

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G619	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2012
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NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 605 SHERWOOD ST CROWN POINT, IN 46307
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: March 12, 21, 23 and 26, 2012</p> <p>Facility number: 001178 Provider number: 15G619 AIM number: 100240150</p> <p>Surveyor: Christine Colon, Medical Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/9/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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

TITLE

(X6) DATE

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

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the governing body failed for 5 of 5 clients living at the group home (clients #1, #2, #3, #4 and #5), to exercise general operating direction in a manner to ensure routine maintenance was completed.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 3/12/12 from 6:15 A.M. until 8:30 A.M.. Upon entering the group home the hallway walls leading to clients #1, #2, #3, #4 and #5's bedrooms were observed to have two 2 feet by 3 feet rough white patches and a 1 foot by 6 inch patch on the right wall and a 6 inch by 6 inch rough white patch on the left wall.</p> <p>An evening observation was conducted at the group home on 3/21/12 from 4:40 P.M. until 5:55 P.M.. Upon entering the group home the hallway walls leading to clients #1, #2, #3, #4 and #5's bedrooms were observed to have two 2 feet by 3 feet rough white patches and one 1 foot by 6 inch patch on the right wall and a 6 inch by 6 inch rough white patch on the left wall.</p>	W0104	<p>A maintenance request was completed to fix holes in wall in the hallway leading to the bedrooms. Holes were repaired and patch work needed to dry before sanding and painting. Another maintenance request was submitted to finish the sanding and painting. Responsible Person: Dana Rock, Group Home Manager.</p> <p>Patch work on the hallway wall were fixed. Responsible Person: Maintenance staff.</p> <p>To ensure future compliance, a monthly program status report will be completed, which will include that all home maintenance needs are submitted. Responsible Person: Susan Whitten, Program Coord/QMRP and Sheila O'Dell, Group Home Director.</p>	04/25/2012			

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	<p>A morning observation was conducted at the group home on 3/23/12 from 6:00 A.M. until 7:30 A.M.. Upon entering the group home the hallway walls leading to clients #1, #2, #3, #4 and #5's bedrooms were observed to have two 2 foot by 3 foot white patches and one 1 foot by 6 inch patch on the right wall and a 6 inch by 6 inch white patch on the left wall.</p> <p>An interview with Residential Instructor (RI) #1 was conducted on 3/12/12 at 8:00 A.M.. DSP #1 indicated the walls needed to be repaired for about a month.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/26/12 at 2:50 P.M.. The QMRP indicated the walls needed to be repaired and further indicated there was no documentation available for review to indicate when the walls would be repaired.</p> <p>9-3-1(a)</p>			

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W0126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on observation and interview, for 5 of 5 clients residing at the group home (clients #1, #2, #3, #4 and #5), the facility failed to encourage and teach each client to access their personal finances.</p> <p>Findings include:</p> <p>A morning observation was conducted at the home of clients #1, #2, #3, #4 and #5 on 3/12/12 from 6:15 A.M. until 8:30 A.M.. At 6:20 A.M., Residential Instructor (RI) #2 was asked if clients kept their personal funds. RI #2 indicated the clients' personal funds were kept locked in the group home manager's office in the basement of the clients' home. When asked if he could unlock the office so the clients could count their personal finances, RI #2 indicated the group home manager was the only person who had access to the locked office.</p> <p>A morning observation was conducted at the home of clients #1, #2, #3, #4 and #5 on 3/23/12 from 6:00 A.M. until 7:30 A.M.. At 7:10 A.M., RI #1 was asked if she could unlock the downstairs office.</p>	W0126	<p>Management staff and direct care staff were re-trained on our policy there is to a system in place to encourage and teach each client to access their personal funds. Responsible person: Susan Whitten, Program Coord/QDDP. Clients # 1, 2, 3, 4 and 5 will have money accessible to them at all times. Responsible person: Dana Rock, Group Home Manager & Susan Whitten, Program Coord/QDDP. To ensure compliance, a program status report will be completed monthly, which will include client access to the money and that safety measure are in place to detour misappropriation of those funds. Responsible person: Susan Whitten, Program Coord/QDDP & Sheila O'Dell, Group Home Services Director.</p>	04/25/2012			

