

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G797		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 9029 S AMERICA RD LA FONTAINE, IN 46940			
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W000000	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: February 20, 21, 22, 25, March 7, 8, and 11, 2013.</p> <p>FACILITY NUMBER: 0012563 PROVIDER NUMBER: 15G797 AIM NUMBER: 201018540</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 19, 2013 by Dotty Walton, Medical Surveyor III.</p>	W000000					

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

TITLE

(X6) DATE

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

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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview, for 4 of 4 clients (clients #1, #2, #3, and #4) who lived in the group home, the governing body failed to exercise operating direction over the facility to complete maintenance and repairs at the group home.</p> <p>Findings include:</p> <p>During observations on 2/20/13 from 3:00pm until 6:05pm, and on 2/21/13 from 6:00am until 8:00am at the group home, client #1, #2, #3, and #4 were at the group home and the following was observed with the RM (Residential Manager), Group Home Staff (GHS) #1, and GHS #2.</p> <p>-On 2/20/13 at 4:15pm, the RM indicated two of three (2/3) cabinet doors under the entertainment center in the living room were missing.</p> <p>-On 2/20/13 at 4:15pm, the RM indicated one of two (1/2) cabinet doors under the kitchen sink was missing and needed repair.</p> <p>-On 2/20/13 at 4:15pm, the RM indicated</p>	W000104	<p>W 104 Governing Body – Repairs & Chairs</p> <p>Corrective action for resident(s) found to have been affected The home is for people with significant behavior problems, which often result in property damage. The damages cited in the survey will be repaired, and sturdier chairs will be purchased.</p> <p>How facility will identify other residents potentially affected & what measures taken All residents potentially affected, and corrective measures address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence Repairs made and sturdier chairs purchased.</p>	04/10/2013			

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	<p>six of six (6/6) dining room chairs were missing and had been replaced by white plastic light weight folding chairs that did not match the table.</p> <p>-On 2/21/13 at 6:21am, client #4 and GHS #2 both indicated client #4's bedroom had four (4) places covering fifteen feet long (15' long) with dried brown liquid on the wall. Client #4 showed over one hundred (100) tears into the dry wall paint and marks on the wall. Both client #4 and GHS #2 indicated client #4's bedroom walls needed repaired.</p> <p>On 2/20/13 at 4:25pm, the facility's maintenance items to be repaired and/or replaced was requested from the RM and none were available for review.</p> <p>An interview with the Site Director (SD) was conducted on 3/7/13 at 3:37pm. At 3:37pm, the SD indicated client #1, #2, #3, and #4's group home had identified maintenance needs for needed repairs. The SD indicated the facility staff were working on the needed repairs.</p> <p>The SD indicated the dining room chairs, client #4's bedroom repainting, and the repairs to cabinet doors had not been completed and no repair maintenance requests records were available for</p>		<p>How corrective actions will be monitored to ensure no recurrence</p> <p>The Group Home Manager is responsible for maintenance needs, including repairs and furniture purchases. The Director supervises the Group Home Manager. At regular team meetings that include both the Director and Group Home Manager, there will be an agenda item on home maintenance.</p>				

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	review. 9-3-1(a)				

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review, for 24 of 72 BDDS (Bureau of Developmental Disability Services) Reports reviewed from 2/1/12 through 2/20/13, the facility neglected to implement policies/procedures to prevent self harm, peer aggression/intimidation of clients #1, #2, #3, and #4. Findings include: 1. On 2/20/13 at 6:20pm, on 2/20/13 at 7:15pm, and on 2/22/13 at 12:00pm, the facility's BDDS reports from 2/1/12 through 2/20/13 were reviewed and indicated the following for client #1's behavioral episodes and threats of suicide. -On 3/6/13 a BDDS report for an incident on 3/5/13 at 4:45pm, indicated client #1 "had behavioral difficulties that lasted 2 hours, [client #1] was upset for unknown reason, went into bedroom with staff beside her, hit 1 time on door staff blocked all other attempts." Client #1 sat down on the floor attempting SIB biting, head banging, and attempted to bend her finger back. Staff restrained client #1, released, client #1 walked to the living</p>	W000149	<p>W 149 Implementing Policies to Protect Clients from Self Harm and Peer Aggression Corrective action for resident(s) found to have been affected The client who has engaged in significant self-harm and suicidal behaviors remains hospitalized and is being evaluated for alternative placement in a more-restrictive setting. Should she return to the group home, new measures will be put into place, including behavior support changes and medication review by the psychiatrist. Peer aggression will be addressed through a staff training on prevention of behavior problems and intervening earlier in the cycle of behavior problems with a focus on keeping peers safe. Training will be conducted by a certified trainer in Mandt, which is the system of de-escalation and physical intervention used by the residential provider.</p>	04/10/2013			

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	<p>room, stopped at the fire extinguisher cabinet and banged her head twice, staff blocked all other attempts, and client #1 was restrained again. Client #1 walked to the kitchen grabbed the toaster, hit herself in the head with the toaster. Client #1 dropped to floor, bit self, restrained again, and released when calm. Client #1 up in the kitchen picked up the skillet on the stove and started to swing at staff and hit the oven door. Staff trying to get the skillet from client #1's hands, client #1 hit the oven with the skillet, and broke the oven glass front. Client #1 dropped to the floor on the glass and cut herself on forehead. Staff restrained client #1, client #1 was combative, and client #1 "retrieved a piece of glass and placed in her mouth." Staff asked her to spit out the glass, client #1 refused, and the report indicated client #1 swallowed it. Client #1 was taken to the hospital by ambulance with police assistance. Client #1 was admitted for observation.</p> <p>On 3/7/13 at 3:37pm, an interview with the Site Director (SD) was conducted. The SD indicated client #1 had been discharged from the Hospital unit and was on the behavioral unit as a inpatient stay.</p>		<p>How facility will identify other residents potentially affected & what measures taken</p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>If client returns to group home, BSP changes and psychiatric medication review will take place. A training will be conducted by a certified trainer to address peer aggression. At least quarterly at a staff meeting, procedures to prevent peer aggression will be reviewed.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The IDT meets regularly and reviews each incident report and generates plans to address problems, including self-harm and peer aggression. Additionally, an Incident Oversight Committee comprised of the Director, an agency Vice President, and a Compliance Officer reviews each incident to ensure timeliness, if investigations are needed and</p>				

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	<p>The SD indicated client #1 was being considered for admission to the State Hospital. The SD indicated client #1 had returned to the group home after the previous inpatient stay for a couple of days when this incident occurred at the group home.</p> <p>-On 2/20/13 a BDDS report for an incident on 2/20/13 at 9:45am, indicated client #1 "continued to have behavioral difficulties today." The report indicated client #1 hit herself with a rock in the head, cut herself on the arm with a coke can, tried to wrap the phone cord around her neck, stab her left arm with a spoon, bang her head on the floor, ate corn starch to choke herself, and attempted to get TV cords to wrap around her neck. Staff blocked and did restrain the client multiple times. Staff performed the Heimlich maneuver with 2 thrusts to open airway after the cornstarch. First aid was applied and client #1 was transported to the local emergency room for evaluation. Client #1 will be admitted to the behavioral health center.</p> <p>-On 2/20/13 a BDDS report for an incident on 2/19/13 at 6:30pm, indicated client #1 "was having behavioral</p>		completed, and whether thorough follow-up measures have been taken to prevent recurrence.				

