

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
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NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 12/11/12, 12/12/12, 12/13/12, 12/14/12, 12/17/12 and 12/19/12.</p> <p>Facility Number: 000927 Provider Number: 15G413 AIMS Number: 10024440</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed December 27, 2012 by Dotty Walton, 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><b>483.410(a)(1) GOVERNING BODY</b> The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#1 and #2), the governing body failed to exercise budgeting and operating direction over the facility to ensure the facility did not allow client #1 to pay for adaptive equipment repairs. The governing body failed to exercise budgeting and operating direction over the facility to ensure client #2 received his SSI (Supplemental Security Income).</p> <p>Findings include:</p> <p>1. Client #1's financial record was reviewed on 12/12/12 at 9:50 AM. Client #1's financial record indicated the following entry:</p> <p>-9/13/12, glasses repair, \$25.00 debit.</p> <p>Interview with CS (clinical supervisor) #1 and QMRP/D (Qualified Mental Retardation Professional Designee) #1 on 12/12/12 at 2:00 PM indicated client #1 paid \$25.00 for eyeglasses repair on 9/13/12. CS #1 and QMRP/D #1 indicated client #1 should not pay for adaptive equipment repairs. CS #1 and QMRP/D #1 indicated client #1 should be</p>	W0104	<p><b>CORRECTION:</b> <i>The Governing body must exercise general policy, budget and operating direction over the facility. Specifically, the governing body has reimbursed Client #1 in the amount of \$25.00 to cover the cost of repairs to his eyeglasses and Client #2 now receives monthly SSI payments.</i></p> <p><b>PREVENTION:</b> The QDDP will receive additional training regarding the facility's responsibility to provide funding to furnish and maintain adaptive equipment for all clients. Additionally, the facility will coordinate with the agency's Business Department as part of its admissions process to assure that new clients have access to all available benefits. Members of the Operations and Quality Assurance Teams will include audits of client finances as part of an ongoing facility audit process which will include assuring that clients do not pay for adaptive equipment from their personal funds and that clients have access to Supplemental Security Income and other benefits as appropriate when they are admitted to the facility.</p> <p><b>RESPONSIBLE PARTIES:</b></p>	01/18/2013			

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	<p>reimbursed \$25.00 for the 9/13/12 eyeglasses repair.</p> <p>2. Client #2's financial record was reviewed on 12/12/12 at 9:50 AM. Client #2's RFMSS (Resident Fund Management Service Statement) from 9/1/12 through 12/12/12 was reviewed. Client #2's RFMSS indicated client #2 had an opening balance of \$0.00 and had no transactions in this period. Client #2's record did not indicate SSI deposits, petty cash or other funds available for client #2.</p> <p>Interview with CS (clinical supervisor) #1 and QMRP/D (Qualified Mental Retardation Professional Designee) #1 on 12/12/12 at 2:00 PM indicated client #2 had been transferred to the group home from another group home within the agency on 4/23/12. QMRP/D #1 and CS #1 indicated client #2's SSI funds had not been transferred or reapplied for when client #2 was admitted to his current group home.</p> <p>9-3-1(a)</p>		QDDPD, Team Lead, Direct Support Professionals, Business Department, Quality Assurance Team, Operations Team	

