pm, [client #8] attacked a staff member and bit her on the arm and twisted her wrist. When other staff attempted to intervene, [client #8] became extremely combative. For the next (approx) 4 hours, [client #8] did not calm down and continued to attack any staff member in her vicinity. In addition to the above injury, two other staff were attacked, one by having her hair pulled with hair actually removed from her scalp, and one with a scratch on her eyeball and forehead. Staff also incurred various scratches on their hands and arms. During this four hour period, at various times staff had to employ physical restraint that exceeded the CPI (restraint procedures) model that is normally employed. Because of the strength of consumer and the amount of energy she was expending, [client #8] was restrained (sic) while lying on the floor with one staff immobilizing her hands, one immobilizing her legs/feet, and one protecting her head from banging on the floor. She was released from this restraint immediately if she showed signed of calming, and no weight or pressure was applied to her body. . .As a result of her combativeness and the restraint taking place on a carpeted floor, the morning staff observed several areas on [client		preventative instead of waiting until she indicates pain or is acting out. Staff were re-trained on her support plan to remove clients in the area or protect them if she is acting out and to use the least restrictive measures in which to keep everyone safe.		

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W0312	<p>#8]'s arms that had the presence of rug burns and some bruising on and around her elbows."</p> <p>Interview on 9/28/11 at 2:50 PM with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated client #8's BSP (Behavior Support Plan) was recently updated September, 2011 to include proactive techniques. She indicated she was not the QMRP of this home back in May, 2011, when this incident with client #8 occurred.</p> <p>9-3-5(a)</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients on behavior medications (client #1) by not including an active treatment plan to address the reason for the medication.</p> <p>Findings include:</p> <p>On 9-28-11 at 10:30 a.m. a record review for client #1 was conducted. A psychiatric medication review dated</p>	W0312	The QDDP will present a formal behavior plan for Client #1 to the Human Rights Committee on 11/10/11. Client #1 previously had goals to address his emotions and how to deal with frustrations. The Social Service Coordinator and/or Residential Coordinator will ensure that consumers who are on psychotropic meds have a formal behavior plan when they routinely complete the Periodic Service	11/10/2011	

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W0368	<p>7-11-11 indicated client #1 took Zoloft 25 mg for depression. The review did not indicate client #1 had a behavior support plan to address client #1 taking of the Zoloft.</p> <p>On 9-28-11 at 12:30 p.m. an interview with the Qualified Mental Retardation Professional indicated client #1 was on Zoloft for depression but there was no plan in place to address it.</p> <p>9-3-5(a)</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed for 3 of 4 sampled clients (clients #1, #2, and #3) and 1 additional client (client #8), by failing to administer client medications correctly.</p> <p>Findings include:</p> <p>Review on 9/27/11 at 9:50 AM of the facility BDDS (Bureau of Developmental Disabilities Services) incident reports included the following med (medication) errors:</p> <p>1. Incident dated 4/16/11: Client #1 had</p>	W0368	<p>Review on the consumers charts.</p> <p>Staff are to follow Med CoreA&amp;B guidelines. If staff do not administer medications properly, a med error is given as outlined in the agency policy and then staff are required to retake Med Core A&amp;B. After so many med errors, they are terminated. The Nurse presented an overview of Med Core A&amp;B at the staff meeting on 10/12/11. The Nurse and House Manager will randomly observe various medpasses to ensure staff are following the Med Core A&amp;B guidelines.</p>	10/12/2011	

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	<p>been prescribed 125 mcg (micrograms) of Levothyroxine (for thyroid) since 12/10/10. This was an increase from his previous dose of 25 mcg. On 4/15/11 at 8:00 AM, it was discovered that client #1 had been given 25 mcg tablet qd (once a day) at 8:00 AM the following days: 4/9/11, 4/10/11, 4/11/11, 4/12/11, 4/13/11 and 4/14/11. It was determined that when he ran out of a bubble pack of the 125 mcg tablets, a bubble pack at 25 mcg tabs which had not been discarded at the time of the increase, was taken from the drawer and erroneously administered. The physician was not contacted.</p> <p>2. Incident dated 4/13/11: Client #3 was receiving her AM meds from staff member and was given 1 tablet of Phenobarbital 30 milligrams (for seizures) to take instead of the prescribed amount of 3 tablets.</p> <p>3. Incident dated 4/14/11: Client #8 was at med cart having AM meds administered to her. Staff member administering meds incorrectly read MAR (Medication Administration Record) and administered Coreg 3.125 mg (milligrams) 1 tablet instead of the prescribed dosage of 1/2 tablet. Client #8 receives 1 tablet in the PM.</p> <p>4. Incident dated 8/6/11: Client #2 was</p>				

