

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G652	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/11/2015
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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240
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W 0000  Bldg. 00	<p>This visit was for a predetermined full recertification and state licensure survey.</p> <p>Survey Dates: December 1, 2, 3, 4 and 11, 2015.</p> <p>Facility Number: 001190 Provider Number: 15G652 AIM Number: 100233930</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/17/15.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the governing body failed to exercise general policy and operating direction over the facility to prevent the abuse/neglect of the clients, to ensure the facility staff reported all allegations of abuse/neglect immediately to the administrator and to the BDDS (Bureau</p>	W 0104	<p><b>Corrective actions taken:</b> · All county QIDPs were in-serviced on client rights, client finance policy, 3 day emergency food supply auditing, DSI's ANE policy, incident reporting and investigations on 12/23/15 ( Attachment J) · Client's #1, #2 &amp; #3 were reimbursed all funds erroneously deducted from their accounts for services that are agency provided. · All expired</p>	01/10/2016

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>of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law and to ensure all allegations of abuse/neglect and injuries of unknown origin were investigated and/or thoroughly investigated.</p> <p>The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the clients did not pay for their own personal haircuts, medications, medical supplies and/or medical tests and to ensure the clients' financial records were maintained for clients #1, #2 and #3.</p> <p>The facility's governing body failed to exercise general policy and operating direction over the facility to ensure an emergency food supply was maintained for clients #1, #2, #3, #4, #5 and #6.</p> <p>Findings include:</p> <p>1. Client #1's, #2's and #3's financial records for 2015 were reviewed with the Social Services Coordinator (SSC) on 12/3/15 at 11 AM.</p> <p>Client #1's Petty Cash Reports (PCRs) indicated:            ___ 11/21/15 - \$15.50 for a haircut.            ___ 8/5/15 - \$4.00 for a TB (Tuberculin)</p>		<p>food from the 3 day emergency supply was thrown out and replaced. · Group home staff will be in-serviced on client rights, finance policy, 3 day emergency food supply check, ANE policy &amp; incident reporting. <b>How will we identify others:</b> · The Quality Assurance auditor for group homes and all QIDPs will audit group home finances from the past year to ensure clients are not paying for services that the agency is responsible for. Any discrepancy found will result in an immediate reimbursement to the client's account. · All DSI group homes have implemented a revised night auditor checklist that requires nightly 3 day emergency food supply inspection for expired food. · The Quality assurance director will review all incidents to ensure proper reporting and investigations. <b>Measures put in place:</b> · Night audit sheet that includes check for expired food in 3 day emergency supply ( Attachment A) · Night audit checklist requires the night auditor to account for all client funds and to report any discrepancies to the QIDP immediately ( Attachment A) · Group home observation sheet ( Attachment B) · Group home monthly record review ( Attachment D) <b>Monitoring of corrective action:</b> · QIDP will perform monthly documented observations on all shifts to ensure staff understand the</p>	

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	<p>test.</p> <p>Client #2's PCRs indicated the following:            ___ 11/9/15 - \$11.71 for diabetic socks.            ___ 11/21/15 - \$14.50 for a haircut.            ___ 8/5/15 - \$4.00 for a TB test.</p> <p>Client #3's 2015 PCRs indicated:            ___ 11/9/15 - \$11.71 for diabetic socks.            ___ 11/21/15 - \$15.50 for a haircut.            ___ 8/5/15 - \$4.00 for a TB test.            ___ 7/21/15 - \$2.67 for medication from a local pharmacy.</p> <p>Interview with the Social Services Coordinator (SSC) on 12/4/15 at 12 PM indicated clients were not to pay for personal haircuts, medications, medical supplies and/or TB tests.</p> <p>2. Observations were conducted at the group home on 12/1/15 between 3:45 PM and 6:45 PM. The facility's three day emergency food supply was in two large plastic tubs in the garage. Inside one of the tubs were the following foods:            ___ Five packages of rice cakes that indicated best buy dates of July 8 and 12, 2015            ___ A generic box of cheerios with no visible expiration date.            ___ Two boxes of snack crackers with a best buy date of 5/8/15.            ___ Packages of instant mashed potatoes</p>		<p>finance policy, incident reporting and that the night auditor is properly completing the night audit checklist. · The Quality Assurance manager for group homes will audit the home monthly to ensure proper accounting of client funds and incident reporting and documentation. · DSI group home finance specialist will audit group home finances twice a month to ensure proper accounting and handling of client funds. · Regional program manager will audit all group home finance books and sign off that they staff are following DSI policy and procedure regarding agency responsibility for paying for medical related items and haircuts.</p>	