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	<p>difficulties" of biting herself, head banging, staff used restraints, bite releases, and followed BSP (Behavior Support Plan). Client #1 making threats of suicide and writing notes about dying. Client #1 placed a marker in her mouth and bit off the top of the marker. Staff asked her to spit it out and client #1 did. Client #1 biting and hitting her head again. Client #1 continued on suicide watch, "not stable today," and suicide watch continued.</p> <p>-On 2/20/13 a BDDS report for an incident on 2/19/13 at 4:40pm, indicated client #1 stabbing herself in the left wrist with a spoon from the sink. Client #1 was restrained after she began to bite herself on left wrist and hand. Client #1 biting self on right wrist 3 times, and restrained again. The report indicated "Plan to resolve:" staff to implement BSP, and counseling appointments to follow up.</p> <p>-On 2/20/13 a BDDS report for an incident on 2/19/13 at 11:15am, indicated client #1 was at a counseling appointment with staff. Client #1 began scratching her Left hand and made a three and one half inch (3 1/2") superficial scratches on left hand. Client #1 was redirected to stop</p>						

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	<p>and did not stop, staff held down client #1's hands. Client #1 began biting her right hand, staff redirected to stop, client #1 did not stop, and staff applied a hand restraint to hold client #1's hands down. During the appointment client #1 told her counselor she was "going to die at 3:30pm by being hit by a train." The report indicated client #1 had scratches on her right hand and a "50 cent" sized bite mark on her right hand. The report indicated "Plan to resolve: IDT and BDDS rep (representative) to generate further recommendations," staff to implement BSP, and counseling appointments to follow up.</p> <p>-On 2/19/13 a BDDS report for an incident on 2/18/13 at 7:15pm, indicated client #1 was "having behavioral difficulties from 7:15pm until 10:50pm, exhibiting SIB (Self Injurious Behaviors)," and staff implemented three (3) separate Mandt restraints (undefined what type of restraints). The report indicated client #1 indicated she was "going to break her leg and then kicked the kitchen cabinet, breaking the front door to the kitchen cabinet." The report indicated client #1 threw a cup against the</p>						

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	<p>wall, scratched her arms, banged her head on the floor, and scratched her arms and face. Client #1 had 3 scratches on her right inner forearm bleeding, a bite mark on top of left hand over a previous bite mark, 2 scratches on right inner forearm with broken skin, 1 scratch on left inner forearm and scratches on left hand with no sizes with broken skin, and was on "Suicide watch due to suicidal gestures from incidents earlier in the day." The report indicated "Plan to resolve: IDT and BDDS rep (representative) to generate further recommendations," staff to implement BSP, and counseling appointments to follow up.</p> <p>-On 2/18/13 a BDDS report for an incident on 2/18/13 at 4:50pm, indicated staff offered client #1 an activity, client #1 got up walked to another room, began to bang her head on wooden door frame, rolled on the floor biting herself, and Mandt restraint applied (no identification of the restraint documented). Client #1 had a golf ball size swollen area in center of forehead and a golf ball size bite on right forearm. The report indicated "Plan to resolve: neuro checks continued, staff to implement BSP, [client #1] supervised</p>			

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	<p>1:1 (one on one supervision), Suicide watch remains in effect, IDT will review weekly."</p> <p>-On 2/18/13 a BDDS report for an incident on 2/18/13 at 4:10pm, indicated client #1 "placed on Suicide Watch an hour earlier due to threats and actual Harm to self." The report indicated client #1 was "sitting in the kitchen, became very quiet, began smacking the table with her hand, and staff redirected." The report indicated client #1 went into the living room, laid on the floor, banged her head, moved on floor toward kitchen continuing to head bang, staff offered use of a weighted blanket (a heavy blanket to cover the client), client #1 continued to bite self on right forearm and head bang, client #1 placed in restraint by staff. Staff noted a bite on right forearm quarter size slightly swollen. "Plan to Resolve: Suicide watch initiated," 1:1 staff supervision at all times, IDT will review incident at least weekly.</p> <p>-On 2/18/13 a BDDS report for an incident on 2/18/13 at 3:05pm, indicated client #1 told staff she wanted "to be dead." The report indicated client #1 told staff she wanted "to kill herself." The</p>						

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	<p>staff called the Behavior Counselor and "initiated a Suicide Protocol" for client #1. Staff removed items from client #1's bedroom, client #1 "began scratching at her left hand and made it bleed." Client #1 began to bite the top of her right hand and client #1 "began to scratch self." Client #1 "then pulled out her head phones from her pocket and began to wrap around her neck. Staff were able to get the headphones away and remove them with no injury. Although the headphones did break. [Client #1] went out of the front door and staff followed. [Client #1] hit her head on the siding of the house." The report indicated client #1 went onto the front porch, sat down, and began to bang her head on the concrete." The report indicated staff intervened each time to redirect and pad the areas between client #1's head and the objects. The report indicated client #1 had 2 1/2" scratches the on top of her left hand. The report indicated "Plan to resolve: Suicide watch was initiated...1:1 staff supervision at all times. IDT will review incident at weekly meeting, headphones will be replaced by AWS when IDT feels it is safe for [client #1] to have possession."</p>			

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	<p>-On 1/29/13 a BDDS report for an incident on 1/28/13 at 11:00pm, indicated client #1 was at a counseling appointment and client #1 stated she was "going to kill herself." Client #1's counselor recommended inpatient treatment and admitted to the hospital.</p> <p>-On 1/28/13 a BDDS report for an incident on 1/28/13 at 3:15am, client #1 told staff she had a headache, received medication for pain of headache, and laid back down. Client #1 told staff she was "angry and did not know why." Client #1 continued to escalate, began scratching her face, client #1 began to bang her head on floor, and kicked staff. The report indicated client #1 was restrained by one staff, then by two staff to prevent injury. Client #1 "continued to scratch and bite her arms. Saying: They don't understand." Client #1 slept the remainder of the night. The report indicated "Plan to resolve:...New order Abilify 15mg (milligrams) will be given in evening." Staff to implement BSP, and counseling appointments to follow up.</p> <p>-On 1/28/13 a BDDS report for an incident on 1/28/13 at 5:25pm, indicated client #1 had been at the Emergency</p>						

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	<p>Room (ER) for evaluation and came home for "a nap." The report indicated client #1 sat at the dining room table began yelling profanities saying she was "crazy." Client #1 "jumped up and grabbed a spoon and began stabbing her left forearm." Two staff struggled with client #1 "went to floor" to remove the spoon. Three staff had to restrain client #1 to remove the spoon. There was no description of the restraints used.</p> <p>-On 1/28/13 a BDDS report for an incident on 1/27/13 at 7:40am, indicated client #1 went into living room with staff and went to the floor, attempting to bang her head. Staff blocked her head from direct contact with objects. Client #1 was placed in an unidentified restraint for ten minutes. Client #1 was released, leaned forward and began to bang her head on the floor five times. Client #1 restrained again for four minutes. The report indicated client #1 had a golf ball size lump on middle of the back of head and some swelling in middle on right side of forehead. To ER for evaluation and possible admission. The report indicated "Attempted to get admitted to [Behavioral Center] for observation but was unable to</p>						