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	<p>RI #1 stated "I don't have the keys to the office, only the group home manager has the keys."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted at the facility's administrative office on 3/26/12 at 2:50 P.M.. The QMRP indicated all group home staff should have access to the office where the clients personal petty cash funds are kept.</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.</p> <p>Based on record review and interview, the facility neglected to implement its abuse/neglect policy, to protect 4 of 5 clients living at the group home, (clients #1, #3, #4 and #5) from being physically aggressive towards self and other clients living at the group home.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 3/12/12 at 1:10 P.M.. Review of the facility's "28. POLICY ON REPORTING AND INVESTIGATING INCIDENTS AND ALLEGATIONS OF ABUSE AND NEGLECT", no date noted, indicated, in part, the following: "Purpose: To establish prompt, accurate and effective procedures for the reporting and investigating of all allegations of abuse or neglect...Consumers must not be subjected to abuse by anyone, including, but not limited to, facility staff, other consumers...Until the incident is reported and investigated, one may not be able to determine whether it is abuse (willful), neglect, or mistreatment but the incident</p>	W0149	<p>All instances of suspected abuse, neglect or mistreatment of consumer(s) towards self or to another consumer was reported and also will be thoroughly investigated for each incident per policy. Responsible persons: Sheila O'Dell, Group Home Services Director The manager/QMRP were re-trained on policy #28 reporting and investigating incidents and allegations of abuse, which includes tag # 149-157 and thorough investigations Responsible Person: Sheila O'Dell, Group Home Services Director To ensure future compliance, all internal incident reports are reviewed daily to ensure that investigations have occurred as needed. Responsible Person: Dana Rock, GH Manager To ensure future compliance, all internal incident reports are reviewed at the time of the monthly Program Status Report. Responsible Persons: Susan Whitten, Program Coordinator/QMRP and Sheila O'Dell, GH Services Director. ADDEMDUM: At signs of agitation, staff is actively intervening per the BSP. The clients are also closely monitored to prevent SIB and client to client aggression. Staff are always near</p>	04/25/2012	

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	<p>must be treated as an allegation of abuse, neglect or mistreatment and follow the regulations for reporting, responding, investigating and correcting... The term 'willful' does not have to do with 'competence' but with 'intent' to cause harm. Someone with a mental illness or mental retardation can willfully inflict harm to someone who has been bothering them, even though they may not be considered 'competent'... It is mandatory in all situations involving abuse, neglect, exploitation, mistreatment of an individual or the violation of an individual's rights that there is notification made to legal representative, guardian/parent, if applicable, Case Manager, if applicable, BDDS (Bureau of Developmental Disabilities Services), APS/CPS (Adult Protection Services/Child Protection Services) and other person the (sic) designated by the consumer."</p> <p>The facility's records were reviewed on 3/23/12 at 6:45 A.M.. A review of 18 of 25 of the facility's internal incident reports from 9/11/11 to 3/19/12 indicated the following:</p> <p>1. Incident dated 9/11/11: "[Client #5] woke up around 1:00 A.M.. Around 1:20 A.M., [client #5] asked to go outside. Staff told him it was too late and he could</p>		<p>and will position themselves in between the agitated client and the others by redirect them away from the area &/or physically intervening to ensure their safety. Client #5's behaviors/BSP is reviewed with the team on a regularly basis and the plan is updated/reviced on a regular basis. This is a newer client and is making some good progress; his BSP has been revised 4 times this past year. Staff were retrained to address the importance of preventing injury from SIB and aggression towards others living in the home.</p>		

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	<p>play outside tomorrow. Began crying, hitting self and head butting the wall. Left dents in the hallway and two holes in bedroom on the right side near the door."</p> <p>2. Incident dated 3/2/12: "Staff was assisting [client #5] with meds. [Client #5] began hitting, pinching and spitting on staff, as well as self."</p> <p>3. Incident dated 3/2/12: "Staff was assisting [client #5] with showering. During shower, [client #5] became aggressive by hitting staff and pulling his hair and pinching himself. All throughout the day [client #5] repeatedly pinched and pulled his hair and punched himself. Pinches left half of a dime sized marks on chest, thighs and arms."</p> <p>4. Incident dated 3/4/12: "[Client #1] was standing in hallway when [client #5] came up behind him and grabbed a hold of [client #1]'s hair. Staff released hair pull and redirected [client #5]."</p> <p>5. Incident dated 3/7/12: "Staff was assisting [client #5] with his 'wait' program. He wanted the edible reinforcement before the time. He began spitting and pinching so the trial was terminated and he was redirected to an activity...He also pulled his own hair, hit his head with his fist and pinched his</p>						