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	<p>with a best by date of November, 2015.</p> <p>___A large bag of animal crackers with a best buy date of November, 2015.</p> <p>___Several containers of ready to serve chicken and rice soup with a best buy date of October, 2015.</p> <p>___A box of saltine crackers with a best buy date of 8/10/15.</p> <p>___A box of graham crackers with a best buy date of 7/22/15.</p> <p>Interview with the SSC and the Team Lead (TL) on 12/4/15 at 11 AM indicated the food in the emergency food supply boxes was to be rotated every three months. The TL stated, "I haven't checked the emergency food supply boxes for a few months." The TL stated currently no one was assigned to maintain or check the emergency food supply boxes.</p> <p>3. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure a full and complete accounting of the clients' personal finances for clients #1, #2 and #3. Please see W140.</p> <p>4. The facility's governing body failed to exercise general policy and operating direction over the facility to prevent the abuse/neglect of the clients, to ensure the facility staff reported all allegations of</p>				

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W 0129	<p>abuse/neglect immediately to the administrator and to the BDDS and APS according to state law and to ensure all allegations of abuse/neglect and injuries of unknown origin were investigated and/or thoroughly investigated for clients #1, #2, #3, #4, #5 and #6. Please see W149.</p> <p>5. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the staff immediately reported all allegations of abuse/neglect to the administrator and to the BDDS and APS according to state law for clients #1, #2, #3, #4, #5 and #6. Please see W153.</p> <p>6. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure an investigation was conducted for all allegations of abuse/neglect and injuries of unknown origin and to ensure all investigations conducted were thorough for clients #1, #2, #3, #4, #5 and #6. Please see W154.</p> <p>9-3-1(a)</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</p>						

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Bldg. 00	<p>The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy.</p> <p>Based on observation and interview for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to ensure the clients' first and last names were not written on a dry erase board between the kitchen and dining room where anyone entering the group home could see and read the clients' names.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/1/15 between 3:45 PM and 6:45 PM and on 12/2/15 between 6 AM and 7:45 AM.</p> <p>__A large dry erase board hung on the wall between the kitchen and the dining room area.</p> <p>__Client #1's, #2's, #3's, #4's, #5's and #6's first and last names were written on the dry erase board along with the chores they were assigned to do for the week.</p> <p>__Anyone entering the home and going through the kitchen and/or the dining room could see and read the clients' first and last names and the chores they were assigned for the week.</p> <p>During interview with the Social Services Coordinator (SSC) on 12/4/15 at 2 PM,</p>	W 0129	<p><b>Corrective actions taken:</b></p> <ul style="list-style-type: none"> <li>· The clients' last names were immediately erased from the board upon discovery by the surveyor</li> <li>· All county QIDPs were in-serviced on client privacy on 12/23/15 ( Attachment J)</li> <li>· Group home staff will be in-serviced on client privacy</li> </ul> <p><b>How will we identify others:</b></p> <ul style="list-style-type: none"> <li>· All QIDPs will ensure that personal client information is protected in all homes. QIDPs will correct any violation of client privacy immediately.</li> <li>· QA for group homes will audit all agency homes monthly to ensure client privacy is protected.</li> <li>· All QIDP s will utilize 3 monthly documented observations to ensure client privacy is being protected</li> </ul> <p><b>Measures put in place:</b></p> <ul style="list-style-type: none"> <li>· Group home observation sheet ( Attachment B)</li> <li>· Group home monthly record</li> </ul>	01/10/2016
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W 0140 Bldg. 00	<p>the SSC:            ___ Indicated the staff were not to post the clients' first and last names anywhere in the home.            ___ Indicated the clients' personal information was to be protected at all times.            ___ Stated, "They (the staff) shouldn't have done that."            9-3-2(a)</p> <p>483.420(b)(1)(i)            CLIENT FINANCES            The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to provide a full and complete accounting of the clients' personal finances.</p> <p>Findings include:            Client #1's, #2's and #3's financial records for 2015 were reviewed with the Social Services Coordinator (SSC) on 12/3/15 at 11 AM.</p>	W 0140	<p>review ( Attachment D)</p> <p><b>Monitoring of corrective action:</b></p> <ul style="list-style-type: none"> <li>QIDP will perform monthly documented observations on all shifts to ensure client privacy continues to be protected</li> <li>The QA for group homes will audit the home monthly to ensure client protection continues to be protected</li> </ul> <p><b>Corrective actions taken:</b></p> <ul style="list-style-type: none"> <li>All county QIDPs were in-serviced on client finance policy on 12/23/15 ( Attachment J)</li> <li>Client's #1, #2 &amp; #3 were reimbursed all funds erroneously deducted from their accounts for services that are agency provided.</li> <li>A day program client discretionary funds ledger was created ( Attachment C)</li> </ul>	01/10/2016			