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	<p>get this approved. ER physician did speak to director and [client #1's] Psychiatrist. Psychiatrist increased Abilify from 10mg to 15mg and will see Wed. (Wednesday) for appt. (appointment)."</p> <p>-On 1/27/13 a BDDS report for an incident on 1/27/13 at 6:20pm, indicated client #1 sat on the couch with staff and began to "escalate...threw self to the floor, face first and began to bang her head." The report indicated client #1 hit her head twice and was restrained by two staff. An injury assessment indicated a two inch dent in the center of forehead. The report indicated "Plan to resolve:...staff to implement BSP, New order Abilify 15mg will be given in evening," client #1 will see counselor and psychiatrist on 1/30/13.</p> <p>-On 1/27/13 a BDDS report for an incident on 1/27/13 at 7:12am, indicated client #1 sat on the sofa, began "displaying SIB by punching herself in right thigh, continued to escalate, staff retrained to hold arms to sides, client #1 was "thrashing" around, a third staff held client #1's legs, attempted to head bang. No injuries.</p> <p>-On 1/27/13 a BDDS report for an</p>						

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	<p>incident on 1/26/13 at 7pm, indicated client #1 had behaviors "all day." The report indicated client #1 was at the dining room table with staff and began making statements that "she did not mess with those girls and she did not burn that bridge." Client #1 banging her head on table, client #1 then to the floor, hitting right side of face on table leg, and staff restrained client #1. Client #1 had a swollen line from right eyebrow to the middle of cheek, two small scratches on the top of left hand and on on left elbow. The report indicated "Plan to resolve:" staff to implement BSP, and counseling appointments to follow up. IDT will review this IR (Incident Report) and consult Psychiatrist."</p> <p>-On 1/10/13 a BDDS report for an incident on 1/9/13 at 6:20pm, indicated client #1 "stormed into her room and slammed the door," client #1 did not want staff to "come into" her bedroom. "Staff heard [client #1] throwing items. Behavior Counselor was called. Told staff to go into room, and saw [client #1] had broken a glass jar against her wall and was sitting on floor leaning against wall. Staff began picking up the glass from</p>						

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	<p>floor, [client #1] picked up a small piece of glass and went to cut her L (left) palm." Client #1 refused to give staff the glass and put the glass into her mouth. Staff restrained client #1 and client #1 spit out the glass. Client #1 biting left hand and restrained again. Client placed on Suicide Precautions, staff cleaned room, staff turned their backs to client #1. Client #1 said staff name, staff turned around and client #1 had removed the draw string from her pants and "wrapped around her neck." Staff and QMRP (Qualified Mental Retardation Professional) removed the string in "less than a minute." The report indicated 9-1-1 was called, Sheriff and EMS arrived, ER Physician x-rays of hand, chest, and abdomen, and results were negative. No glass swallowed. The report indicated "Plan to resolve: IDT met. Psychiatrist notified and placed on Abilify 5mg in evening. Appt. 1/11/13 [client #1] remains on suicide watch...IDT meets again to review."</p> <p>-On 12/26/12 a BDDS report for an incident on 12/25/12 at 3:10pm, indicated client #1 asked client #3 to "be quiet" because client #1 had a headache. Client</p>						

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	<p>#3 threw a cup at the television. Staff got between the two clients. Client #3 "destroyed a stuffed monkey" of client #1's. Client #3 ran toward client #1 and bit her on her right breast, client #1 bit client #3 on left shoulder and right temple. Staff separated the two clients and applied restraints. Client #1 was taken to the ER because right breast had open skin. Client #3 had bruised areas.</p> <p>-On 12/1/12 a BDDS report for an incident on 11/30/12 at 8:30pm, indicated client #1 had threatened her roommates with "harm." Client #1 stated she was "going to kill staff," tear up the group home, and "burn the house down." The report indicated client #1 broke her personal belongings and broke her bedroom window and frame.</p> <p>-On 11/20/12 a BDDS report for an incident on 11/19/12 at 5:45pm, indicated client #1 was in bedroom SIB scratching her arms with nails. Client #1 was restrained, client #1 attempted to head bang, staff blocked, and client #1 bite herself on her right hand and left arm. Staff noted a golf ball size bit mark on upper left arm, bit mark on right hand that</p>						

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	<p>was golf ball size and dark in color.</p> <p>Client #1 had a 3" scratch on lower left arm.</p> <p>On 3/7/13 at 3:37pm, an interview with the SD was conducted. The SD indicated client #1 had targeted behaviors of Physical Aggression, Self Injurious Behavior (SIB), Verbal Aggression, AWOL (Absent without Leave) behaviors, and Suicidal Threats. The SD indicated staff implemented client #1's plan each time she displayed the behaviors and when a threat to harm herself was identified staff implemented physical restraints. The SD indicated client #1's BSP remained sufficient to meet client #1's identified needs. The SD indicated client #1 had psychiatric medications changed and continued behavioral counseling. The SD indicated the facility and the agency staff were implementing client #1's BSP. The SD indicated when the facility identified when client #1 was not safe in the group home environment, the agency transferred client #1 to the hospital for further treatment and evaluation. The SD indicated the group home was looking into alternate placement because of client</p>			

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	<p>#1's continued behavioral needs. The SD indicated the corrective action the facility implemented did not effectively resolve client #1's continued behavioral needs and did not effectively resolve client #1's intimidation of others.</p> <p>2. On 2/20/13 at 6:20pm, on 2/20/13 at 7:15pm, and on 2/22/13 at 12:00pm, the facility's BDDS reports from 2/1/12 through 2/20/13 were reviewed and indicated the following for client #2, #3, and #4's peer to peer physical aggression.</p> <p>-On 11/11/12 a BDDS report for an incident on 11/10/12 at 11:30am, indicated client #2 had enough money to purchase fries at McDonalds but not enough for a coke too. Client #2 became upset. Client #2 banged her head on the wall next to pop machine at the restaurant, client #2 "flipped off staff and other clients," client #3 upset and punched client #2 in the face, bit client #2 in the arm, and kicked client #2. Client #2 was taken to the emergency room for injuries and a police report filed because of the disruption inside the restaurant. No corrective action was available for review.</p> <p>-On 11/2/12 a BDDS report for an incident on 11/1/12 at 3:25pm, indicated at day program while walking to a staff</p>						

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	<p>car, client #2 wanted to ride in car with client #3, staff unlocking door to car, and client #3 was angry at client #2. Client #3 hit client #2 and pushed client #2 down, staff placed client #3 in restraint. Once calm client #3 released from restraint, walking back into day program, client #3 picked up a pumpkin threw the pumpkin at the ground. The report indicated client #2 had a "half dollar sized discoloration red and light bruising with quarter size lump on right side of forehead." The report indicated staff followed the clients' Behavior Support Plans. No corrective action was available for review.</p> <p>-On 10/28/12 a BDDS report for an incident on 10/27/12 at 6:00pm, indicated client #3 was upset with another client having behaviors, client #4 threw items, client #2 was told by staff to leave the area because staff were going to restrain client #3, and client #2 did not promptly move out of the way. Client #3 kicked client #2 in right upper leg. Corrective action was for client #2 to move out of the way faster.</p> <p>-On 9/4/12 a BDDS report for an incident on 9/3/12 at 2:50pm, indicated client #4 was hit by peer in the back of the head and her hair was bitten. No corrective action was available for review.</p>						

