

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G724	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2015
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NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9321 SULLIVAN LN CROWN POINT, IN 46307
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W000000	<p>This visit was for a full annual recertification and state licensure survey.</p> <p>This visit was done in conjunction with the post certification revisit to the investigation of Complaint #IN00158472 conducted on 11/14/14.</p> <p>Dates of Survey: January 6, 7, 8 and 9, 2015</p> <p>Facility number: 004837 Provider number: 15G724 AIM number: 200803700</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/20/15 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview, for 2 of 3 sampled clients (clients B and C), the governing body failed to exercise</p>	W000104	Management staff will be re-trained to ensure that clients do not pay for sensory equipment. Responsible person:	02/06/2015

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

TITLE

(X6) DATE

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

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	<p>general policy and operating direction over the facility to ensure it developed and implemented a policy and procedure to give group home and facility staff guidance on checking in client medications when delivered by the pharmacy to prevent medication errors. The governing body failed to exercise general policy and operating direction over the facility to ensure client B did not pay for sensory equipment. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted investigations in regard to an allegation of abuse/injuries of unknown origin and an incident of staff neglect.</p> <p>Findings include:</p> <p>1. A financial record review was conducted on 1/8/15 at 1:30 P.M.. A review of client B's financial record indicated: Online order dated 3/30/14 in the amount of \$268.03 for the purchase of "20 pound Weighted Vest...\$47.97...Bean Bag Chair...\$52.04... Weighted Blanket...\$74.18 and Rocking Chair Cushion Set...\$59.98." Further review of the record failed to indicate he had been reimbursed for the expenditures.</p> <p>An interview with the Qualified</p>		<p>Sheila O'Dell, Group Home Director. Client B will be reimbursed in the amount of \$268.03. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, the QIDP will review client finances. Responsible person: Traci Hardesty, QIDP. All staff are trained upon hire and annually their after, which includes medication procedures. Responsible person: Ruth Estrada, training Coord, Sherri DiMarco, RN & Traci Hardesty, QIDP. To ensure future compliance, a protocol was developed on how to check in medication when delivered from the pharmacy. Responsible person: Sheila O'Dell, Group Home Director & Traci Hardesty, QIDP. All staff will be trained on the protocol on how to check in medication when delivered from the pharmacy. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, a check in/tracking sheet has been put into place. Responsible person: Traci Hardesty, QIDP & Airielle Roger, Group Home Manager.</p> <p>All management staff will be re-trained on the abuse/neglectpolicy, Responsible person: Sheila O'Dell, Group Home Director.</p> <p>All staff will bere-trained on the abuse/neglect policy. Responsible person: Traci Hardesty,QIDP.</p> <p>To ensure future compliance, the</p>		

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	<p>Intellectual Disabilities Professional (QIDP) was conducted on 1/8/15 at 1:50 P.M.. The QIDP indicated the cushions were purchased for a rocking chair for client B's bedroom and living room. The QIDP indicated the bean bag was not at the group home and further indicated she believes it is at the day program. The QIDP indicated the other items were sensory items for client B's programming and further indicated clients should not pay for sensory equipment.</p> <p>2. A review of the facility's records was conducted at the facility's administrative office on 1/6/15 at 2:35 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-BDDS report dated 1/2/15...Date of Knowledge: 1/3/15...Submitted Date: 1/5/15 involving client C indicated: "[Client C]'s seizure medication Onfi was delivered on 1/2/15 and staff put the bubble pack in his medication box without following the medication check in procedure. Per the script the pharmacy received from the doctor, the pharmacy did not send half tabs like usual but instead sent whole tabs. On 1/2/15 at 8 P.M., [client C] received 30 mg (milligrams) of Onfi instead of 15 mg.</p>		<p>Manager will review all internal incident reports daily when present for medication errors, injury of unknown origin, falls and significant injuries &/or allegations. Responsible person: Airielle Rogers, Group Home Manager.</p> <p>To ensure future compliance, the QIDP will review in the home three times a month, all internal incident reports for medication error, injury of unknown origin, falls and significant injuries &/or allegations the first month and then monthly thereafter. Responsible person: Traci Hardesty, QIDP</p> <p>To ensure future compliance, all incident reports will be reviewed at least monthly during the program status review and at least monthly by our Nurse to ensure that the facility's abuse and neglect policy has been followed. Responsible person: Traci Hardesty, QIDP, Sheila O'Dell Group Home Director</p> <p>All management staff will be re-trained on the abuse/neglect policy, which includes thorough investigation. Responsible person: Sheila O'Dell, Group Home Director.</p> <p>All staff will be re-trained on the abuse/neglect policy, which includes thorough investigation. Responsible person: Traci Hardesty, QIDP.</p> <p>To ensure future compliance, the Manager will review all internal incident reports daily when present</p>	