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	<p>Client #1's Petty Cash Reports (PCRs) indicated:</p> <p>__ On 12/1/15 \$20.00 was removed from client #1's PC (Petty Cash) for the workshop.</p> <p>__ Client #1's PCR for October indicated an ending balance of \$25.22. Client #1's November PCR beginning balance indicated \$29.85, a difference of \$4.63.</p> <p>__ On 10/12/15 \$10.00 was removed from client #1's PC for the workshop. Client #1's financial records indicated no signed receipt by client #1 and/or the staff for the \$10.00 that went to the workshop.</p> <p>__ On 9/1/15 \$20.00 was removed from client #1's PC for the workshop and to go out to eat. Client #1's financial records indicated no signed receipt by client #1 or the staff for the \$20.00 and indicated no receipt for dining out on 9/1/15.</p> <p>__ On 8/7/15 client #1 went out to eat and spent \$8.00. Client #1's record indicated no receipt for the \$8.00.</p> <p>__ Client #1's check book indicated a withdrawal on 7/9/15 of \$30.00 for PC. Client #1's July PCR indicated no deposit of \$30.00 into client #1's PC on 7/9/15.</p> <p>__ On 7/1/15 \$20.00 was removed from client #1's PC for the workshop.</p> <p>Client #2's PCRs indicated:</p> <p>__ On 5/13/15 "[Client #3] paid back" in the amount of \$6.93. Client #2's records</p>		<ul style="list-style-type: none"> <li>· Group home staff will be in-serviced on client finances.</li> </ul> <p><b>How will we identify others:</b></p> <ul style="list-style-type: none"> <li>· The Quality Assurance auditor for group homes and all QIDPs will audit group home finances from the past year to ensure clients are not paying for services that the agency is responsible for. Any discrepancy found will result in an immediate reimbursement to the client's account.</li> <li>· All DSI day programs will implement client discretionary funds ledger ( Attachment C)</li> </ul> <p><b>Measures put in place:</b></p> <ul style="list-style-type: none"> <li>· Night audit checklist requires the night auditor to account for all client funds and to report any discrepancies to the QIDP immediately ( Attachment A)</li> <li>· Day program client discretionary funds ledger ( Attachment C)</li> </ul> <p><b>Monitoring of corrective action:</b></p>	