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	<p>On 3/7/13 at 3:37pm, an interview with the SD was conducted. The SD indicated the facility continues to address peer to peer aggression in an effort to decrease the behaviors. The SD indicated the injuries suffered by the clients from peer to peer physical aggression continue to be a priority to decrease. The SD indicated the staff implemented each clients' BSP, the IDT was reviewing incidents during weekly meetings, and action would be taken based on the discussion and team decisions made. The SD indicated the plan to resolve client to client physical aggression had decreased the incidents of client to client physical aggression. The SD indicated client to client physical aggression had continued at the group home.</p> <p>On 2/20/13 at 7:00pm, the undated facility's policy on abuse "Group Home Abuse and Neglect" was reviewed and indicated: "Purpose. To educate and inform staff of the definition, define reporting requirements and stress that AWS will not tolerate abuse, neglect or exploitation of any kind...Description, AWS does not tolerate abuse in any form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse." The policy indicated:</p>				

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	"Results of the investigation must be reported within 5 days. All corrective action will be written and disseminated to the appropriate entities." 9-3-2(a)				

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review, for 24 of 72 BDDS (Bureau of Developmental Disability Services) Reports reviewed from 2/1/12 through 2/20/13, the facility failed to implement policies/procedures to prevent self harm, and peer aggression/intimidation of clients #1, #2, #3, and #4. Findings include: 1. On 2/20/13 at 6:20pm, on 2/20/13 at 7:15pm, and on 2/22/13 at 12:00pm, the facility's BDDS reports from 2/1/12 through 2/20/13 were reviewed and indicated the following for client #1's behavioral episodes and threats of suicide. -On 3/6/13 a BDDS report for an incident on 3/5/13 at 4:45pm, indicated client #1 "had behavioral difficulties that lasted 2 hours, [client #1] was upset for unknown reason, went into bedroom with staff beside her, hit 1 time on door staff blocked all other attempts." Client #1 sat down on the floor attempting SIB biting, head banging, and attempted to bend her finger back. Staff restrained client #1, released, client #1 walked to the living room, stopped at the fire extinguisher</p>	W000157	<p>W 157 Implementing Policies to Protect Clients from Self Harm and Peer Aggression Corrective action for resident(s) found to have been affected The client who has engaged in significant self-harm and suicidal behaviors remains hospitalized and is being evaluated for alternative placement in a more-restrictive setting. Should she return to the group home, new measures will be put into place, including behavior support changes and medication review by the psychiatrist. Peer aggression will be addressed through a staff training on prevention of behavior problems and intervening earlier in the cycle of behavior problems with a focus on keeping peers safe. Training will be conducted by a certified trainer in Mandt, which is the system of de-escalation and physical intervention used by the residential provider.</p>	04/10/2013			

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	cabinet and banged her head twice, staff blocked all other attempts, and client #1 was restrained again. Client #1 walked to the kitchen grabbed the toaster, hit herself in the head with the toaster. Client #1 dropped to floor, bit self, restrained again, and released when calm. Client #1 up in the kitchen picked up the skillet on the stove and started to swing at staff and hit the oven door. Staff trying to get the skillet from client #1's hands, client #1 hit the oven with the skillet, and broke the oven glass front. Client #1 dropped to the floor on the glass and cut herself on forehead. Staff restrained client #1, client #1 was combative, and client #1 "retrieved a piece of glass and placed in her mouth." Staff asked her to spit out the glass, client #1 refused, and the report indicated client #1 swallowed it. Client #1 was taken to the hospital by ambulance with police assistance. Client #1 was admitted for observation. On 3/7/13 at 3:37pm, an interview with the Site Director (SD) was conducted. The SD indicated client #1 had been discharged from the Hospital unit and was on the behavioral unit as a inpatient stay. The SD indicated client #1 was being		<p>How facility will identify other residents potentially affected & what measures taken</p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>If client returns to group home, BSP changes and psychiatric medication review will take place. A training will be conducted by a certified trainer to address peer aggression. At least quarterly at a staff meeting, procedures to prevent peer aggression will be reviewed.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The IDT meets regularly and reviews each incident report and generates plans to address problems, including self-harm and peer aggression. Additionally, an Incident Oversight Committee comprised of the Director, an agency Vice President, and a Compliance Officer reviews each incident to ensure timeliness, if investigations are needed and completed, and whether thorough</p>				

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	<p>considered for admission to the State Hospital. The SD indicated client #1 had returned to the group home after the previous inpatient stay for a couple of days when this incident occurred at the group home. No effective corrective action was available to review.</p> <p>-On 2/20/13 a BDDS report for an incident on 2/20/13 at 9:45am, indicated client #1 "continued to have behavioral difficulties today." The report indicated client #1 hit herself with a rock in the head, cut herself on the arm with a coke can, tried to wrap the phone cord around her neck, stab her left arm with a spoon, bang her head on the floor, ate corn starch to choke herself, and attempted to get TV cords to wrap around her neck. Staff blocked and did restrain the client multiple times. Staff performed the Heimlich maneuver with 2 thrusts to open airway after the cornstarch. First aid was applied and client #1 was transported to the local emergency room for evaluation. Client #1 will be admitted to the behavioral health center. No effective corrective action was available to review.</p>		follow-up measures have been taken to prevent recurrence.				

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	<p>-On 2/20/13 a BDDS report for an incident on 2/19/13 at 6:30pm, indicated client #1 "was having behavioral difficulties" of biting herself, head banging, staff used restraints, bite releases, and followed BSP (Behavior Support Plan). Client #1 making threats of suicide and writing notes about dying. Client #1 placed a marker in her mouth and bit off the top of the marker. Staff asked her to spit it out and client #1 did. Client #1 biting and hitting her head again. Client #1 continued on suicide watch, "not stable today," and suicide watch continued. No effective corrective action was available to review.</p> <p>-On 2/20/13 a BDDS report for an incident on 2/19/13 at 4:40pm, indicated client #1 stabbing herself in the left wrist with a spoon from the sink. Client #1 was restrained after she began to bite herself on left wrist and hand. Client #1 biting self on right wrist 3 times, and restrained again. The report indicated "Plan to resolve:" staff to implement BSP, and counseling appointments to follow up. No effective corrective action was available to review.</p>						

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	<p>-On 2/20/13 a BDDS report for an incident on 2/19/13 at 11:15am, indicated client #1 was at a counseling appointment with staff. Client #1 began scratching her Left hand and made a three and one half inch (3 1/2") superficial scratches on left hand. Client #1 was redirected to stop and did not stop, staff held down client #1's hands. Client #1 began biting her right hand, staff redirected to stop, client #1 did not stop, and staff applied a hand restraint to hold client #1's hands down. During the appointment client #1 told her counselor she was "going to die at 3:30pm by being hit by a train." The report indicated client #1 had scratches on her right hand and a "50 cent" sized bite mark on her right hand. The report indicated "Plan to resolve: IDT and BDDS rep (representative) to generate further recommendations," staff to implement BSP, and counseling appointments to follow up. No effective corrective action was available to review.</p> <p>-On 2/19/13 a BDDS report for an incident on 2/18/13 at 7:15pm, indicated client #1 was "having behavioral</p>						

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	<p>difficulties from 7:15pm until 10:50pm, exhibiting SIB (Self Injurious Behaviors)," and staff implemented three (3) separate Mandt restraints (undefined what type of restraints). The report indicated client #1 indicated she was "going to break her leg and then kicked the kitchen cabinet, breaking the front door to the kitchen cabinet." The report indicated client #1 threw a cup against the wall, scratched her arms, banged her head on the floor, and scratched her arms and face. Client #1 had 3 scratches on her right inner forearm bleeding, a bite mark on top of left hand over a previous bite mark, 2 scratches on right inner forearm with broken skin, 1 scratch on left inner forearm and scratches on left hand with no sizes with broken skin, and was on "Suicide watch due to suicidal gestures from incidents earlier in the day." The report indicated "Plan to resolve: IDT and BDDS rep (representative) to generate further recommendations," staff to implement BSP, and counseling appointments to follow up. No effective corrective action was available to review.</p> <p>-On 2/18/13 a BDDS report for an</p>			