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W0112	<p>483.410(c)(2) CLIENT RECORDS</p> <p>The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#3) plus 2 additional clients (#6 and #7), the facility failed to ensure the confidentiality of the clients' medical information.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/12/12 from 5:45 AM through 7:45 AM. At 7:40 AM the medication administration area trash can had five individual client PPM (Pharmacy Packaged Medications) inside of it. The trash can contained client #3's 12/12/12 7:00 AM PPM for Fluoxetine 20 milligram (anti depressant), client #6's 12/12/12 7:00 AM PPM for Strattera 3 milligrams (behaviors), client #7's 12/12/12 7:00 AM PPM for Naproxen 500 milligrams (anti-inflammatory), propranolol 1 milligram (hypertension) and fluoxetine 20 milligrams. The client's PPM's had ink pen lines drawn through the clients' names. Staff #1 and/or QMRP/D (Qualified Mental Retardation Professional Designee) #1 did not redact the clients medications or prescribing physicians information. The clients'</p>	W0112	<p><b>CORRECTION:</b></p> <p><i>The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. Specifically, private medical information on Client #3, #6 and #7's empty medication cards were properly redacted prior to disposal after discovery of the deficiency.</i></p> <p><b>PREVENTION:</b></p> <p>Professional staff have been trained regarding the need to protect the confidentiality of individuals residing at the facility. Members of the Operations and Quality Assurance Teams will perform visual observations of the home no less than monthly to assure that confidentiality is maintained.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDPD, Team Lead, Direct Support Professionals, Quality Assurance Team, Operations Team</p>	01/18/2013
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	<p>names were visible through the ink pen marks.</p> <p>Client #3's 12/12/12 7:00 AM PPM for Fluoxetine 20 milligrams (antidepressant) was reviewed on 12/12/12 at 7:40 AM. Client #3's PPM indicated the client's name, medication and prescribing physician information. Client #3's name was visible through ink pen marks.</p> <p>Client #6's 12/12/12 7:00 AM PPM for Strattera 3 milligrams was reviewed on 12/12/12 at 7:40 AM. Client #6's PPM indicated the client's name, medication and prescribing physician information. Client #6's name was visible through ink pen marks.</p> <p>Client #7's 12/12/12 7:00 AM PPM for Naproxen 500 milligrams (anti-inflammatory), propranolol 1 milligram (hypertension) and fluoxetine 20 milligrams (anti-depressant) were reviewed on 12/12/12 at 7:40 AM. Client #7's PPM indicated the client's name, medication and prescribing physician information. Client #7's name was visible through ink pen marks.</p> <p>Interview with QMRP/D (Qualified Mental Retardation Professional Designee) #1 on 12/12/12 at 2:00 PM indicated the pharmacy medication bubble packages for clients #3, #6 and #7 had been thrown in the medication administration trash can on the morning</p>			

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	<p>of 12/12/12. QMRP/D #1 indicated the names of the clients had been marked through with an ink pen and then placed in the trash can.</p> <p>Interview with facility nurse, LPN (Licensed Practical Nurse) #1, on 12/13/12 at 12:40 PM stated, "Before staff throw the packages into the trash, they should use a magic marker and mark out the client's name. Staff should be using the magic marker to mark out all of their information. The clients name and medications should all be concealed with the magic marker. Staff should not be using an ink pen."</p> <p>9-1-3(a)</p>			

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 5 of 32 reportable incidents reviewed, for 3 of 4 sampled clients (#2, #3 and #4), plus 2 additional clients (#7 and #8), the facility failed to implement its policy and procedures to ensure the facility immediately notified BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an incident of client to client aggression for clients #2 and #8, a medication omission for client #4 and an incident of client to client aggression for clients #3 and #4. The facility failed to implement its policy and procedures to ensure the facility put in place corrective actions/measures following an incident of client to client aggression with clients #4 and #7 and following an incident of client to client aggression with clients #2, #3 and #4.</p> <p>Findings include:</p> <p>1. The facility's policy and procedures were reviewed on 12/14/12 at 11:25 AM. The facility's 9/14/07 policy and procedure entitled Abuse, Neglect, Exploitation operating standard 1.26 indicated, "Following ResCare protocol for the exact process to report incidents, once the suspicion has been reported to the supervisor and/or PD (Program Director), the PD will report, within 24 hours, the suspected abuse, neglect or exploitation as follows:</p>	W0149	<p><b>CORRECTION:</b> <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</i></p> <p>1. The facility has submitted BDDS Incident reports for omitted medication for Client #4 which occurred on 7/12/12, aggression between Client #2 and Client #8 that occurred on 10/29/12, and aggression that occurred between Client #3 and Client #4 that occurred on 12/7/12.</p> <p>2. The facility will conduct interdisciplinary team meetings to address aggression that occurred between Client #2 and Client #3 on 10/9/12 and between Client #4 and Client #7 on 11/25/12.</p> <p><b>PREVENTION:</b> Facility professional staff will be provided with clear expectations regarding reporting and follow-up for all required incidents. Facility direct support staff will be retrained regarding agency reporting procedures, with emphasis on immediate notification of supervisors. Staff who fail to report incidents immediately will receive corrective action up to and including termination of employment. The Quality</p>	01/18/2013			