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	<p>On 1/3/15 at 7 A.M., [client C] received 20 mg of Onfi instead of 10 mg. The error was noticed in the evening of 1/3/15 before 8 PM meds were passed. The copy of the script received at the home is hard to read due to it being faxed but it appears that the doctor ordered 10 mg in the AM and 20 mg in the PM-this is an increase of 5 mg per day in the PM based on previous prescriptions. The agency nurse and Administration was (sic) notified when the error was found. The nurse told staff not to pass [client C]'s evening meds since he had gotten too much in the past 24 hours. His regular scheduled passing of Onfi resumed on the morning of 1/4/15. As of 1/4/15, [client C] has received 10 mg on (sic) Onfi in the AM and 20 mg of Onfi in the PM, per the most recent prescription. [Client C] was sleepy all day on 1/3/15 but did not exhibit any other side effects from receiving too much medication. [Client C]'s doctor will be contacted today to get clarification on the correct dosage of Onfi and a new prescription will be requested if needed. Staff will be retrained on the check in procedure for all medications and a form will be created to document that the procedure has been done correctly and in a timely manner. The staff who did not properly check in the meds and the staff who passed the incorrect dosage will receive disciplinary</p>		<p>for medication error, injury of unknown origin, falls and significantinjuries &/or allegations. Responsible person: Airielle Rogers, Group HomeManager.</p> <p>To ensure futurecompliance, the QIDP will review in the home three times a month, all internalincident reports for medication errors, injury of unknown, origin, falls andsignificant injuries &/or allegations the first month and then monthly thereafter.Responsible person: Traci Hardesty, QIDP.</p> <p>To ensure futurecompliance, all incident reports will be reviewed at least monthly during theprogram status review and at least monthly by our Nurse to ensure that thefacility's abuse and neglect policy has been followed. Responsible person:Traci Hardesty, QIDP, Sheila O'Dell Group Home Director, and Sherri Dimarco,RN.</p>	

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	<p>action. The reason for the late submission of this report was miscommunication as to who was going to submit the report."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/6/15 at 2:55 P.M.. A request was made for the facility's policy and procedure which gave staff guidance on how to check medications in when delivered from the pharmacy. The QIDP indicated the facility did not have a policy and procedure developed which gave staff guidance on checking in medications when delivered from the pharmacy. The QIDP stated "We verbally tell staff how to check in medications."</p> <p>3. Please refer to W149: The governing body failed for 1 of 3 sampled clients (client C), to implement written policy and procedures to provide written evidence thorough investigations were conducted in regard to an allegation of abuse and an incident of staff neglect.</p> <p>4. Please refer to W154: The governing body failed to exercise general policy and operating direction over the facility for 1 of 3 sampled clients (client C) to ensure the facility provided written evidence thorough investigations were conducted</p>						

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W000149	<p>in regard to an allegation of abuse and an incident of staff neglect.</p> <p>5. Please refer to W189: The governing body failed for 1 of 3 sampled clients (client C) to ensure all staff who worked with client C were sufficiently trained to assure competence in checking in medications when delivered from the pharmacy to prevent medication errors.</p> <p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 2 of 2 incidents, involving 1 of 3 sampled clients (client C), the facility failed to implement policy and procedure to provide written evidence thorough</p>	W000149	<p>All management staff will be re-trained on the abuse/neglectpolicy, Responsible person: Sheila O'Dell, Group Home Director.</p> <p>All staff will bere-trained on the</p>	02/06/2015

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	<p>investigations were conducted in regard to an allegation of abuse and an incident of staff neglect.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 1/6/15 at 2:35 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-IR dated 12/21/14 involving client C indicated: "Injury: Unknown: While assisting [client C] with dinner, [client C] pulled his arm sleeve up and showed staff a red mark on his right wrist, [client C] stated that he was bitten, when staff asked [client C] who bit him he replied 'My Dad.' [Client C has a 2 inch by 1 inch red mark on his right wrist." The record failed to indicate there was written documentation to indicate the facility conducted a thorough investigation in regard to this incident.</p> <p>-BDDS report dated 1/2/15...Date of Knowledge: 1/3/15...Submitted Date: 1/5/15 involving client C indicated: "[Client C]'s seizure medication Onfi was delivered on 1/2/15 and staff put the bubble pack in his medication box</p>		<p>abuse/neglect policy. Responsible person: Traci Hardesty,QIDP.</p> <p>To ensure future compliance, the Manager will review all internal incident reports daily when present for medication errors, injury of unknown origin, falls and significant injuries &/or allegations. Responsible person: Airielle Rogers, Group Home Manager.</p> <p>To ensure future compliance, the QIDP will review in the home three times a month, all internal incident reports for medication error, injury of unknown, origin, falls and significant injuries &/or allegations the first month and then monthly thereafter. Responsible person: Traci Hardesty,QIDP.</p> <p>To ensure future compliance, all incident reports will be reviewed at least monthly during the program status review and at least monthly by our Nurse to ensure that the facility's abuse and neglect policy has been followed. Responsible person: Traci Hardesty, QIDP, Sheila O'Dell Group Home Director, and Sherri Dimarrco, RN.</p>	

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	without following the medication check in procedure. Per the script the pharmacy received from the doctor, the pharmacy did not send half tabs like usual but instead sent whole tabs. On 1/2/15 at 8 P.M., [client C] received 30 mg (milligrams) of Onfi instead of 15 mg. On 1/3/15 at 7 A.M., [client C] received 20 mg of Onfi instead of 10 mg. The error was noticed in the evening of 1/3/15 before 8 PM meds were passed. The copy of the script received at the home is hard to read due to it being faxed but it appears that the doctor ordered 10 mg in the AM and 20 mg in the PM-this is an increase of 5 mg per day in the PM based on previous prescriptions. The agency nurse and Administration was (sic) notified when the error was found. The nurse told staff not to pass [client C]'s evening meds since he had gotten too much in the past 24 hours. His regular scheduled passing of Onfi resumed on the morning of 1/4/15. As of 1/4/15, [client C] has received 10 mg on (sic) Onfi in the AM and 20 mg of Onfi in the PM, per the most recent prescription. [Client C] was sleepy all day on 1/3/15 but did not exhibit any other side effects from receiving too much medication. [Client C]'s doctor will be contacted today to get clarification on the correct dosage of Onfi and a new prescription will be requested if needed. Staff will be retrained on the			