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	<p>incident on 2/18/13 at 4:50pm, indicated staff offered client #1 an activity, client #1 got up walked to another room, began to bang her head on wooden door frame, rolled on the floor biting herself, and Mandt restraint applied (no identification of the restraint documented). Client #1 had a golf ball size swollen area in center of forehead and a golf ball size bite on right forearm. The report indicated "Plan to resolve: neuro checks continued, staff to implement BSP, [client #1] supervised 1:1 (one on one supervision), Suicide watch remains in effect, IDT will review weekly." No effective corrective action was available to review.</p> <p>-On 2/18/13 a BDDS report for an incident on 2/18/13 at 4:10pm, indicated client #1 "placed on Suicide Watch an hour earlier due to threats and actual Harm to self." The report indicated client #1 was "sitting in the kitchen, became very quiet, began smacking the table with her hand, and staff redirected." The report indicated client #1 went into the living room, laid on the floor, banged her head, moved on floor toward kitchen continuing to head bang, staff offered use</p>						

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	<p>of a weighted blanket (a heavy blanket to cover the client), client #1 continued to bite self on right forearm and head bang, client #1 placed in restraint by staff. Staff noted a bite on right forearm quarter size slightly swollen. "Plan to Resolve: Suicide watch initiated," 1:1 staff supervision at all times, IDT will review incident at least weekly. No effective corrective action was available to review.</p> <p>-On 2/18/13 a BDDS report for an incident on 2/18/13 at 3:05pm, indicated client #1 told staff she wanted "to be dead." The report indicated client #1 told staff she wanted "to kill herself." The staff called the Behavior Counselor and "initiated a Suicide Protocol" for client #1. Staff removed items from client #1's bedroom, client #1 "began scratching at her left hand and made it bleed." Client #1 began to bite the top of her right hand and client #1 "began to scratch self." Client #1 "then pulled out her head phones from her pocket and began to wrap around her neck. Staff were able to get the headphones away and remove them with no injury. Although the headphones did break. [Client #1] went</p>			

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	<p>out of the front door and staff followed. [Client #1] hit her head on the siding of the house." The report indicated client #1 went onto the front porch, sat down, and began to bang her head on the concrete." The report indicated staff intervened each time to redirect and pad the areas between client #1's head and the objects. The report indicated client #1 had 2 1/2" scratches the on top of her left hand. The report indicated "Plan to resolve: Suicide watch was initiated...1:1 staff supervision at all times. IDT will review incident at weekly meeting, headphones will be replaced by AWS when IDT feels it is safe for [client #1] to have possession." No effective corrective action was available to review.</p> <p>-On 1/29/13 a BDDS report for an incident on 1/28/13 at 11:00pm, indicated client #1 was at a counseling appointment and client #1 stated she was "going to kill herself." Client #1's counselor recommended inpatient treatment and admitted to the hospital. No effective corrective action was available to review.</p> <p>-On 1/28/13 a BDDS report for an</p>						

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	<p>incident on 1/28/13 at 3:15am, client #1 told staff she had a headache, received medication for pain of headache, and laid back down. Client #1 told staff she was "angry and did not know why." Client #1 continued to escalate, began scratching her face, client #1 began to bang her head on floor, and kicked staff. The report indicated client #1 was restrained by one staff, then by two staff to prevent injury. Client #1 "continued to scratch and bite her arms. Saying: They don't understand." Client #1 slept the remainder of the night. The report indicated "Plan to resolve:...New order Abilify 15mg (milligrams) will be given in evening." Staff to implement BSP, and counseling appointments to follow up. No effective corrective action was available to review.</p> <p>-On 1/28/13 a BDDS report for an incident on 1/28/13 at 5:25pm, indicated client #1 had been at the Emergency Room (ER) for evaluation and came home for "a nap." The report indicated client #1 sat at the dining room table began yelling profanities saying she was "crazy." Client #1 "jumped up and grabbed a spoon and began stabbing her</p>						

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	<p>left forearm." Two staff struggled with client #1 "went to floor" to remove the spoon. Three staff had to restrain client #1 to remove the spoon. There was no description of the restraints used. No effective corrective action was available to review.</p> <p>-On 1/28/13 a BDDS report for an incident on 1/27/13 at 7:40am, indicated client #1 went into living room with staff and went to the floor, attempting to bang her head. Staff blocked her head from direct contact with objects. Client #1 was placed in an unidentified restraint for ten minutes. Client #1 was released, leaned forward and began to bang her head on the floor five times. Client #1 restrained again for four minutes. The report indicated client #1 had a golf ball size lump on middle of the back of head and some swelling in middle on right side of forehead. To ER for evaluation and possible admission. The report indicated "Attempted to get admitted to [Behavioral Center] for observation but was unable to get this approved. ER physician did speak to director and [client #1's] Psychiatrist. Psychiatrist increased</p>						

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	<p>Abilify from 10mg to 15mg and will see Wed. (Wednesday) for appt. (appointment)." No effective corrective action was available to review.</p> <p>-On 1/27/13 a BDDS report for an incident on 1/27/13 at 6:20pm, indicated client #1 sat on the couch with staff and began to "escalate...threw self to the floor, face first and began to bang her head." The report indicated client #1 hit her head twice and was restrained by two staff. An injury assessment indicated a two inch dent in the center of forehead. The report indicated "Plan to resolve:...staff to implement BSP, New order Abilify 15mg will be given in evening," client #1 will see counselor and psychiatrist on 1/30/13. No effective corrective action was available to review.</p> <p>-On 1/27/13 a BDDS report for an incident on 1/27/13 at 7:12am, indicated client #1 sat on the sofa, began "displaying SIB by punching herself in right thigh, continued to escalate, staff retrained to hold arms to sides, client #1 was "thrashing" around, a third staff held client #1's legs, attempted to head bang.</p>			

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	<p>No injuries. No effective corrective action was available to review.</p> <p>-On 1/27/13 a BDDS report for an incident on 1/26/13 at 7pm, indicated client #1 had behaviors "all day." The report indicated client #1 was at the dining room table with staff and began making statements that "she did not mess with those girls and she did not burn that bridge." Client #1 banging her head on table, client #1 then to the floor, hitting right side of face on table leg, and staff restrained client #1. Client #1 had a swollen line from right eyebrow to the middle of cheek, two small scratches on the top of left hand and on on left elbow. The report indicated "Plan to resolve:" staff to implement BSP, and counseling appointments to follow up. IDT will review this IR (Incident Report) and consult Psychiatrist." No effective corrective action was available to review.</p> <p>-On 1/10/13 a BDDS report for an incident on 1/9/13 at 6:20pm, indicated client #1 "stormed into her room and slammed the door," client #1 did not want staff to "come into" her bedroom. "Staff</p>						