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	<p>G. "To the BDDS central office...."</p> <p>The facility failed to implement its policy and procedures to ensure the facility immediately notified BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an incident of client to client aggression for clients #2 and #8, a medication omission for client #4 and an incident of client to client aggression for clients #3 and #4. Please see W153.</p> <p>2. The facility's 9/14/07 policy and procedure entitled, Investigations indicated, "10. A thorough investigation final report will be written at the completion of the investigation. The report shall include, but is not limited to the following: concerns and recommendations; methods to prevent future incidents."</p> <p>The facility failed to implement its policy and procedures to ensure the facility put in place corrective actions/measures following an incident of client to client aggression with clients #4 and #7 and following an incident of client to client aggression with clients #2, #3 and #4. Please see W157.</p> <p>9-3-2(a)</p>		<p>Assurance and Operations Teams will monitor compliance with reporting timelines and coordinate corrective measures as needed.</p> <p>The QDDP will bring all relevant elements of the interdisciplinary team together after incidents of client to client aggression to review current supports and to make adjustments and revisions as needed. The QDDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDPD, Team Lead, Direct Support Professionals, Quality Assurance Team, Operations Team</p>		

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 4 of 32 allegations of abuse, neglect, mistreatment and/or injuries of unknown origin reviewed for 3 of 4 sampled clients (#2, #3 and #4) plus 1 additional client (#8), the facility failed to immediately notify BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an incident of client to client aggression for clients #2 and #8. The facility failed to immediately notify BDDS in accordance with state law regarding a medication omission for client #4. The facility failed to immediately notify BDDS in accordance with state law regarding an incident of client to client aggression for clients #3 and #4.</p> <p>Findings include:</p> <p>The facility's BDDS reports, investigations and incident reports were reviewed on 12/11/12 at 11:00 AM. The review indicated the following:</p> <p>-BDDS report dated 7/16/12 indicated, "On Thursday July 12, 2012 [staff #1] did</p>	W0153	<p><b>CORRECTION:</b> <i>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Specifically, the facility has submitted BDDS Incident reports for omitted medication for Client #4 which occurred on 7/12/12, aggression between Client #2 and Client #8 that occurred on 10/29/12, and aggression that occurred between Client #3 and Client #4 that occurred on 12/7/12.</i></p> <p><b>PREVENTION:</b> Facility professional staff will be provided with clear expectations regarding reporting and follow-up for all required incidents. Facility direct support staff will be retrained regarding agency reporting procedures, with emphasis on immediate notification of supervisors. Staff who fail to report incidents immediately will receive corrective action up to and including termination of</p>	01/18/2013			

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	<p>not administer [client #4] his Oxcarasepine (sic) 600 milligram seizure medication during the lunchtime medication pass. The error was realized the next day on Friday July 13, 2012 during the medication pass."</p> <p>-BDDS report for client #2 dated 10/1/12 indicated on 9/29/12, "[Client #2] got upset with a housemate, [client #8] due to [client #8] constantly yelling. As a result [client #2] threw a dining room chair at [client #8]. [Client #8] then ran outside with a paper towel rack and attempted to throw the paper towel rack at staff, but instead missed staff and hit the group home van leaving a dent." The 10/1/12 BDDS report indicated, "[Client #8] was struck with a dining room chair by housemate [client #2] which resulted in an inch scratch and some swelling to [client #8's] chin."</p> <p>-BDDS report for client #8 dated 10/1/12 indicated on 9/29/12, "[Client #2] got upset with a housemate, [client #8] due to [client #8] constantly yelling. As a result [client #2] threw a dining room chair at [client #8]. [Client #8] then ran outside with a paper towel rack and attempted to throw the paper towel rack at staff, but instead missed staff and hit the group home van leaving a dent." The 10/1/12 BDDS report indicated, "[Client #8] was</p>		<p>employment. The Quality Assurance and Operations Teams will monitor compliance with reporting timelines and coordinate corrective measures as needed.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDPD, Team Lead, Direct Support Professionals, Quality Assurance Team, Operations Team</p>		