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	<p>check in procedure for all medications and a form will be created to document that the procedure has been done correctly and in a timely manner. The staff who did not properly check in the meds and the staff who passed the incorrect dosage will receive disciplinary action. The reason for the late submission of this report was miscommunication as to who was going to submit the report." Further review of the report failed to indicate this incident was immediately reported and investigated.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/6/15 at 2:55 P.M.. A request for all investigations for this group home was made for the second time. The QIDP indicated investigation records are attached to the BDDS reports along with the IR. No written documentation was submitted for review to indicate the facility conducted an investigation in regard to the abuse allegation and the incident of neglect.</p> <p>A review of the facility's records was conducted at the facility's administrative office on 1/6/15 at 1:30 P.M.. Review of the facility's "28. POLICY ON REPORTING AND INVESTIGATING INCIDENTS AND ALLEGATIONS OF</p>				

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	<p>ABUSE AND NEGLECT", no date noted, indicated, in part, the following: "... Consumers must not be subjected to abuse by anyone, including, but not limited to, facility staff, other consumers...Until the incident is reported and investigated, one may not be able to determine whether it is abuse (willful), neglect, or mistreatment but the incident must be treated as an allegation of abuse, neglect or mistreatment and follow the regulations for reporting, responding, investigating and correcting... The term 'willful' does not have to do with 'competence' but with 'intent' to cause harm. Someone with a mental illness or mental retardation can willfully inflict harm to someone who has been bothering them, even though they may not be considered 'competent'... It is mandatory in all situations involving abuse, neglect, exploitation, mistreatment of an individual or the violation of an individual's rights that there is notification made to legal representative, guardian/parent, if applicable, Case Manager, if applicable, BDDS (Bureau of Developmental Disabilities Services), APS/CPS (Adult Protection Services/Child Protection Services) and other person the (sic) designated by the consumer...Physical-includes willful infliction of injury, unnecessary physical or chemical restraints or isolation, and</p>			

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	<p>punishment with resulting physical harm or pain....b. Neglect-includes failure to provide appropriate care, food, medical care or supervision...13. Medication errors....b. Wrong dose given that place (sic) an individual's health and safety in jeopardy as determined by the personal physician....Incident Reporting: In-Pact requires that all staff immediately verbally report all incidents as defined in this policy to their Program Director/Administrator. Under no conditions may an employee leave the work site without reporting and documenting any incident which occurred during his/her shift or for which an allegation was communicated to him/her during his/her shift."</p> <p>An interview with the Group Home Director (GHD) and the QIDP was conducted on 1/9/15 at 11:30 A.M.. The QIDP indicated all allegations of abuse and neglect should be investigated. When asked if the above incidents were investigated, the QIDP indicated if the incidents were investigated the investigations would have been attached to the BDDS reports. The QIDP stated "I'm pretty sure I did an investigation about this incident (12/21/14), but I'm not sure if [Clerical Staff] or I gave it to you (GHD)." When asked if an investigation was conducted in regard to the</p>			

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W000154	<p>medication error, the GHD stated "No, because we knew what happened." No written documentation was submitted for review to indicate investigations were conducted in regards to the mentioned incidents.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 2 incidents, involving 1 of 3 sampled clients (client C), the facility failed to provide written evidence thorough investigations were conducted in regard to an allegation of abuse and an incident of neglect.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 1/6/15 at 2:35 P.M.. Review of the facility's Bureau of Developmental</p>	W000154	<p>All management staff will be re-trained on the abuse/neglect policy, which includes thorough investigation. Responsible person: Sheila O'Dell, Group Home Director.</p> <p>All staff will bere-trained on the abuse/neglect policy, which includes thorough investigation. Responsible person: Traci Hardesty, QIDP.</p> <p>To ensure future compliance, the Manager will review all internal incident reports daily when present for medication error, injury of unknown origin, falls and significant injuries &/or allegations.</p>	02/06/2015			

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	<p>Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-IR dated 12/21/14 involving client C indicated: "Injury: Unknown: While assisting [client C] with dinner, [client C] pulled his arm sleeve up and showed staff a red mark on his right wrist, [client C] stated that he was bitten, when staff asked [client C] who bit him he replied 'My Dad.' [Client C has a 2 inch by 1 inch red mark on his right wrist." The record failed to indicate there was written documentation to indicate the facility conducted a thorough investigation in regard to this allegation of abuse.</p> <p>-BDDS report dated 1/2/15...Date of Knowledge: 1/3/15...Submitted Date: 1/5/15 involving client C indicated: "[Client C]'s seizure medication Onfi was delivered on 1/2/15 and staff put the bubble pack in his medication box without following the medication check in procedure. Per the script the pharmacy received from the doctor, the pharmacy did not send half tabs like usual but instead sent whole tabs. On 1/2/15 at 8 P.M., [client C] received 30 mg (milligrams) of Onfi instead of 15 mg. On 1/3/15 at 7 A.M., [client C] received 20 mg of Onfi instead of 10 mg. The error was noticed in the evening of 1/3/15</p>		<p>Responsible person: Airielle Rogers, Group HomeManager.</p> <p>To ensure futurecompliance, the QIDP will review in the home three times a month, all internalincident reports for medication errors, injury of unknown, origin, falls andsignificant injuries &/or allegations the first month and then monthlythere after. Responsible person: Traci Hardesty, QIDP.</p> <p>To ensure futurecompliance, all incident reports will be reviewed at least monthly during theprogram status review and at least monthly by our Nurse to ensure that thefacility's abuse and neglect policy has been followed. Responsible person:Traci Hardesty, QIDP, Sheila O'Dell Group Home Director, and Sherri Dimarco,RN.</p>	