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	<p>heard [client #1] throwing items. Behavior Counselor was called. Told staff to go into room, and saw [client #1] had broken a glass jar against her wall and was sitting on floor leaning against wall. Staff began picking up the glass from floor, [client #1] picked up a small piece of glass and went to cut her L (left) palm." Client #1 refused to give staff the glass and put the glass into her mouth. Staff restrained client #1 and client #1 spit out the glass. Client #1 biting left hand and restrained again. Client placed on Suicide Precautions, staff cleaned room, staff turned their backs to client #1. Client #1 said staff name, staff turned around and client #1 had removed the draw string from her pants and "wrapped around her neck." Staff and QMRP (Qualified Mental Retardation Professional) removed the string in "less than a minute." The report indicated 9-1-1 was called, Sheriff and EMS arrived, ER Physician x-rays of hand, chest, and abdomen, and results were negative. No glass swallowed. The report indicated "Plan to resolve: IDT met. Psychiatrist notified and placed on Abilify 5mg in evening. Appt. 1/11/13</p>				

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	<p>[client #1] remains on suicide watch...IDT meets again to review." No corrective action was available to review.</p> <p>-On 12/26/12 a BDDS report for an incident on 12/25/12 at 3:10pm, indicated client #1 asked client #3 to "be quiet" because client #1 had a headache. Client #3 threw a cup at the television. Staff got between the two clients. Client #3 "destroyed a stuffed monkey" of client #1's. Client #3 ran toward client #1 and bit her on her right breast, client #1 bit client #3 on left shoulder and right temple. Staff separated the two clients and applied restraints. Client #1 was taken to the ER because right breast had open skin. Client #3 had bruised areas.</p> <p>-On 12/1/12 a BDDS report for an incident on 11/30/12 at 8:30pm, indicated client #1 had threatened her roommates with "harm." Client #1 stated she was "going to kill staff," tear up the group home, and "burn the house down." The report indicated client #1 broke her personal belongings and broke her bedroom window and frame. No corrective action was available to review.</p>						

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	<p>-On 11/20/12 a BDDS report for an incident on 11/19/12 at 5:45pm, indicated client #1 was in bedroom SIB scratching her arms with nails. Client #1 was restrained, client #1 attempted to head bang, staff blocked, and client #1 bite herself on her right hand and left arm. Staff noted a golf ball size bit mark on upper left arm, bit mark on right hand that was golf ball size and dark in color. Client #1 had a 3" scratch on lower left arm. No corrective action was available to review.</p> <p>On 3/7/13 at 3:37pm, an interview with the SD was conducted. The SD indicated client #1 had targeted behaviors of Physical Aggression, Self Injurious Behavior (SIB), Verbal Aggression, AWOL (Absent without Leave) behaviors, and Suicidal Threats. The SD indicated staff implemented client #1's plan each time she displayed the behaviors and when a threat to harm herself was identified staff implemented physical restraints. The SD indicated client #1's BSP remained sufficient to meet client #1's identified needs. The SD indicated client #1 had psychiatric</p>						

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	<p>medications changed and continued behavioral counseling. The SD indicated the facility and the agency staff were implementing client #1's BSP. The SD indicated when the facility identified when client #1 was not safe in the group home environment, the agency transferred client #1 to the hospital for further treatment and evaluation. The SD indicated the group home was looking into alternate placement because of client #1's continued behavioral needs. The SD indicated the corrective action the facility implemented did not effectively resolve client #1's continued behavioral needs and did not effectively resolve client #1's intimidation of others.</p> <p>2. On 2/20/13 at 6:20pm, on 2/20/13 at 7:15pm, and on 2/22/13 at 12:00pm, the facility's BDDS reports from 2/1/12 through 2/20/13 were reviewed and indicated the following for client #2, #3, and #4's peer to peer physical aggression. -On 11/11/12 a BDDS report for an incident on 11/10/12 at 11:30am, indicated client #2 had enough money to purchase fries at McDonalds but not enough for a coke too. Client #2 became upset. Client #2 banged her head on the</p>						

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	<p>wall next to pop machine at the restaurant, client #2 "flipped off staff and other clients." Client #3 upset and punched client #2 in the face, bit client #2 in the arm, and kicked client #2. Client #2 was taken to the emergency room for injuries and a police report filed because of the disruption inside the restaurant. No corrective action was available for review.</p> <p>-On 11/2/12 a BDDS report for an incident on 11/1/12 at 3:25pm, indicated at day program while walking to a staff car, client #2 wanted to ride in car with client #3, staff unlocking door to car, and client #3 was angry at client #2. Client #3 hit client #2 and pushed client #2 down, staff placed client #3 in restraint. Once calm client #3 released from restraint, walking back into day program, client #3 picked up a pumpkin threw the pumpkin at the ground. The report indicated client #2 had a "half dollar sized discoloration red and light bruising with quarter size lump on right side of forehead." The report indicated staff followed the clients Behavior Support Plans. No corrective action was available for review.</p> <p>-On 10/28/12 a BDDS report for an incident on 10/27/12 at 6:00pm, indicated client #3 was upset with another client having behaviors, client #4 threw items,</p>				

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	<p>client #2 was told by staff to leave the area because staff were going to restrain client #3, and client #2 did not promptly move out of the way. Client #3 kicked client #2 in right upper leg. Corrective action was for client #2 to move out of the way faster.</p> <p>-On 9/4/12 a BDDS report for an incident on 9/3/12 at 2:50pm, indicated client #4 was hit by peer in the back of the head and her hair was bitten. No corrective action was available for review.</p> <p>On 3/7/13 at 3:37pm, an interview with the SD was conducted. The SD indicated the facility continues to address peer to peer aggression in an effort to decrease the behaviors. The SD indicated the injuries suffered by the clients from peer to peer physical aggression continue to be a priority to decrease. The SD indicated the staff implemented each clients' BSP, the IDT was reviewing incidents during weekly meetings, and action would be taken based on the discussion and team decisions made. The SD indicated the plan to resolve client to client physical aggression had decreased the incidents of client to client physical aggression. The SD indicated client to client physical aggression had continued at the group home.</p>						

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</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, for 4 of 4 clients (clients #1, #2, #3, and #4) living in the group home, the facility failed to administer medications without error and as prescribed by the clients' personal physician.</p> <p>Findings include:</p> <p>On 2/20/13 at 6:20pm, on 2/20/13 at 7:15pm, and on 2/22/13 at 12:00pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 2/1/12 through 2/20/13 were reviewed and indicated the following for client #1, #2, #3, and #4's medication errors.</p> <p>For client #1.</p> <p>-On 1/22/13 a BDDS report for an incident on 1/21/13 at 8pm, indicated during medication pass, client #1 "did not have any Amitiza (for constipation) left to be given."</p> <p>-On 11/20/12 a BDDS report for an incident on 11/19/12 at 4pm, indicated client #1 "was sent with her routine medications and Saturday morning she had a headache...AWS nurse had staff go</p>	W000368	<p>W 368</p> <p>Medication Errors</p> <p>Corrective action for resident(s) found to have been affected</p> <p>All staff receive training on medication administration prior to giving clients medications. Additionally, staff are retrained whenever a medication error occurs. A new procedure will be implemented that includes sequential actions for all future medication errors. The first error will require retraining. Subsequent errors will include disciplinary action that can lead to suspension from work without pay and eventual termination.</p> <p>How facility will identify other residents potentially affected & what measures taken</p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p>	04/10/2013			