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	<p>struck with a dining room chair by housemate [client #2] which resulted in an inch scratch and some swelling to [client #8's] chin."</p> <p>-BDDS report dated 12/13/12 indicated on 12/7/12 client #4 pushed client #3 into a couch in the group home living room.</p> <p>Client #4's record was reviewed on 12/12/12 at 12:15 PM. Client #4's Physicians Order form dated 11/1/12 indicated client #4 had an order for Oxcarbazepine 600 milligrams for seizure control.</p> <p>Interview with CS (clinical supervisor) #1 and QMRP/D (Qualified Mental Retardation Professional Designee) #1 on 12/13/12 at 2:15 PM indicated client to client aggression and allegations of abuse, neglect or mistreatment should be reported to the QMRP/D within 24 hours of the incident and within 24 hours of the QMRP/D's knowledge of the allegation or incident to BDDS.</p> <p>9-3-1(b)(5) 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. Based on record review and interview for 2 of 34 allegations of abuse, neglect, mistreatment and/or injuries of unknown origin reviewed for 3 of 4 sampled clients (#2, #3 and #4) plus 1 additional client (#7), the facility failed to formulate corrective actions/measures following an incident of client to client aggression with clients #4 and #7. The facility failed to put in place corrective actions/measures following an incident of client to client aggression with clients #2, #3 and #4.</p> <p>Findings include:</p> <p>The facility's BDDS reports, investigations and incident reports were reviewed on 12/11/12 at 11:00 AM. The review indicated the following:</p> <p>-BDDS report dated 11/26/12 indicated, "On 11/25/12, [client #4] approached another consumer [client #7], that was already having behaviors to talk with him. The client, [client #7], felt as if [client #4] was being threatening and responded verbally with threats of bodily harm as well as stole fries off of [client #4's] plate. [Client #4] then became physically aggressive toward [client #7] hitting him in the face. The clients were separated and</p>	W0157	<p><b>CORRECTION:</b> <i>If the alleged violation is verified, appropriate corrective action must be taken. Specifically, the facility will conduct interdisciplinary team meetings to address aggression that occurred between Client #2 and Client #3 on 10/9/12 and between Client #4 and Client #7 on 11/25/12.</i></p> <p><b>PREVENTION:</b> The QDDP will bring all relevant elements of the interdisciplinary team together after incidents of client to client aggression to review current supports and to make adjustments and revisions as needed. The QDDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDPD Team Lead, Direct Support Professionals, Quality Assurance Team, Operations Team</p>	01/18/2013			

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	<p>asked to go to separate areas of the home."</p> <p>-Investigation form dated 11/26/12 regarding the 11/25/12 incident of aggression between client #4 and client #7 indicated the IDT (Interdisciplinary Team) would be convened and make recommendations to prevent reoccurrence. The review did not indicate documentation of an IDT meeting and/or recommendations regarding the 11/25/12 incident.</p> <p>-BDDS report dated 10/10/12 indicated on 10/9/12, "[Client #2] became agitated with a housemate, [client #3], that he felt was faking a seizure and threw water on him and then became physically aggressive toward that housemate, [client #3]. As a result the housemate, [client #3] retaliated and bit [client #2] on his right upper arm. [Client #2] then separated himself and went into the medication room with a staff. Another housemate, [client #4] entered the medication room and became verbally aggressive toward [client #2], in turn [client #3] threw a chair and hit the housemate, [client #4], below the left eye and the bridge of the nose. The housemate, [client #4], then called the police who arrived and discussed the situation with all individuals involved." The 10/10/12</p>			

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	<p>BDDS report indicated, "An IDT will be held to discuss [client #2's] increase in physical aggression toward his peers."</p> <p>-Investigation dated 10/10/12 regarding the 10/9/12 incident with clients #2, #3 and #4 indicated the IDT would meet and make recommendations to prevent reoccurrence. The review did not indicate documentation of an IDT meeting and/or recommendations regarding the 10/9/12 incidents.</p> <p>Interview with CS (clinical supervisor) #1 and QMRP/D (Qualified Mental Retardation Professional Designee) #1 on 12/13/12 at 2:15 PM indicated the facility's IDT or facility's administrative peer review process should determine corrective actions following an investigation. CS #1 indicated there were no IDT or peer review recommendations regarding the 11/25/12 incident for clients #4 and #7 or the 10/10/12 incidents regarding clients #2, #3, and #4.</p> <p>9-3-2(a)</p>			