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	<p>indicated no receipt for the \$6.93.</p> <p>Client #3's PCRs indicated:            ___ On 10/10/15 a purchase in the amount of \$13.78 was made at a local department store. Client #3's records indicated no receipt for the purchase.            ___ On 10/22/15 \$20.00 was removed from client #3's checking account to replenish client #3's PC. Client #3's October PCR indicated no deposit for the \$20 removed from client #3's checking account.            ___ On 9/1/15 \$20.00 was removed from client #3's PC for the workshop.</p> <p>Interview with the TL (Team Lead) on 12/4/15 at 11:50 AM indicated clients #1 and #3 maintained a small amount of money at the day program. The TL indicated the staff would replenish the money at the day program with the clients' PC.</p> <p>During interview with the SSC on 12/4/15 at 12 PM, the SSC:            ___ Indicated receipts were to be obtained for all purchases.            ___ Indicated the clients' financial records were to be maintained and accurate at all times.            ___ Indicated the day program was facility owned.            ___ Indicated the staff would take money</p>		<ul style="list-style-type: none"> <li>· QIDP will perform monthly documented observations on all shifts to ensure staff are properly documenting client finances.</li> <li>· The QA for group homes will audit the home monthly to ensure proper accounting of client funds and incident reporting and documentation.</li> <li>· DSI group home finance specialist will audit group home finances twice a month to ensure proper accounting and handling of client funds.</li> </ul>				

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W 0149 Bldg. 00	<p>periodically from client #1's and client #3's PC to keep at the DP to use for outings and activities while at the day program.</p> <p>___ Indicated the day program staff did not keep a PCR and/or receipts to account for the money taken to the day program for clients #1 and #3.</p> <p>9-3-2(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. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to implement its policy and procedures to prevent abuse/neglect of the clients, to ensure the facility staff reported all allegations of abuse/neglect immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law and to ensure all allegations of abuse/neglect and injuries of unknown origin were investigated and/or thoroughly investigated.</p>	W 0149	<p><b>Corrective actions taken:</b></p> <ul style="list-style-type: none"> <li>· All county QIDPs were in-serviced on client rights, DSI's ANE policy, incident reporting and investigations on 12/23/15 ( Attachment J)</li> <li>· Group home staff will be in-serviced on client rights, ANE policy &amp; incident reporting.</li> </ul> <p><b>How will we identify others:</b></p> <ul style="list-style-type: none"> <li>· The Quality assurance director will review all incidents to ensure proper reporting and investigations</li> </ul>	01/10/2016	

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	<p>Findings include:</p> <p>Review of the 4/12/06 facility policy "Identifying and Reporting Suspected Abuse and Neglect" on 12/3/15 at 1 PM indicated:</p> <p>___ "Neglect: Placing an individual in a situation that may endanger his or her life or health; includes failure to provide appropriate care, food, medical care, shelter, or supervision."</p> <p>___ "Injuries of unknown origin: Any significant injury of unknown origin should be investigated as potential abuse or neglect. Description of any area that is visibly swollen or red; finger like bruising as if grabbed; any unusual complaints of pain by the client with no known medical reason."</p> <p>___ "Any DSI staff member or consultant who suspects an individual is the victim of abuse or neglect will immediately report this suspicion within one hour of discovery to their supervisor/QIDP (Qualified Intellectual Disabilities Professional) or the emergency response system. The QIDP will report the incident immediately to the Program Manager, Program Director, and Executive Director or other identified designee of the Executive Director. The QIDP is ultimately responsible for ensuring the report is also made to the Adult</p>		<p><b>Measures put in place:</b></p> <ul style="list-style-type: none"> <li>· Group home observation sheet ( Attachment B)</li> <li>· Group home monthly record review ( Attachment D)</li> </ul> <p><b>Monitoring of corrective action:</b></p> <ul style="list-style-type: none"> <li>· QIDP will perform monthly documented observations on all shifts to ensure staff understand the incident reporting</li> <li>· The QA for group homes will audit the home monthly to ensure proper incident reporting and documentation.</li> <li>· RPM will review all incident reports to ensure proper follow up and investigation</li> </ul>	
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W 0153 Bldg. 00	<p>Protective Services Representative or Child Protective Services within 24 hours." __The policy indicated all allegations of abuse/neglect were to be investigated.</p> <p>1. The facility failed to implement its policy and procedures to ensure the staff immediately reported all allegations of abuse/neglect to the administrator and to the BDDS and APS according to state law for clients #1, #2, #3, #4, #5 and #6. Please see W153.</p> <p>2. The facility failed to implement its policy and procedures to ensure an investigation was conducted for all allegations of abuse/neglect and injuries of unknown origin and to ensure all investigations conducted were thorough for clients #1, #2, #3, #4, #5 and #6. Please see W154.</p> <p>9-3-2(a) 9-3-1(b)(5)</p> <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.</p>			