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	before 8 PM meds were passed. The copy of the script received at the home is hard to read due to it being faxed but it appears that the doctor ordered 10 mg in the AM and 20 mg in the PM-this is an increase of 5 mg per day in the PM based on previous prescriptions. The agency nurse and Administration was (sic) notified when the error was found. The nurse told staff not to pass [client C]'s evening meds since he had gotten too much in the past 24 hours. His regular scheduled passing of Onfi resumed on the morning of 1/4/15. As of 1/4/15, [client C] has received 10 mg on (sic) Onfi in the AM and 20 mg of Onfi in the PM, per the most recent prescription. [Client C] was sleepy all day on 1/3/15 but did not exhibit any other side effects from receiving too much medication. [Client C]'s doctor will be contacted today to get clarification on the correct dosage of Onfi and a new prescription will be requested if needed. Staff will be retrained on the check in procedure for all medications and a form will be created to document that the procedure has been done correctly and in a timely manner. The staff who did not properly check in the meds and the staff who passed the incorrect dosage will receive disciplinary action. The reason for the late submission of this report was miscommunication as to who was going						

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	<p>to submit the report." Further review of the report failed to indicate an investigation was conducted in regard to this incident of neglect.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/6/15 at 2:55 P.M.. A request for all investigations for this group home was made for the second time. The QIDP indicated investigation records are attached to the BDDS reports along with the IR. No written documentation was submitted for review to indicate the facility conducted investigations in regard to the abuse allegation and incident of neglect.</p> <p>An interview with the Group Home Director (GHD) and the QIDP was conducted on 1/9/15 at 11:30 A.M.. The QIDP indicated all allegations of abuse and neglect should be investigated. When asked if the above incidents were investigated, the QIDP indicated if the incidents were investigated the investigations would have been attached to the BDDS reports. The QIDP stated "I'm pretty sure I did an investigation about this incident (12/21/14), but I'm not sure if [Clerical Staff] or I gave it to you (indicating the GHD)." When asked if an investigation was conducted in regard to the medication error, the GHD stated</p>						

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W000159	<p>"No, because we knew what happened." No written documentation was submitted for review to indicate investigations were conducted in regards to the mentioned incidents.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on observation, record review and interview, for 1 of 3 sampled clients (client B), the facility's Qualified Intellectual Disabilities Professional failed to ensure client B's diet order included the recommendation of the client's "Speech Assessment" and failed to include a training objective in his Individual Support Plan (ISP) in regard to him shoving food in his mouth.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/6/15 from 5:05 P.M. until 6:05 P.M.. At 5:25 P.M., client B was prompted to the dining table by Direct Support Professional (DSP) #5.</p>	W000159	<p>QIDP will be retrained to ensure that all recommendations are being integrated, coordinated and monitored. Responsible person: Sheila O'Dell, Group Home Director.</p> <p>Consultants will be contacted to inform them of any medical changes or recommendations. Responsible person: Sheila O'Dell, Group Home Director and Traci Hardesty, QIDP.</p> <p>Client B's nutritional assessment will be updated to include speech recommendations. Responsible person: Sheila O'Dell, Group Home Director and Traci Hardesty, QIDP.</p> <p>Client B's self-feeding program will be revised to address not to shove food in his mouth. Responsible person: Traci Hardesty, QIDP.</p> <p>To ensure future compliance, a book review will be completed, which will include that all recommendations</p>	02/06/2015

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	<p>Client B sat down and grabbed the whole chicken leg off his plate and began taking large bites of the meat off the bone. Client B's chicken leg was not deboned and was not cut into small bite size pieces. Client B then began grabbing handfuls of broccoli and rice and shoving the food in his mouth. DSP #5 prompted client B to use his spoon and sat next to him and helped him scoop his food on a spoon as he shoved the food in his mouth.</p> <p>A review of client B's record was conducted on 1/7/15 at 2:37 P.M.. Review of client B's "Speech and Language Assessment" dated 6/29/14 indicated: "Should ensure all food items are cut into small bite size pieces for safety while eating/feeding to prevent choking and as he has no independent knife usage. Staff should ensure that meats are deboned whether eating at home or in the community." Review of client B's Nutritional Assessment dated 8/28/14 indicated: "Regular diet with double portions." Client B's Nutritional Assessment did not indicate small bite size pieces and meats should be deboned. Client B's Individual Support ISP dated 2/28/14 failed to include a training objective on shoving food in his mouth.</p> <p>An interview with the Qualified</p>		<p>are integrated and coordinated. Responsible person: Traci Hardesty, QIDP.</p>				

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W000189	<p>Intellectual Disabilities Professional (QIDP) was conducted on 1/9/15 at 11:30 A.M.. The QIDP indicated she did not know why client B's diet order did not indicate his meat should always be deboned and cut into small bite size pieces. When asked if client B's diet order should include the recommendation of his "Speech and Language Assessment", the QIDP indicated yes. The QIDP further indicated client B's ISP did not have a training objective to teach client B to not shove food in his mouth.</p> <p>9-3-3(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client C), the facility failed to ensure all staff who worked with the client C were sufficiently trained to assure competence in checking in medications when delivered from the pharmacy.</p> <p>Findings include:</p>	W000189	<p>All staff are trained upon hire and annually thereafter, which includes medication procedures. Responsible person: Ruth Estrada, training Coord, Sherri DiMarco, RN & Traci Hardesty, QIDP.</p> <p>To ensure future compliance, a protocol was developed on how to check in medication when delivered from the pharmacy. Responsible person: Sheila O'Dell, Group Home Director & Traci Hardesty, QIDP.</p> <p>All staff will be trained on the</p>	02/06/2015