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W0192	<p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure the staff was trained to meet the health needs of the client.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/12/12 from 5:45 AM through 7:45 AM. At 6:18 AM client #1 was prompted by staff #1 to come to the medication administration room for his morning medications. Client #1 entered the medication administration area and observed his morning medications were on the counter in a souffle cup. Client #1 pointed at the souffle cup that contained his medications and stated to staff #1, "applesauce." Staff #1 indicated client #1 asks for his medications to be crushed and put into applesauce.</p> <p>Client #1's record was reviewed on 12/13/12 at 11:04 AM. Client #1's Physicians Order form dated 12/1/12 indicated, "take medication in puree consistency food, applesauce/pudding, may cut appropriate pills in half." Client</p>	W0192	<p><b>CORRECTION:</b> <i>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</i> Specifically, Facility staff will be retrained regarding the need to communicate client requests for specialized medication delivery (i.e. crushed medications) with the facility nurse so that the request can be evaluated and approved by appropriate medical professionals prior to implementation.</p> <p><b>PREVENTION:</b> Supervisory staff will monitor medication administration as part of regularly scheduled active treatment observations and will perform formal medication training with all staff no less than quarterly to assure medications are administered per physician's orders. Members of the Quality Assurance and Operations teams will perform active treatment observations at the facility that include the administration of medication as needed but no less than monthly.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDPD, Team Lead, Direct Support Professionals, Health</p>	01/18/2013

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	<p>#1's record did not indicate client #1's medications should be crushed.</p> <p>Interview with staff #1 on 12/12/12 at 6:30 AM indicated client #1, "Asks for his medications to be crushed every morning. [Client #1] has a hard time taking the pills and wants them crushed. [Client #1] generally takes them with applesauce or pudding." When asked if the facility nurse was aware of client #1's medications being crushed, staff #1 stated, "Yes, its per the nurse's orders. We crush his pills and put them in applesauce."</p> <p>Interview with LPN #1 (Licensed Practical Nurse) on 12/13/12 at 12:40 PM indicated client #1's medications should not be crushed. LPN #1 stated, "I was not made aware of [client #1's] medications being crushed. LPN #1 indicated client #1's Physician's Orders allowed staff to cut client #1's pills in half. LPN #1 indicated client #1's primary care physician should be contacted to write an order for client #1's medications to be crushed.</p> <p>9-3-3(a)</p>		Services Team, Quality Assurance Team, Operations Team	

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W0227	<p><b>483.440(c)(4)</b> <b>INDIVIDUAL PROGRAM PLAN</b> The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 1 of 4 sampled clients (#4), the clients ISP (Individual Support Plan) failed to address client #4's identified behavioral needs in regard to refusals to attend day services.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 12/12/12 at 12:15 PM. Client #4's Progress Notes indicated the following entries:</p> <p>-9/19/12, refused to go to work.</p> <p>-9/24/12, refused to go to work.</p> <p>-9/25/12, refused to go to work.</p> <p>-10/2/12, refused to go to work.</p> <p>-10/3/12, refused to go to work.</p> <p>-10/4/12, refused to go to work.</p> <p>-10/11/12, refused to go to work.</p>	W0227	<p><b>CORRECTION:</b> <i>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Specifically the interdisciplinary team will develop supports that address Client #4's refusals to participate in day program activities.</i></p> <p><b>PREVENTION:</b> The QDDPD will receive training regarding the need to monitor and evaluate documentation and update assessments and supports to reflect the current needs of all clients. Members of the Operations and Quality Assurance Teams will monitor support documents and corresponding documentation as needed but no less than monthly and make recommendations for modifications as appropriate.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDPD, Team Lead, Direct Support Professionals, Quality Assurance Team, Operations Team</p>	01/18/2013			

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	<p>-10/15/12, refused to go to work.</p> <p>-10/16/12, refused to go to work.</p> <p>-10/31/12, refused to go to work.</p> <p>-11/8/12, refused to go to work.</p> <p>-11/28/12, refused to go to work.</p> <p>-11/29/12, refused to go to work.</p> <p>-11/30/12, refused to go to work.</p> <p>-12/6/12, refused to go to work.</p> <p>-12/7/12, refused to go to work.</p> <p>-12/11/12, refused to go to work.</p> <p>Client #4's ISP dated 9/14/12 did not address client #4's refusals to attend day services/work.</p> <p>Staff #2 was interviewed on 12/12/12 at 7:30 AM. Staff #2 stated, "[Client #4] refuses to go work about 2 to 3 time a week. [Client #4] refuses to go then stays home all day with staff."</p> <p>Interview with CS (clinical supervisor) #1 and QMRP/D (Qualified Mental Retardation Professional Designee) #1 on 12/13/12 at 2:15 PM indicated client #4</p>			

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	<p>had a pattern of day service/work refusals. CS #1 and QMRP/D indicated the IDT (Interdisciplinary Team) had not addressed client #4's refusals. QMRP/D indicated there had been a meeting scheduled with day services to discuss client #4's refusals but it had been canceled and rescheduled.</p> <p>9-3-4(a)</p>			