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	<p>get a small bottle of Ibuprofen since it is an over the counter medication so [client #1] would be able to take it and not have to wait for pharmacy to get it in, the tablets in the bottle were 200mg (milligrams) so the MAR (Medication Administration Record) said to give 3 tablets to equal 600mg which is how much she is to receive. Saturday afternoon her medications came in from Pharmacy and the order on the card from Pharmacy reads Ibuprofen 600mg give one tablet every 8 hours for pain/fever." The report indicated "staff read the order on the MAR and it said to give 3 tablets, the order didn't get changed on the MAR sheet when the (Pharmacy medication) cards came in to match the card and (staff) punched 3 of the 600mg tabs and gave [client #1] 3 of the 600mg tabs she dated and signed the card for all 3 tabs she gave."</p> <p>Client #1's record was reviewed on 2/25/13 at 9:15am. Client #1's 11/2012 "Physician's Order" indicated Amitiza 24mcg (microgram), give one cap orally once a day for constipation and Ibuprofen 600mg "give 1 tablet orally every 8 hours as needed for pain/fever." Client #1 had a physician's order 2/1/13 "Abilify 15mg, (for behaviors) give 1 tab orally daily at med (medication) time."</p>		<p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>A new procedure of sequential actions that will make staff members more accountable for errors committed. Additionally, the IDT will assess possible new ways to reduce the likelihood of errors occurring. This will include attempts to reduce distractions whenever staff are administering medication.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>Staff are supervised by the Group Home Manager who will keep track of medication errors and will implement any discipline up to and including possible termination. The Group Home Manager is supervised by the Director who monitors all disciplinary action. They meet regularly.</p>				

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	<p>Client #1's 2/2013 MAR was reviewed on 2/28/13 at 5pm, and indicated the following.</p> <p>-On 2/15/13 at 8pm, client #1's "Abilify 15mg 1 tab was "not given, none on card, none found."</p> <p>For client #2.</p> <p>-On 2/18/13 a BDDS report for an incident on 2/18/13 at 8am, indicated client #2 had been placed on Bactrim DS (an antibiotic) for acute sinus infection and on 2/15/13 the medication was not given.</p> <p>-On 1/24/13 a BDDS report for an incident on 1/22/13 at 8pm, indicated client #2 was "prescribed Buspar 15mg 1/2 tab for 7 days then 15mg BID (twice daily) for anxiety." The report indicated the medication was started on 1/22/13 order was written incorrectly on the 1/2013 MAR, so both the 1/2 tab and full tab were started at the same time. Client #2 received too much medication.</p> <p>-On 10/12/12 a BDDS report for an incident on 10/12/12 at 9:45am, indicated client #2 had an "increase in her Topamax (for behaviors) to 100mg twice daily and had been receiving 2 (two) 50mg tablets." on 10/8/12, 10/9/12, and 10/11/12 at 8am and on 10/9/12 and 10/11/12 client #2 "received 1 (one) 50mg tab." Client #2</p>						

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	<p>did not receive the correct dose of medication.</p> <p>Client #2's record was reviewed on 2/25/12 at 9am. Client #2's 2/10/13 "Physician's Order" indicated Bactrim DS 1 tablet by mouth twice daily, Buspar 15mg, give 1 tablet 2 times a day for anxiety, and "Topamax 50mg tablet, give 1 tablet 2 orally 2 times a day for aggression/mood (changed 11/29/12)."</p> <p>For client #3. -On 10/16/12 a BDDS report for an incident on 10/16/12 at 8:30am, indicated the group home received an "order for Mucinex D ER (extended release) 600mg 60 mg tablet (for congestion), one tab orally 2 times a day x (times) 10 days. This medication was started last night at 8pm. The medication sent was not in a bubble pack, but a card of 18 pills and 2 pills separate and were packaged in a bag with a label. Staff gave 1 dose last night using 1 of the 2 single pills. This morning staff was giving the AM (morning) dose and noted the other single pill was different size than the pack of 18. Staff notified the nurse, and the GH Nurse went out to the home and evaluated the concern. The Nurse discovered the Pharmacy sent 18 tabs of the Mucinex D ER 600mg-60mg and they sent 2 tablets of Mucinex D ER Maximum Strength</p>						

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	<p>1200mg-120mg which staff gave one of these to [client #3] last night." The pharmacy had mislabeled the bag and client #3 did not receive the correct dose.</p> <p>On 2/28/13 at 5:30pm, client #3's 2/2013 MAR and 2/10/13 "Physician's Order" were reviewed and did not indicate the use of Mucinex D ER 600mg-60mg.</p> <p>For client #4.</p> <p>-On 12/31/12 a BDDS report for an incident on 12/31/12 at 8am, indicated client #4 was "supposed to be done with her medication for ringworm and there were two pills left. After some investigation it was noted that on 12/22/12 and on 12/23/12 [client #4] was given half of the correct dose and therefore, there were two pills left when there should have been no pills remaining."</p> <p>-On 11/12/12 a BDDS report for an incident on 11/11/12 at 8am, indicated the "nurse found a med error that occurred during the 8am med (medication) pass on 11/11/12." Client #4 was not given her Olanzapine (anti psychotic medication) 10mg at 8am on 11/11/12.</p> <p>On 2/28/13 at 5:45pm, client #4's 2/10/13 "Physician's Order" was reviewed and indicated "Olanzapine 10mg (anti</p>			

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	<p>psychotic medication), give 1 tablet orally 2 times a day for Impulse Control Disorder."</p> <p>On 2/25/13 at 12:15pm, an interview with the agency nurse was conducted. The agency nurse indicated staff should administer medications according to physician's orders. The agency nurse indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders and should have been.</p> <p>On 2/25/13 at 12:15pm, a review of the facility's 11/30/12 Medication Administration Policy and Procedure was conducted. The policy and procedure indicated staff should administer client medications according to physician's orders.</p> <p>9-3-6(a)</p>			

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W000391	<p>483.460(m)(2)(ii) DRUG LABELING</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation, record review, and interview, for 1 of 15 medications observed administered (client #4), the facility failed to ensure each medication was labeled.</p> <p>Findings include:</p> <p>On 2/20/13 at 4:00pm, the facility's Group Home Staff (GHS) #3 entered the medication room and selected client #4's unlabeled Neil Med Sinus Rinse (Saline Nasal Rinse) medication for allergies which was inside the locked medication cabinet. GHS #3 opened one package of medication from the unlabeled box and mixed 8 ounces of distilled water into an ear irrigation apparatus with the saline nasal rinse. GHS #3 then heated the mixture in the microwave. GHS #3 handed the heated mixture in the apparatus to client #4, instructed her to "angle it into her ear," and client #4 rinsed each ear with the mixture. No label identifying the medication as client #4's was on the box. At 4:10pm, client #4's MAR (Medication Administration Record) indicated "Saline Irrigation, sinus rinse 3x (three times) a day follow directions on box. Angle towards ears</p>	W000391	<p>W 391 Medication Labeling Corrective action for resident(s) found to have been affected The medication cited will have a label added by the nurse unless its use is discontinued prior to the date this plan of correction is to be completed. Staff will receive a training that all medications need a label and that the nurse needs to be notified if a medication is unlabeled or a label becomes illegible. How facility will identify other residents potentially affected & what measures taken All residents potentially affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Label corrected and staff trained. Additionally, the nurse will conduct a label audit of all medications across the home to ensure that all medications have proper labeling. How corrective actions will be monitored to ensure no recurrence The staff and the Nurse are responsible to ensure that all medications are appropriately labeled. The Nurse is responsible for training staff on medication related requirements.</p>	04/10/2013			

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	<p>when rinsing."</p> <p>On 2/25/13 at 12:15pm, client #4's 2/10/13 "Physician's Order" did not indicate the use of Neil Sinus Rinse for client #4's ears.</p> <p>On 2/25/13 at 12:15pm, an interview with the agency Nurse was conducted. The agency Nurse indicated client #4's medication should have had a pharmacy label on the medication. The agency Nurse indicated client #4's medication did not have a pharmacy label on it.</p> <p>9-3-6(a)</p>		The Director supervises the Nurse, and they meet regularly.		