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	<p>A review of the facility's records was conducted at the facility's administrative office on 1/6/15 at 2:35 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-BDDS report dated 1/2/15...Date of Knowledge: 1/3/15...Submitted Date: 1/5/15 involving client C indicated: "[Client C]'s seizure medication Onfi was delivered on 1/2/15 and staff put the bubble pack in his medication box without following the medication check in procedure. Per the script the pharmacy received from the doctor, the pharmacy did not send half tabs like usual but instead sent whole tabs. On 1/2/15 at 8 P.M., [client C] received 30 mg (milligrams) of Onfi instead of 15 mg. On 1/3/15 at 7 A.M., [client C] received 20 mg of Onfi instead of 10 mg. The error was noticed in the evening of 1/3/15 before 8 PM meds were passed. The copy of the script received at the home is hard to read due to it being faxed but it appears that the doctor ordered 10 mg in the AM and 20 mg in the PM-this is an increase of 5 mg per day in the PM based on previous prescriptions. The agency nurse and Administration was (sic) notified when the error was found. The nurse told staff not to pass [client C]'s</p>		<p>protocol on how to check in medication when delivered from the pharmacy. Responsible person: TraciHardesty, QIDP.</p> <p>To ensure future compliance, a check in/tracking sheet hasbeen put into place. Responsible person: Traci Hardesty, QIDP & AirielleRoger, Group Home Manager.</p>	

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	<p>evening meds since he had gotten too much in the past 24 hours. His regular scheduled passing of Onfi resumed on the morning of 1/4/15. As of 1/4/15, [client C] has received 10 mg on (sic) Onfi in the AM and 20 mg of Onfi in the PM, per the most recent prescription. [Client C] was sleepy all day on 1/3/15 but did not exhibit any other side effects from receiving too much medication. [Client C]'s doctor will be contacted today to get clarification on the correct dosage of Onfi and a new prescription will be requested if needed. Staff will be retrained on the check in procedure for all medications and a form will be created to document that the procedure has been done correctly and in a timely manner. The staff who did not properly check in the meds and the staff who passed the incorrect dosage will receive disciplinary action. The reason for the late submission of this report was miscommunication as to who was going to submit the report."</p> <p>A review of the staff personnel records was conducted on 1/8/15 at 1:35 P.M.. Review of the personnel records and staff training records failed to indicate all staff who worked at the group home were trained prior to 1/7/15 on how to check in medications when delivered from the pharmacy.</p>			

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W000227	<p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/7/15 at 2:10 P.M.. The QIDP stated staff were trained "today" on how to check in medication when delivered from the pharmacy.</p> <p>9-3-3(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN 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.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 3 sampled clients (client B), to ensure the Individual Support Plan (ISP) addressed client B's shoving of food into his mouth while eating.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/6/15 from 5:05 P.M. until 6:05 P.M.. At 5:25 P.M., client B</p>	W000227	<p>Client B's Individual support plan goal to self-feed was revised to address shoving food into his mouth. Responsible person: TraciHardesty, QIDP. All staff will be re-trained on the revision to client B's self-feed program. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, meal time reliability will be completed to show competency. Responsible person: Traci Hardesty, QIDP & Airielle Roger, Group Home Manager.</p>	02/06/2015

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	<p>was prompted to the dining table by Direct Support Professional (DSP) #5. Client B sat down and grabbed the whole chicken leg off his plate and began taking large bites of the meat off the bone. Client B's chicken leg was not deboned and was not cut into small bite size pieces. Client B then began grabbing handfuls of broccoli and rice and shoving the food in his mouth. DSP #5 prompted client B to use his spoon and sat next to him and helped him scoop his food on a spoon as he shoved the food in his mouth.</p> <p>A review of client B's record was conducted on 1/7/15 at 2:37 P.M.. Review of client B's "Speech and Language Assessment" dated 6/29/14 indicated: "Should ensure all food items are cut into small bite size pieces for safety while eating/feeding to prevent choking and as he has no independent knife usage. Staff should ensure that meats are deboned whether eating at home or in the community." Review of client B's Nutritional Assessment dated 8/28/14 indicated: "Regular diet with double portions." Client B's Nutritional Assessment did not indicate small bite size pieces and meats should be deboned. Client B's Individual Support ISP dated 2/28/14 failed to include a training objective on shoving food in his mouth.</p>			

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W000249	<p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/9/15 at 11:30 A.M.. The QIDP indicated she did not know why client B's diet order did not indicate his meat should always be deboned and cut into small bite size pieces. When asked if client B's diet order should include the recommendation of his "Speech and Language Assessment", the QIDP indicated yes. The QIDP further indicated client B's ISP did not have a training objective to teach client B to not shove food in his mouth.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 3 of 3 sampled clients (clients A, B and C), the facility failed to implement the clients' Individual Support Plan (ISPs) objectives when formal</p>	W000249	Client's objectives that are formal or informal for communication will be used during all times of opportunities. Responsible person: Traci Hardesty, QIDP. Staff will be retrained on the communication goals and that	02/06/2015