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W0250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to provide an active treatment schedule for staff to follow.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 12/13/12 at 11:04 AM. Client #1's record did not contain an active treatment schedule for staff to follow.</p> <p>Interview with CS (clinical supervisor) #1 and QMRP/D (Qualified Mental Retardation Professional Designee) #1 on 12/13/12 at 2:15 PM indicated there was no active treatment schedule to review.</p> <p>9-3-4(a)</p>	W0250	<p><b>CORRECTION:</b> <i>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.</i></p> <p>Specifically, Client #3's learning objectives have been modified to reflect current developmental status. <b>PREVENTION:</b> The QDDP will receive training regarding the need to monitor objective data on a monthly basis and to modify objectives as needed but no less than quarterly. Additionally, members of the Operations and Quality Assurance Teams will conduct periodic reviews of individual support plans and monthly/quarterly ISP reviews on an ongoing basis to assure the QDDP and Behavioral clinician are monitoring progress on client's learning objectives behavior trends and making appropriate modifications as needed. <b>RESPONSIBLE PARTIES:</b> QDDPD, Team Lead, Direct Support Professionals, Quality Assurance Team, Operations Team</p>	01/18/2013	

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W0255	<p><b>483.440(f)(1)(i)</b> <b>PROGRAM MONITORING &amp; CHANGE</b> The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure training objectives were monitored and revised on a routine basis.</p> <p>Findings include:</p> <p>1. Client #3's record was reviewed on 12/12/12 at 10:41 AM. Client#3's ISP (Individual Support Plan) dated 2/7/12 indicated the following training objectives:</p> <ul style="list-style-type: none"> <li>-will remain on task for 45 consecutive minutes.</li> <li>-will record all daily transactions independently.</li> <li>-will stand at arms length from the person assisting him.</li> <li>-will identify a side effect of his Abilify (antipsychotic) medication.</li> <li>-will complete a chosen relaxation technique for 15 consecutive minutes.</li> <li>-will participate in an activity of his choosing</li> </ul>	W0255	<p><b>CORRECTION:</b> <i>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.</i> Specifically, Client #3's learning objectives have been modified to reflect current developmental status.</p> <p><b>PREVENTION:</b> The QDDP will receive training regarding the need to monitor objective data on a monthly basis and to modify objectives as needed but no less than quarterly. Additionally, members of the Operations and Quality Assurance Teams will conduct periodic reviews of individual support plans and monthly/quarterly ISP reviews on an ongoing basis to assure the QDDP and Behavioral clinician are monitoring progress on client's learning objectives behavior trends and making appropriate modifications as needed.</p>	01/18/2013

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	<p>three times a week.</p> <p>Client #3's record did not indicate the training objectives had been monitored and/or updated since 2/7/12. Client #3's record did not indicate QMRP (qualified mental retardation professional) monthly or quarterly summaries/review of training objectives progress or regression.</p> <p>Interview with CS (clinical supervisor) #1 and QMRP/D (designee) #1 on 12/13/12 at 3:00 PM indicated there were no QMRP review of programs since the ISP meeting of 2/7/12. CS #1 indicated client #3's training objectives should be reviewed by the QMRP on a quarterly basis.</p> <p>9-3-4(a)</p>		<p><b>RESPONSIBLE PARTIES:</b> QDDPD, Team Lead, Direct Support Professionals, Quality Assurance Team, Operations Team</p>	

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W0259	<p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 3 of 4 sampled clients (#1, #2 and #4), the facility failed to ensure the clients' CFA (Comprehensive Functional Assessments) were reviewed annually.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Client #1's record was reviewed on 12/13/12 at 11:04 AM. Client #1's record indicated the most recent review of client #1's CFA was 2/5/11.</li> <li>Client #2's record was reviewed on 12/12/12 at 3:15 PM. Client #2's record did not contain a CFA.</li> <li>Client #4's record was reviewed on 12/12/12 at 12:15 PM. Client #4's record indicated the most recent review of client #4's CFA was 9/5/11.</li> </ol> <p>Interview with CS (clinical supervisor) #1 and QMRP/D (Qualified Mental Retardation Professional Designee) #1 on 12/13/12 at 2:15 PM indicated client #2 should be assessed and clients #1 and #4's CFAs should be reassessed. CS #1 and QMRP/D #1 indicated CFAs should be updated/reviewed annually.</p> <p>9-3-4(a)</p>	W0259	<p><b>CORRECTION:</b> <i>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Specifically, the team has completed an updated Comprehensive Consent Assessments for Clients #1, #2 and #4.</i></p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding the need to include an annually updated Comprehensive Functional Assessment included in each individual's record. Members of the Quality Assurance and Operations Teams will review assessment data during routine visits to the facility which will occur no less than monthly as part of the agency's formal internal audit process.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDPD, Team Lead, Direct Support Professionals, Quality Assurance Team, Operations Team</p>	01/18/2013	