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	<p>chest. After several attempts to redirect him, he was put in an upper arm restraint until aggression stopped."</p> <p>6. Incident dated 3/7/12: "Staff was assisting [client #5] with his proximity shaping program. He wanted the edible reinforcement before it was time so he became aggressive and self injurious...hitting his head and chin and head butting the wall...red marks on his forehead and chin about the size of a quarter."</p> <p>7. Incident dated 3/8/12: "...[Client #5] began to cry and engage in SIB (Self Injurious Behavior) pulling his hair, pinching his chest and hitting his head and chin with his fist."</p> <p>8. Incident dated 3/11/12: "...He began to spit, pinch, head butt the walls and made attempts to pull his housemates hair."</p> <p>9. Incident dated 3/12/12: "...[Client #5] began to pinch staff and himself and hit his chin with his fist."</p> <p>10. Incident dated 3/13/12: "...[Client #5] began crying, pulling hair, pinching, hitting head with fist."</p> <p>11. Incident dated 3/14/12: "...[Client</p>			

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	<p>#5] threw food at staff attempted to bite staff, pinched staff and began head butting the walls...slight red mark on forehead 1/2 inch in length."</p> <p>12. Incident dated 3/16/12: "[Client #1] was sitting in the doorway to his room, listening to music, when [client #5] exited the bathroom and pulled his hair."</p> <p>13. Incident dated 3/16/12: "[Client #3] was walking from his room to the living room. While passing the bathroom, [client #5] pinched his left forearm...small red mark the size of a quarter on left forearm."</p> <p>14. Incident dated 3/17/12: "...[Client #5] became aggressive...During this behavior, he repeatedly hit himself on the chin as well as pinching himself."</p> <p>15. Incident dated 3/17/12: "...When finished [client #5] came out of the bathroom crying and hitting his fist to his chin."</p> <p>16. Incident dated 3/17/12: "...[Client #5] began to cry hit his chin with his fist and hit his head against the wall."</p> <p>17. Incident dated 3/18/12: "...[Client #5] then became aggressive pinching his chest, crying, throwing mulch, head</p>			

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	<p>butting the wooden pole at a nearby pavilion. Staff blocked aggression and then used an upper arm wrap to prevent any further SIB...red mark in the center of his forehead about the size of a quarter."</p> <p>18. Incident dated 3/19/12: "...[Client #5] got up walked over to [client #4] and slapped him twice."</p> <p>A review of client #5's record was conducted on 3/22/12 at 12:50 P.M.. Review of the record neglected to indicate the Interdisciplinary Team (IDT) met to address client #5's documented SIB. Further review of his BSP dated 2/2/12 neglected to indicate any revisions were made to address client #5's documented SIB.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/26/12 at 2:50 P.M.. The QMRP indicated the facility's Abuse and Neglect policy is to be followed at all times. The QMRP further indicated client #5 has a lot of SIB and is aggressive toward staff and his fellow housemates.</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 4 of 25 incidents, involving 4 of 5 clients (clients #1, #3, #4 and #5) the facility failed to provide written evidence thorough investigations were conducted of incidents of client to client aggression.</p> <p>Findings include:</p> <p>A request for all investigation records for this group home was made on 3/12/12 at 9:40 A.M.. Program Director (PD) stated "There are no investigations for this group home."</p> <p>The facility's records were reviewed on 3/23/12 at 6:45 A.M.. A review of 18 of 25 of the facility's internal incident reports from 9/11/11 to 3/19/12 indicated the following:</p> <p>1. Incident dated 3/4/12: "[Client #1] was standing in hallway when [client #5] came up behind him and grabbed a hold of [client #1]'s hair. Staff released hair pull and redirected [client #5]." No written documentation was available for review to indicate the facility had conducted a thorough investigation of the</p>	W0154	<p>All instances of suspected abuse, neglect or mistreatment of consumer(s) by another consumer will be thoroughly investigated for each incident per policy. Responsible persons: Sheila O'Dell, Group Home Services Director The group home manager/QMRP were re-trained on policy #28 reporting and investigating incidents and allegations of abuse, which includes tag # 149-157 and thorough investigations</p> <p>Responsible Person: Sheila O'Dell, Group Home Services Director To ensure future compliance, all internal incident reports are reviewed daily to ensure that investigations have occurred as needed.</p> <p>Responsible Person: Dana Rock, GH Manager. To ensure future compliance, all internal incident reports are reviewed at the time of the monthly Program Status Report. Responsible Persons: Susan Whitten, Program Coordinator/QMRP and Sheila O'Dell, GH Services Director.</p>	04/25/2012	