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	<p>and/or informal opportunities for training existed.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/6/15 from 6:45 A.M. until 8:00 A.M.. During the entire observation period, clients A and B were non-verbal in communication in that the clients did not speak. No communication training was provided and/or encouraged. Client C only used 1 word answers during the entire observation. No communication training was provided and/or encouraged.</p> <p>A review of client A's record was conducted on 1/7/15 at 1:20 P.M.. Review of client A's most current speech assessment dated 6/29/14 indicated: "[Client A] speaks very little uses PEC (Picture Exchange Communication) and sign language." Review of client A's Individual Support Plan (ISP) dated 9/16/14 indicated: "Uses PECS and sign language...Will increase communication, will respond to staff."</p> <p>A review of client B's record was conducted on 1/7/15 at 2:37 P.M.. Review of client B's ISP dated 2/28/14 indicated "Will use PECs."</p>		<p>each client's programs need to be ran in sufficient number and frequency to support the achievement of the objective. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, reliabilities will be completed to show staff competency. Responsible person: Traci Hardesty, QIDP & Airielle Roger, Group Home Manager. To ensure that the minimum frequency per objective is completed, all programs are scheduled weekly on the each client's daily activity schedule at least that minimum amount. Responsible person: Traci Hardesty, QIDP, Airielle Rogers, Manager & Angela Lewis, Data Specialist. To ensure future compliance daily, spot checks will be completed to ensure/enforce that communication will be used during times of opportunity for one week. Spot checks will then be done five times a week for another 3 weeks. Responsible person: Traci Hardesty, QIDP, Airielle Rogers, Manager & Angela Lewis, Data Specialist. To ensure future compliance, monthly a frequency report will be completed to compare number of times the objective should be ran verses the number of actual times the objective was completed and documented. Responsible person: Traci Hardesty, QIDP, Airielle Rogers, Manager & Angela Lewis, Data Specialist.</p>	

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W000260	<p>A review of client C's record was conducted on 1/7/15 at 3:16 P.M. Review of client C's ISP dated 2/12/14 indicated he should use a picture book while communicating.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/9/15 at 11:30 A.M.. The QIDP indicated the facility staff should implement clients A, B and C's communication training objectives at all times of opportunity.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview for 1 of 6 clients residing at the group home (client F), the facility failed to ensure the client's Individual Support Plan (ISP) was revised within 365 days of the previous</p>	W000260	All client's ISP are reviewed and a meeting is held within 365 days. The ISP and revisions are in place and trained on within two weeks of the ISP meeting. Responsible person: Traci Hardesty, QIDP & Airielle Roger, Group Home Manager.	02/06/2015

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W000323	<p>ISP.</p> <p>Findings include:</p> <p>A review of client F's record was conducted on 1/7/15 at 4:30 P.M.. Client F's record indicated a most recent ISP dated 12/11/13. There was no evidence of a more recent signed and dated ISP.</p> <p>An interview with the Group Home Director (GHD) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/9/15 at 11:30 A.M.. The QIDP indicated client F's ISP should be updated annually. The GHD stated the facility had 14 days to train staff and implement client F's updated ISP and that is "probably" why it was not available for review.</p> <p>9-3-4(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client C) to provide annual vision evaluations/assessments as recommended</p>	W000323	<p>Client F's ISP was completed and in the home. It is now filed in his records. Responsible person: Traci Hardesty, QIDP & Airielle Roger, Group Home Manager.</p> <p>Staff was re-trained on the ISP/revisions. Responsible person: Traci Hardesty, QIDP.</p> <p>To ensure future compliance, a check list for the ISP will be complete, which will include all of the changes, who is responsible for those changes, training and filed. Responsible person: Traci Hardesty, QIDP, Airielle Roger, Group Home Manager & Data Specialist, Angie.</p> <p>All examinations of each client are obtained annual or as recommended. Responsible person: Sherri DiMarco, RN, Traci Hardesty, QIDP, Airielle Roger, Group</p>	02/06/2015

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W000368	<p>by the optometrist.</p> <p>Findings include:</p> <p>A review of client C's record was conducted on 1/7/15 at 3:16 P.M. Review of client C's most current vision assessment/evaluation dated 12/18/12 indicated: "Return in 2 years." Further review of the record failed to indicate client C returned in 2 years as recommended by the optometrist.</p> <p>An interview with the Group Home Manager (GHM) was conducted on 1/7/15 at 3:30 P.M.. The GHM indicated there was no evidence client C returned in 2 years as recommended by the optometrist for an evaluation/assessment of his vision.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed to assure drugs administered to 1 of 3 sampled clients</p>	W000368	<p>Home Manager Client C's vision was completed as ordered. Responsible person: Traci Hardesty, QIDP, Airielle Roger, Group Home Manager Client C's vision report is filed in his records. Responsible person: Traci Hardesty, QIDP, Airielle Roger, Group Home Manager To ensure future compliance, at least monthly the nurse reviews all exams and recommendations for next appointment. Responsible person: Sherri DiMarco, RN. To ensure future compliance, a book review will be completed, which will include that all required exams are filed. Responsible person: Traci Hardesty, QIDP.</p> <p>All staff are trained upon hire and annually their after, which includes med administration/medication pass/procedures.</p>	02/06/2015			