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W0264	<p>483.440(f)(3)(iii) PROGRAM MONITORING &amp; CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#1), the facility's HRC (human rights committee) failed to review, monitor and approve the use of psychotropic medication for management of client #1's behavior.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 12/13/12 at 11:04 AM. Client #1's BSP (behavior support plan) dated 2/6/12 indicated the use of Haldol 4 milligrams (antipsychotic), Zyprexa 2.5 milligrams (antipsychotic) and lithium carbonate 300 milligrams (bipolar). Client #1's physician's prescription dated 2/16/12 indicated orders for Haldol 2 milligrams, lithium 150 milligrams and Zyprexa 5 milligrams. Client #1's physician order form dated 12/1/12 indicated the daily use of haloperidol 2 milligrams, lithium carbonate 150 milligrams and Zyprexa 5 milligrams. Client #1's record did not indicate review or approval by the</p>	W0264	<p><b>CORRECTION:</b> <i>The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Specifically, The Human Rights Committee has reviewed and approved the use of Client #1's psychotropic medications.</i></p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding the need to obtain prior written informed consent and Human Rights Committee approval for all restrictive programs prior to implementation. Retraining will focus on assuring that the QDDP has a clear understanding of what specifically constitutes a restrictive program and proper preparation for presenting program modifications to the Human Rights Committee. The training will also focus on helping professional staff develop</p>	01/18/2013

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	<p>facility's HRC of the use of the psychotropic medications.</p> <p>The facility's HRC record was reviewed on 12/13/12 at 10:30 AM. The HRC file did not indicate review or approval for client #1 to use haloperidol, lithium carbonate or Zyprexa for behavior management.</p> <p>Interview with CS (clinical supervisor) #1 on 12/13/12 at 3:00 PM indicated there were no HRC notes regarding client #1.</p> <p>9-3-4(a)</p>		<p>adequate record keeping practices to assure that HRC approval records are available for review. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to due process and prior written informed consent. Administrative staff will conduct visits to the facility as needed but no less than monthly.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDPD, Team Lead, Direct Support Professionals, Human Rights Committee, Behavior Clinician, Health Services Team, Quality Assurance Team, Operations Team</p>	

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W0327	<p>483.460(a)(3)(iv) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure annual TB (Tuberculosis) testing, x-ray or symptom checklist screening was completed.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 12/13/12 at 11:04 AM. Client #1's IF (Immunization Form) undated, indicated client #1's most recent TB screening was completed on 3/7/11. Client #1's Nursing Assessment for 2012 indicated client #1's most recent TB screening was completed on 3/7/11. Client #1's Nursing Assessment for 2012 did not indicate TB screening/symptom screening had been completed.</p> <p>Interview with LPN #1 (Licensed Practical Nurse) on 12/13/12 at 12:40 PM indicated client #1's record should contain documentation of a yearly TB screening or checklist. LPN #1 stated, "I think we did [client #1's] TB in March of 2012 but</p>	W0327	<p><b>CORRECTION:</b></p> <p><i>The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Specifically, Client #1 has received annual Tuberculosis screening.</i></p> <p><b>PREVENTION:</b></p> <p>The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to annual Tuberculosis screening, occur within required time frames. Members of the Operations and Quality Assurance Teams will incorporate medical chart reviews into their formal audit process, which will occur no less than quarterly to assure appropriate medical follow-up takes place as required.</p>	01/18/2013			

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	I will have to check. We should have that in the chart." LPN #1 did not provide documentation of a recent/annual TB screening/checklist for client #1.  9-3-6(a)		<b>RESPONSIBLE PARTIES:</b> QDDPD, Team Lead, Direct Support Professionals, Health Services Team, Quality Assurance Team, Operations Team		