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W0369	<p>having her 8:00 pm meds administered to her by staff. Staff gave client #2 one Dilantin 100 mg tablet. Order calls for two tablets to be administered.</p> <p>5. Incident dated 8/6/11: Client #4 did not receive her midnight dose of Baclofen 30 mg.</p> <p>Interview on 9/28/11 at 2:10 PM with the agency vice president was conducted. She indicated staff who administer meds in error are disciplined according to the agency's med policy. She indicated the staff who administered client #1's meds in error for 5 straight days was terminated according to the med policy.</p> <p>9-3-6(a)</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview, the facility failed for 2 of 4 clients (clients #5 and #6) observed during a medication administration, to ensure all medications were administered without error.</p> <p>Findings include:</p>	W0369	<p>The Dr. wrote the med order to reflect the way client #5 can take the medication. The staff had been dissolving the medication in water for years. The medication had been changed at some point. The med orders and labels match. The nurse will review med sheets, Dr. orders to ensure accuracy. Staff will follow Med Core A&amp;B guidelines and notify the nurse of any discrepancies.</p>	10/21/2011	

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	<p>On 9-27-11 from 6:25 a.m. until 8:00 a.m. an observation at the home of clients #5 and #6 was observed. At 6:48 a.m. client #6 was observed to take her Prilosec 20 milligrams (mg) for acid reflux. At 7:00 a.m. client #6 was observed to eat a sausage patty. At 7:47 a.m. direct care staff (DCS) #4 was observed to put client #5's Claritin for allergies in a souffle cup. DCS #4 then added water to the souffle cup and dissolved the Claritin. DCS #4 then gave client #5 his Claritin in a liquid form. Client #5 was observed to drink the water and Claritin mixture.</p> <p>On 9-28-11 at 10:00 a.m. a review of client #6's physician's orders dated 9-11 indicated she was to take Prilosec 20 mg 15-30 minutes before breakfast.</p> <p>On 9-28-11 at 10:15 a.m. a review of client #5's physician's orders dated 9-11 indicated he was prescribed Claritin 10 mg for allergies and it was to be given orally on his tongue to dissolve.</p> <p>On 9-27-11 at 7:50 a.m. an interview with DCS #4 indicated the Claritin was dissolved in water so client #5 wouldn't spit it out.</p> <p>On 9-28-11 at 12:30 p.m. an interview with the Qualified Mental Retardation Professional indicated physician's orders</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2011
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W0436	<p>for clients #5 and #6 should be followed.</p> <p>On 9-28-11 at 11:15 a.m. an interview with the facility nurse indicated physician's orders should be followed for client #5.</p> <p>9-3-6(a)</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, the facility failed for 1 of 4 sampled clients (client #1) to follow a recommendation for the client to wear hearing aids.</p> <p>Findings include:</p> <p>On 9-27-11 from 6:25 a.m. until 8:00 a.m an observation at the home of client #1 was conducted. During this observation client #1 was not observed to wear hearing aids.</p> <p>On 9-28-11 at 10:30 a.m. a record review for client #1 was conducted. An appointment on 4-19-10 with the</p>	W0436	<p>The nurse is in the process of getting hearing aids for Client #1. The Nurse will monitor the health needs of all consumers and review their charts for past services needed. The social Service Coordinator and/or Residential Coordinator will review all medical sections when completing the Periodic Service Review to ensure compliance.</p>	11/25/2011	

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	<p>recommendation written in letter form on 4-20-10 indicated the audiologist documented the results of the appointment were "moderately-severe sensorineural hearing loss for the right ear." The letter dated 4-20-10 from the [name of hearing center] indicated the need for hearing aids when he becomes medically eligible through his insurance. The letter also indicated asymmetrical hearing loss and an irritated left ear canal. Client #1's Individual Support Plan dated 7-28-11 did not indicate he had hearing aids available to him.</p> <p>On 9-28-11 at 11:00 a.m. an interview with the agency nurse indicated client #1 did not have hearing aids and she was not aware of the recommendation.</p> <p>9-3-7(a)</p>				