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	<p>(client C) were administered in compliance with the physician's orders.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 1/6/15 at 3:50 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-BDDS report dated 1/2/15...Date of Knowledge: 1/3/15...Submitted Date: 1/5/15 involving client C indicated: "[Client C]'s seizure medication Onfi was delivered on 1/2/15 and staff put the bubble pack in his medication box without following the medication check in procedure. Per the script the pharmacy received from the doctor, the pharmacy did not send half tabs like usual but instead sent whole tabs. On 1/2/15 at 8 P.M., [client C] received 30 mg (milligrams) of Onfi instead of 15 mg. On 1/3/15 at 7 A.M., [client C] received 20 mg of Onfi instead of 10 mg. The error was noticed in the evening of 1/3/15 before 8 PM meds were passed. The copy of the script received at the home is hard to read due to it being faxed but it appears that the doctor ordered 10 mg in the AM and 20 mg in the PM-this is an</p>		<p>Responsibleperson: Ruth Estrada, training Coord, Sherri DiMarco, RN & Traci Hardesty,QIDP.</p> <p>Staff that did not follow proper protocol received disciplinaryaction. Responsible person: Traci Hardesty, QIDP.</p> <p>To ensure future compliance, a protocol was developed on howto check in medication when delivered from the pharmacy. Responsible person:Sheila O'Dell, Group Home Director & Traci Hardesty, QIDP. All staff will be trained on the protocol on how to check inmedication when delivered from the pharmacy. Responsible person: TraciHardesty, QIDP.</p> <p>To ensure future compliance, a check in/tracking sheet hasbeen put into place. Responsible person: Traci Hardesty, QIDP & AirielleRoger, Group Home Manager.</p> <p>To ensure future compliance, a med pass buddycheck was put into place to review that all meds were passed. Responsibleperson: Traci Hardesty, QIDP.</p>	

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	<p>increase of 5 mg per day in the PM based on previous prescriptions. The agency nurse and Administration was (sic) notified when the error was found. The nurse told staff not to pass [client C]'s evening meds since he had gotten too much in the past 24 hours. His regular scheduled passing of Onfi resumed on the morning of 1/4/15. As of 1/4/15, [client C] has received 10 mg on (sic) Onfi in the AM and 20 mg of Onfi in the PM, per the most recent prescription. [Client C] was sleepy all day on 1/3/15 but did not exhibit any other side effects from receiving too much medication. [Client C]'s doctor will be contacted today to get clarification on the correct dosage of Onfi and a new prescription will be requested if needed. Staff will be retrained on the check in procedure for all medications and a form will be created to document that the procedure has been done correctly and in a timely manner. The staff who did not properly check in the meds and the staff who passed the incorrect dosage will receive disciplinary action. The reason for the late submission of this report was miscommunication as to who was going to submit the report."</p> <p>An interview with the Qualified Intellectual Disabilities Professional</p>			

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W000460	<p>(QIDP) was conducted on 1/8/15 at 11:30 A.M.. The QIDP indicated client C did not receive his prescribed medication as ordered. The QIDP indicated client C should have received his medication as ordered. The QIDP further indicated the facility should have ensured client C's prescribed medication was available as ordered for administration.</p> <p>9-3-6(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview, for 1 of 2 sampled clients (client A), the facility failed to assure the staff followed the client's diet orders.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/6/15 from 6:45 A.M. until 8:00 A.M.. During the entire observation period Direct Support Professionals (DSPs) #1 and #2 did not prompt or provide client A with any water before his meal, during or after his meal.</p>	W000460	<p>QIDP, nurse and management staff will be retrained to ensure that all recommendations are being integrated, coordinated and monitored. Responsible person: Sheila O'Dell, Group Home Director. All staff will be re-trained on Client A's diet orders. Responsible person: Traci Hardesty, QIDP.</p> <p>To ensure future compliance, the activity schedule and the fluid tracking sheet will be updated to include the specific water times that are to be offered. Responsible person: Traci Hardesty, QIDP & Airielle Roger, Group Home Manager.</p>	02/06/2015

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W000484	<p>An observation was conducted at the group home on 1/6/15 from 5:05 P.M. until 6:05 P.M.. During the observation period DSPs #3, #4 and #5 did not prompt and did not provide client A with water before, during his or after his meal.</p> <p>A review of client A's record was conducted on 1/7/15 at 1:20 P.M.. Review of client A's "Nutritional Assessment" dated 8/28/14 indicated: "Constipation, one glass of water between and after each meal."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/9/15 at 11:30 A.M.. The QIDP indicated staff should prompt or offer client A to drink water as recommended by the dietician due to his diagnosis of constipation.</p> <p>9-3-8(a)</p> <p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p>			

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	<p>Based on observation and interview, the facility failed for 6 of 6 clients (clients A, B, C, D, E and F) residing in the group home to provide sugar/sugar substitute, jelly, milk, butter/margarine and syrup at the dining table.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 1/6/15 from 6:45 A.M. until 8:00 A.M.. At 7:30 A.M., clients A and B were prompted to sit at the table located in the kitchen to eat their breakfast which consisted of oatmeal and toast. Clients C, D, E and F were prompted to sit at the dining room table. Clients C and D's breakfast consisted of oatmeal and toast and client F's breakfast consisted of cold cereal and toast. At 7:35 A.M. , Direct Support Professional (DSP) #2 set bottles of cinnamon and yellow mustard on the kitchen table where clients A and B sat eating their breakfast. There was no sugar/sugar substitute, butter/margarine, milk or jelly on the table for clients A and B to use for their meal. Client A kept looking at the bottle of mustard while he ate his toast. At 7:40 A.M., after eating his toast, client A took the bottle of yellow mustard and poured 1/4 of the bottle on to his plate and began eating the mustard. DSPs #1</p>	W000484	<p>All staff were re-trained on providing thedesignated/appropriate condiments for the clients at each meal.</p> <p>To ensure future compliance, mealtime reliability will becompleted to ensure competency on each staff during several mealtimeobservations.</p> <p>To ensure future compliance, the mealtime reliability will becompleted weekly for one month. Responsible person: Traci Hardesty, QIDP &Airielle Roger, Group Home Manager.</p>	02/06/2015