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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 4 sampled clients (#1), the facility nurse failed to ensure staff completed routine toenail trimming for client #1.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/12/12 from 5:45 AM through 7:45 AM. At 6:18 AM client #1 was prompted to remove his socks and shoes to allow staff #1 to apply his foot powder. Client #1 removed his right foot from his shoe which exposed a sock with a hole in the sock exposing his Hallux (grand toe) and 2nd toe. Client #1's Hallux/grand toe's toenail length was 3 millimeters in length past the skin portion of the Hallux/grand toe. Client #1's Hallux/grand toenail had edges that were not smooth/contoured. Client #1's 2nd toenail length was 3 millimeters in length with edges that were not smooth/contoured.</p> <p>Interview with staff #1 on 12/12/12 at 6:20 AM indicated client #1's toenails had been trimmed at his last podiatry appointment in November 2012. Staff #1 stated, "They are long, he is scheduled to</p>	W0331	<p><b>CORRECTION:</b></p> <p><i>The facility must provide clients with nursing services in accordance with their needs. Specifically, Client #1's toenails have been trimmed and staff will be retrained regarding weekly nail care expectations.</i></p> <p><b>PREVENTION:</b></p> <p>In addition to regular physical assessments performed by the facility nurse, supervisory staff and team leads will perform visual observations of clients' feet no less than weekly to assure nail care occurs as ordered.</p> <p><b>RESPONSIBLE PARTIES:</b></p> <p>QDDPD, Team Lead, Direct Support Professionals, Health Services Team, Quality Assurance Team, Operations Team</p>	01/18/2013			

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	<p>go back to the podiatrist soon.</p> <p>Interview with QMRP/D on 12/12/12 at 6:30 AM indicated client #1 had been to the podiatrist in November and was scheduled to return.</p> <p>Client #1's record was reviewed on 12/13/12 at 11:04 AM. Client #1's Physician's Order form dated 12/1/12 indicated direct care staff were to trim client #1's mails weekly on Sunday at 9:00 PM.</p> <p>The facility nurse, LPN (Licensed Practical Nurse) #1, on 12/13/12 at 12:40 PM indicated staff should be checking client #1's toenails and trimming weekly on Sunday's at 9:00 PM. LPN #1 stated, "[Client #1] goes to the podiatrist on a routine basis but staff should still be trimming his nails weekly."</p> <p>9-3-6(a)</p>			

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W0356	<p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1's dentures fit properly.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 12/13/12 at 11:04 AM. Client #1's dental visit form dated 2/14/12 indicated, "[Client #1] feels dentures are ill fitting. Dentures are assessed as being okay, needs to use Fixadent or adhesive to stabilize the lower denture. If the Fixadent is not working a permanent fix would be to have a snap on denture which includes a visit to the oral surgeon and have an implant placed to give the denture something to grab onto for stabilization."</p> <p>Interview with CS (clinical supervisor) #1 and QMRP/D #1 (qualified mental retardation professional designee) on 12/13/12 at 12:15 PM indicated client #1 had a pair of upper and lower dentures. QMRP/D #1 stated, "[Client #1] has the dentures but he won't eat with them. [Client #1] takes them out when he is</p>	W0356	<p><b>CORRECTION:</b> The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Specifically, the facility will follow the dentist recommendations to apply adhesive to Client #1's dentures to secure them during meals. If the adhesive does not resolve Client #1's misperception that the dentures do not fit, the facility will work with the dentist to develop alternative solutions.</p> <p><b>PREVENTION:</b> The facility nurse will review dental records and follow up with other team members to assure recommendations are implemented as appropriate. The QDDPD and members of the Operations and Quality Assurance Teams will review medical records on an ongoing basis to assure dental treatment services occur as required.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDPD, Team Lead, Direct Support Professionals, Health Services Team, Quality Assurance Team, Operations Team</p>	01/18/2013

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	<p>eating." When asked if the facility had provided client #1 with the recommended Fixadent or other denture adhesive, QMRP/D #1 stated, "No." When asked if the facility's IDT (interdisciplinary team) had met to discuss client #1's refusal to wear the dentures during meals, denture care or the recommendation for an implant, QMRP/D #1 stated, "No."</p> <p>Interview with facility nurse, LPN (licensed practical nurse) #1 on 12/13/12 at 12:00 PM indicated client #1 was diagnosed with dysphasia. LPN #1 indicated client #1 should wear dentures to eat his food. LPN #1 indicated there had been no discussion regarding client #1's dentures and refusal to wear them during meals.</p> <p>9-3-6(a)</p>			