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W000417	<p>483.470(b)(4)(i) CLIENT BEDROOMS</p> <p>The facility must provide each client with a separate bed of proper size and height for the convenience of the client.</p> <p>Based on observation, record review, and interview, for 1 of 2 sampled clients (client #1) who lived at the group home, the facility failed to ensure client #1 was provided with a bed available for use if and when client #1 choose to sleep in a bed.</p> <p>Findings include:</p> <p>During observations on 2/20/13 from 3:00pm until 6:05pm, and on 2/21/13 from 6:00am until 8:00am at the group home, client #1's bedroom was not equipped with a functional bed. Client #1's bedroom had an oversized bean bag on the floor and no other furniture in the room. On 2/20/13 at 4:25pm, the Residential Manager (RM) and the Surveyor inspected inside the locked garage. A single twin box spring portion of a bed with holes in the bottom was against the wall of the garage. At 4:25pm, the RM indicated the holes in the bottom of the twin box spring portion of the bed were the result of client #1 trying to remove the springs to kill herself. At 4:25pm, the RM indicated no mattress was available for use.</p>	W000417	<p>W 417 Client Bed Corrective action for resident(s) found to have been affected The client prefers to sleep on a bean bag rather than a bed. She had a bed in her room and asked that it be removed. Prior to its eventual removal, she destroyed the mattress. The mattress and box spring were removed, and the destroyed mattress was discarded. A new mattress will be purchased so that the client will have access to a regular bed should she decide that she no longer wants to sleep on a bean bag instead. How facility will identify other residents potentially affected & what measures taken All residents potentially affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Mattress purchase. How corrective actions will be monitored to ensure no recurrence The IDT meets regularly and decided that it was okay to honor the client's bedding choice, which is sleeping on a bean bag. The Group Home Manager is responsible for maintenance needs, including furniture purchases. The Director</p>	04/10/2013			

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	<p>On 2/20/13 at 4:25pm, the facility's maintenance items to be repaired and/or replaced was requested from the RM and none had been completed to address the clients' bedding needs.</p> <p>An interview with the Site Director (SD) was conducted on 3/7/13 at 3:37pm. At 3:37pm, the SD indicated client #1 did not use a bed to sleep in. The SD indicated a bed should have been available at the group home so client #1 had access to a bed.</p> <p>9-3-7(a)</p>		supervises the Group Home Manager. At regular team meetings that include both the Director and Group Home Manager, there will be an agenda item on home maintenance.		

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 2 sampled clients (client #2) who wore prescribed eye glasses, the facility failed to to teach and encourage client #2 to wear her prescribed eye glasses.</p> <p>Findings include:</p> <p>During observations on 2/20/13 from 3:00pm until 6:05pm at the group home, on 2/21/13 from 6:00am until 8:00am at the group home, and on 2/20/13 from 10:50am until 12:15pm at the facility owned day service, client #2 was not prompted and was not encouraged to wear her prescribed eye glasses.</p> <p>Client #2's record was reviewed on 2/25/13 at 9:00am. Client #2's 5/3/12 ISP (Individual Support Plan) did not include a goal/objective to wear her prescribed eye glasses. Client #2's 5/24/12 vision assessment indicated she wore prescribed eye glasses. Client #2's 2/10/13 "Physician's Order" indicated "Glasses to be checked, cleaned every AM (morning),</p>	W000436	<p>W 436 Clients' Glasses</p> <p>Corrective action for resident(s) found to have been affected A reminder is now on the MAR for each client with glasses so staff will encourage wearing them daily. Glasses wearing is described on the ISP as is the prompting on the MAR.</p> <p>How facility will identify other residents potentially affected & what measures taken All residents potentially affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Staff will encourage clients to wear their glasses daily during medication pass, and the prompt is on the MAR to remind staff. How corrective actions will be monitored to ensure no recurrence The ISPs are monitored by the QDDP and the IDT at regular meetings.</p>	04/10/2013			

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	<p>notify nurse if glasses need repair." Client #2's 2/2013 MAR (Medication Administration Record) indicated "Glasses to be checked & (and) cleaned every AM" and indicated facility staff had initialed as completed daily from 2/1/13 through 2/20/13.</p> <p>An interview with the Site Director (SD) was conducted on 3/7/13 at 3:37pm. At 3:37pm, the SD indicated client #2 should have been taught and encouraged during formal and informal opportunities to wear her prescribed eye glasses.</p> <p>9-3-7(a)</p>			

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W000455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation, record review, and interview, for 3 of 3 clients (clients #2, #3, and #4) who consumed the evening meal and were at the facility owned day service site, the facility staff failed to teach and encourage clients to use sanitary methods during cooking and dining opportunities.</p> <p>Finding include:</p> <p>On 2/20/13 at 5:00pm, Group Home Staff (GHS) #1 was in the kitchen of the group home cooking with client #2. At 5:00pm, GHS #1 stood at the stove, stirred the pan of noodles, put his bare fingers into the hot pan of water, removed a single noodle, placed it into his mouth, wiped his lips, and indicated the noodles were done. No handwashing was completed. At 5:15pm, client #4 with GHS #1 emptied the drained noodles into a baking dish. From 5:15pm until 5:45pm, client #2 colored in a book at the dining room table, sorted soiled laundry and started the washer then laid on the sofa under a blanket. Client #3 colored at the table and was in her bedroom watching television. Client #4 was in her bedroom, put on her coat, walked to the kitchen,</p>	W000455	<p>W 455</p> <p>Hand Washing</p> <p>Corrective action for resident(s) found to have been affected</p> <p>The staff member who did not wash his hands will be retrained. All staff members will be trained on the need for staff and clients to wash hands in order to maintain a sanitary environment, including before table setting, food preparation, eating, and after laundry duties or using the bathroom.</p> <p>How facility will identify other residents potentially affected & what measures taken</p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p>	04/10/2013			

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	<p>and stood in the kitchen. At 5:45pm, GHS #1 asked clients #2, #3, and #4 to set the dining room table. From 5:45pm until 6:00pm, clients #2 and #4 set the dining room table and did not clean or wipe off the table before setting plates, silverware, and glasses on the table. Clients #2 and #4 did not wash their hands before setting the table. At 6:00pm, clients #2, #3, and #4 sat down for dinner at the dining room table and were not taught or encouraged to wash their hands before the meal.</p> <p>Client #2's record was reviewed on 2/25/13 at 9:00am. Client #2's 5/3/12 ISP (Individual Support Plan) did not indicate a goal/objective to wash her hands before meals and setting the table.</p> <p>On 2/25/13 at 12:15pm, an interview was conducted with the agency Nurse The agency Nurse indicated clients #2, #3, and #4 should have been redirected to wash their hands before cooking and setting the table. The agency Nurse indicated GHS #1 should not have placed his fingers into the cooking pan.</p> <p>9-3-7(a)</p>		<p>Training will occur.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The Group Home manager trains the staff and is supervised by the Director. They meet regularly.</p>				