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	<p>and #2 did not prompt client A not to eat the mustard. At 7:42 A.M., client E asked DSP #1 for syrup. DSP #1 indicated there was no syrup. On the dining room table where clients C, D, E and F ate their breakfast was an empty jar of grape jelly and a jar of mayonnaise. There was no sugar/sugar substitute, butter/margarine, milk, jelly or syrup on the kitchen or dining room tables.</p> <p>An interview with DSP #1 was conducted at the group home on 1/6/15 at 7:50 A.M.. When asked if condiments should coordinate with the meals, DSP #1 indicated yes. When asked why mayonnaise and mustard were put on the table, DSP #1 indicated he did not know.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/9/15 at 11:30 A.M.. When asked if condiments that should be used with the meals should have been provided for clients to use with their meal, the QIDP indicated yes. The QIDP further indicated staff should not have put mayonnaise and mustard on the tables for breakfast.</p> <p>9-3-8(a)</p>				

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W009999	<p>1. State Findings:</p> <p>460 IAC 9-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This state rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client C), to report a medication error to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 1/6/15 at 3:50 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p>	W009999	<p>All incident report will be reported to BDDS within 24hours.</p> <p>QIDP will be re-trained on reporting to BDDS within 24hours. Responsible person: Sheila O'Dell, Group Home Director.</p> <p>To ensure future compliance, when an incident is reported immediately; it will be stated/clarified who will be submitting the report. Responsible person: Sheila O'Dell, Group Home Director, Traci Hardesty, QIDP & Airielle Roger, Group Home Manager.</p> <p>All employees have 3 references prior to employment.</p> <p>Responsible person: Mary Jane Lewis, Human Resource Director.</p>	02/06/2015

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	<p>-BDDS report dated 1/2/15...Date of Knowledge: 1/3/15...Submitted Date: 1/5/15 involving client C indicated: "[Client C]'s seizure medication Onfi was delivered on 1/2/15 and staff put the bubble pack in his medication box without following the medication check in procedure. Per the script the pharmacy received from the doctor, the pharmacy did not send half tabs like usual but instead sent whole tabs. On 1/2/15 at 8 P.M., [client C] received 30 mg (milligrams) of Onfi instead of 15 mg. On 1/3/15 at 7 A.M., [client C] received 20 mg of Onfi instead of 10 mg. The error was noticed in the evening of 1/3/15 before 8 PM meds were passed. The copy of the script received at the home is hard to read due to it being faxed but it appears that the doctor ordered 10 mg in the AM and 20 mg in the PM-this is an increase of 5 mg per day in the PM based on previous prescriptions. The agency nurse and Administration was (sic) notified when the error was found. The nurse told staff not to pass [client C]'s evening meds since he had gotten too much in the past 24 hours. His regular scheduled passing of Onfi resumed on the morning of 1/4/15. As of 1/4/15, [client C] has received 10 mg on (sic) Onfi in the AM and 20 mg of Onfi in the PM, per the most recent prescription. [Client C]</p>			

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	<p>was sleepy all day on 1/3/15 but did not exhibit any other side effects from receiving too much medication. [Client C]'s doctor will be contacted today to get clarification on the correct dosage of Onfi and a new prescription will be requested if needed. Staff will be retrained on the check in procedure for all medications and a form will be created to document that the procedure has been done correctly and in a timely manner. The staff who did not properly check in the meds and the staff who passed the incorrect dosage will receive disciplinary action. The reason for the late submission of this report was miscommunication as to who was going to submit the report." Further review of the report failed to indicate this incident was reported to BDDS in a timely manner.</p> <p>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 1/6/15 at 4:15 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS....Incidents to be reported to</p>			

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	<p>BDDS...16. A medication error or medical treatment error as follows: ...b. wrong medication dosage given."</p> <p>An interview with the Group Home Director (GHD) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/9/15 at 11:30 A.M.. The QIDP indicated the incident should have been reported immediately to the administrator and within 24 hours to BDDS. The QIDP further indicated the incident was not reported/reported timely to BDDS.</p> <p>9-3-1(b)</p> <p>2. State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-2 Resident Protections</p> <p>(c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is:</p> <p>(3) conviction of a crime substantially related to a dependent population or any violent crime.</p> <p>The provider shall obtain, as a minimum,</p>				

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	<p>a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5 [IC 5-2-5 was repealed by P.L.2-2003, SECTION 102, effective July 1, 2003. See IC 10-13-3-27.], and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>This State Rule is not met as evidenced by:</p> <p>Based on record review and interview, for 1 of 3 staff (staff #13) personnel files reviewed, the facility failed to ensure three references were obtained prior to employment.</p> <p>Findings include:</p> <p>The facility's administrative records were reviewed on 1/8/15 at 1:35 P.M.. Review of the personnel files for staff #13 indicated three references were not obtained. The personnel files indicated only two references were obtained for staff #13.</p> <p>An interview with the Human Resource Director (HRD) was conducted on 1/8/15 at 2:31 P.M.. The HRD indicated the facility's policy is that each employee should have three references, completed</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	prior to employment with the facility. The HRD further indicated staff #13 did not have 3 references in their personnel record prior to employment. 9-3-2(c)(3)				