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	<p>incident.</p> <p>2. Incident dated 3/16/12: "[Client #1] was sitting in the doorway to his room, listening to music, when [client #5] exited the bathroom and pulled his hair." No written documentation was available for review to indicate the facility had conducted a thorough investigation of the incident.</p> <p>3. Incident dated 3/16/12: "[Client #3] was walking from his room to the living room. While passing the bathroom, [client #5] pinched his left forearm...small red mark the size of a quarter on left forearm." No written documentation was available for review to indicate the facility had conducted a thorough investigation of the incident.</p> <p>4. Incident dated 3/19/12: "...[Client #5] got up walked over to [client #4] and slapped him twice." No written documentation was available for review to indicate the facility had conducted a thorough investigation of the incident.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/26/12 at 2:50 P.M.. The QMRP indicated the facility did not investigate each incident to rule out abuse or neglect. The QMRP further indicated</p>				

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	<p>there was no investigation conducted in regards to the above mentioned incidents. No further written documentation was available for review to indicate thorough investigations were conducted.</p> <p>9-3-2(a)</p>			

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed for 4 of 5 clients residing at the group home (clients #1, #3, #4 and #5) to take effective corrective action for 18 of 18 incidents of Self Injurious Behavior (SIB) and client to client aggression.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 3/23/12 at 6:45 A.M.. A review of 18 of 25 of the facility's internal incident reports from 9/11/11 to 3/19/12 indicated the following:</p> <p>1. Incident dated 9/11/11: "[Client #5] woke up around 1:00 A.M.. Around 1:20 A.M., [client #5] asked to go outside. Staff told him it was too late and he could play outside tomorrow. Began crying, hitting self and head butting the wall. Left dents in the hallway and two holes in bedroom on the right side near the door." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>2. Incident dated 3/2/12: "Staff was</p>	W0157	<p>Regular and effective corrective action for all behaviors are and will be reviewed by the IDT to address the behaviors and indicate any revisions/recommendations that need to be made. Responsible person: Susan Whitten, Program Coord/QDDP. All behavior data for every client is reviewed at least quarterly and as much as a couple times a month through different avenues: progress reviews, monthly reviews, safety committee, med review, HRC, quarterlies and other scheduled meetings. Responsible person: Dana Rock, GH manager & Susan Whitten, Program Coord/QDDP. To ensure future compliance, documentation of review/recommendations will be part of the investigation notes. Responsible person: Susan Whitten, Program Coord/QDDP. ADDEMDUM: At signs of agitation, staff is actively intervening per the BSP. The clients are also closely monitored to prevent SIB and client to client aggression. Staff are always near and will position themselves in between the agitated client and the others by redirect them away from the area &/or physically intervening to ensure their safety. Client #5's behaviors/BSP is reviewed with the team on a</p>	04/25/2012			

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	<p>assisting [client #5] with meds. [Client #5] began hitting, pinching and spitting on staff, as well as self." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>3. Incident dated 3/2/12: "Staff was assisting [client #5] with showering. During shower, [client #5] became aggressive by hitting staff and pulling his hair and pinching himself. All throughout the day [client #5] repeatedly pinched and pulled his hair and punched himself. Pinches left half of a dime sized marks on chest, thighs and arms." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>4. Incident dated 3/4/12: "[Client #1] was standing in hallway when [client #5] came up behind him and grabbed a hold of [client #1]'s hair. Staff released hair pull and redirected [client #5]." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>5. Incident dated 3/7/12: "Staff was assisting [client #5] with his 'wait'</p>		regularly basis and the plan is updated/revised on a regular basis. This is a newer client and is making some good progress; his BSP has been revised 4 times this past year. Staff were retrained to address the importance of preventing injury from SIB and aggression towards others living in the home.		

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	<p>program. He wanted the edible reinforcement before the time. He began spitting and pinching so the trial was terminated and he was redirected to an activity...He also pulled his own hair, hit his head with his fist and pinched his chest. After several attempts to redirect him, he was put in an upper arm restraint until aggression stopped." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>6. Incident dated 3/7/12: "Staff was assisting [client #5] with his proximity shaping program. He wanted the edible reinforcement before it was time so he became aggressive and self injurious...hitting his head and chin and head butting the wall...red marks on his forehead and chin about the size of a quarter." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>7. Incident dated 3/8/12: "...[Client #5] began to cry and engage in SIB (Self Injurious Behavior) pulling his hair, pinching his chest and hitting his head and chin with his fist." No documentation was available for review to indicate the facility took</p>			

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	<p>sufficient/effective corrective action after this incident.</p> <p>8. Incident dated 3/11/12: "...He began to spit, pinch, head butt the walls and made attempts to pull his housemates hair." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>9. Incident dated 3/12/12: "...[Client #5] began to pinch staff and himself and hit his chin with his fist." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>10. Incident dated 3/13/12: "...[Client #5] began crying, pulling hair, pinching, hitting head with fist." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>11. Incident dated 3/14/12: "...[Client #5] threw food at staff attempted to bite staff, pinched staff and began head butting the walls...slight red mark on forehead 1/2 inch in length." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p>						

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	<p>12. Incident dated 3/16/12: "[Client #1] was sitting in the doorway to his room, listening to music, when [client #5] exited the bathroom and pulled his hair." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>13. Incident dated 3/16/12: "[Client #3] was walking from his room to the living room. While passing the bathroom, [client #5] pinched his left forearm...small red mark the size of a quarter on left forearm." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>14. Incident dated 3/17/12: "...[Client #5] became aggressive...During this behavior, he repeatedly hit himself on the chin as well as pinching himself." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>15. Incident dated 3/17/12: "...When finished [client #5] came out of the bathroom crying and hitting his fist to his chin." No documentation was available for review to indicate the facility took</p>				

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	<p>sufficient/effective corrective action after this incident.</p> <p>16. Incident dated 3/17/12: "...[Client #5] began to cry hit his chin with his fist and hit his head against the wall." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>17. Incident dated 3/18/12: "...[Client #5] then became aggressive pinching his chest, crying, throwing mulch, head butting the wooden pole at a nearby pavilion. Staff blocked aggression and then used an upper arm wrap to prevent any further SIB...red mark in the center of his forehead about the size of a quarter." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>18. Incident dated 3/19/12: "...[Client #5] got up walked over to [client #4] and slapped him twice." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>A review of client #5's record was conducted on 3/22/12 at 12:50 P.M.. Review of the record failed to indicate the</p>						

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	<p>Interdisciplinary Team (IDT) met to address client #5's documented SIB. Further review of his BSP dated 2/2/12 failed to indicate any revisions were made to address client #5's documented SIB.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/26/12 at 2:50 P.M.. The QMRP indicated there was no documentation available for review to indicate the facility took effective/sufficient corrective action to address each of these incidents involving clients #1, #3, #4 and #5.</p> <p>9-3-2(a)</p>				

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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, the facility failed to implement written objectives during times of opportunity for 1 of 5 clients (client #5), residing at the group home.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 3/12/12 from 6:15 A.M. until 8:30 A.M.. From 6:15 A.M. until 7:10 A.M., client #5 sat at the end of the hallway on top of a bed comforter with no activity. From 7:15 A.M. until 8:30 A.M., client #5 sat in a corner in the living room manipulating a phone cord. During the noted time periods, Residential Instructors (RI) #1 and #2 would occasionally walk through and visually check on client #5 but did not offer meaningful active treatment activities or implement client objectives.</p> <p>A morning observation was conducted at the group home on 3/23/12 from 6:00 A.M. until 7:30 A.M.. From 6:00 A.M.</p>	W0249	<p>Staff will implement all written objective during times of opportunity, not just during scheduled times. Responsible person: Dana Rock, GH Manager. All staff were retrained in active treatment and missed opportunities. Responsible person: Dana Rock, GH Manager. To ensure future compliance, a reliability will be completed on each shift. Responsible person: Dana Rock, GH Manager & Susan Whitten, Program Coord/QDDP.</p>	04/25/2012			

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	<p>until 6:40 A.M., client #5 sat at the end of the hallway on top of a bed comforter with no activity. At 6:40 A.M., client #5 ate breakfast which consisted of cinnamon rolls and sausage links with his bare hands. RI #1 went into the kitchen and retrieved a butter knife and cut the meal up. Client #5 was not observed to learn to use the proper utensils while dining. From 6:50 A.M. until 7:30 A.M., client #5 sat in a corner in the living room manipulating a phone cord. During the noted time periods, RI #1 and #8 would occasionally walk through and visually check on client #5 but did not offer meaningful active treatment activities or implement client objectives.</p> <p>A review of client #5's record was conducted on 3/22/12 at 1:00 P.M.. A review of the client's 2/28/12 Individual Program Plan (ISP) indicated the following objectives which could have been implemented during the 3/12/12 and 3/23/12 morning observation periods: "Will learn to identify copper and silver coins, show staff the money identified...will learn to use the washing machine to wash his clothes...will learn to fold his shirts on hangers...will learn to use proper utensils when dining...will learn to mix hot/cold water." Further review of the record indicated a Behavior Support Plan (BSP) dated 2/2/12 which</p>			

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	<p>indicated he had a "Shaping Wait" and "Proximity" shaping program.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/26/12 at 2:50 P.M.. The QMRP stated client objectives should be implemented "during times of opportunity." The QMRP further indicated client #5 should have been provided with meaningful active treatment activities during the 3/12/12 and 3/23/12 morning observation periods.</p> <p>9-3-4(a)</p>				

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W0289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based on observation record review and interview for 1 of 5 clients residing at the group home (client #5), the facility failed to ensure systematic interventions in the Behavior Support Plans (BSP) were specifically written.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 3/12/12 from 6:15 A.M. until 8:30 A.M.. At 7:30 A.M., client #5 was observed during medication administration. During the entire medication administration client #5 grabbed and pulled Residential Instructor (RI) #2's hair, slapped her in her face and pinched her arm repeatedly.</p> <p>A review of client #5's record was conducted on 3/22/12 at 12:50 P.M.. Review of his BSP dated 2/2/12 indicated: "Restrictive Methods: Restraints (hands down, arm wrap, full physical intervention)." Further review of the BSP failed to specifically describe the above interventions to be used.</p>	W0289	<p>All interventions used to manage behaviors are incorporated into the BSP. Responsible person: Karen Warner, Behavior Specialist. Client #5's BSP was revised to include the steps of interventions. Responsible person: Karen Warner, Behavior Specialist. All staff are trained on physical interventions use per policy annually and on BSP as needed. Responsible person: Dana Rock, GH Manager & Ruth Fields, Training Coord.</p>	04/25/2012

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	An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/26/12 at 2:50 P.M.. The QMRP indicated client #5's BSP failed to indicate how the holds/techniques would be implemented when needed. 9-3-5(a)				

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W0484	<p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation and interview, the facility failed for 2 of 3 sampled clients and 1 additional client observed eating breakfast (clients #1, #2 and #5) to provide silver ware and condiments at the dining table.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 3/23/12 from 6:00 A.M. until 7:30 A.M.. At 6:05 A.M. clients #1 and #2 ate breakfast which consisted of cinnamon rolls and sausage links with their hands. Residential Instructor #1 went into the kitchen drawer and retrieved a butter knife and cut up the clients' cinnamon rolls. The table was observed to have no forks, butter knives, milk or ketchup available for use. Residential Instructor #1 failed to offer silverware and these condiments to clients #1 and #2 for their food.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/26/12 at 2:50 P.M.. The QMRP indicated silverware and condiments should be put on the table for</p>	W0484	<p>All eating utensils and all condiments will be provided at the dining room table at all times. Responsible Person: Dana Rock, GH Manager</p> <p>Staff will be re-trained to include all utensils and condiments to be available to seize teachable moments. Responsible Person: Dana Rock, GH Manager.</p> <p>To ensure future compliance, meal time reliabilities will be completed on staff to promote more independence for the consumers at the dining table. Responsible Person: Dana Rock, GH Manager</p>	04/25/2012	

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	the clients to use at all times. 9-3-8(a)				