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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240			
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	<p>Based on record review and interview for 2 of 12 allegations of abuse/neglect reviewed, the facility failed to ensure the staff immediately reported all allegations of abuse/neglect to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for clients #1, #2, #3, #4, #5 and #6.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 12/2/15 at 9 AM.</p> <p>1. The Bureau of Developmental Disabilities Services (BDDS) report dated 2/5/15 indicated on 2/4/15 staff #6 and #7 notified the Qualified Intellectual Disabilities Professional (QIDP) of alleged abuse/neglect of clients #1, #2, #3, #4, #5 and #6 by the night shift staff (staff #5). Staff #6 and staff #7 alleged staff #5:</p> <p>__ Smoked "marijuana" prior to coming into work.</p> <p>__ Slept while working the overnight shift.</p> <p>__ Allowed off duty staff to come into the group home at night.</p> <p>__ Staff #5 left clients #1, #2, #3, #4, #5 and #6 unattended during the overnight</p>	W 0153	<p><b>Corrective actions taken:</b></p> <ul style="list-style-type: none"> <li>· All county QIDPs were in-serviced on client rights, medication pass procedure, client privacy DSI's ANE policy, incident reporting and investigations on 12/23/15 and peer to peer aggression reporting. ( Attachment J)</li> <li>· Group home staff will be in-serviced on client rights, ANE policy &amp; incident reporting, client privacy, medication pass procedure and peer on peer aggression reporting.</li> <li>· Day program staff were in-serviced on incident reporting and peer to peer aggression reporting on 12/22/15. ( Attachment E)</li> <li>· Staff #5 was terminated from employment at DSI on 2/6/15</li> </ul> <p><b>How will we identify others:</b></p> <ul style="list-style-type: none"> <li>· The Quality assurance director will review all incidents to ensure proper reporting and investigations</li> </ul> <p><b>Measures put in place:</b></p>	01/10/2016			

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	<p>shift when staff #5 left the home to meet his "dealer."</p> <p>The BDDS report indicated interviews with staff and clients.</p> <p>__Staff #6 and staff #7 indicated staff #5 "reeked of weed" and "his eyes were glossy and red" when he reported to work the night of 2/3/15.</p> <p>__Staff #6 and staff #7 alleged staff #5 told them he slept "all the time" while working.</p> <p>__Staff #4 indicated staff #5 told her he was "stoned (on drugs)" and alleged staff #5 would leave trash lying on the floor and the trash cans running over with trash.</p> <p>__Staff #8 indicated staff #5 told her he slept at night while at work, he smoked "weed (marijuana)" every night and he (staff #5) turned the clients' bed alarms off at night so he wouldn't have to hear them.</p> <p>__The TL (Team Lead) and staff #8 indicated staff #5 told them he was previously fired from another facility for having marijuana in his car.</p> <p>__Staff #8 indicated staff #5's eyes were "always red and glassy."</p> <p>__Staff #8 alleged staff #5 had left the group home at night while working to meet his drug dealer.</p> <p>__The TL alleged staff #5 would set the clients' medications on the dining room</p>		<ul style="list-style-type: none"> <li>· Group home observation sheet ( Attachment B)</li> <li>· Group home monthly record review ( Attachment D)</li> </ul> <p><b>Monitoring of corrective action:</b></p> <ul style="list-style-type: none"> <li>· QIDP will perform monthly documented observations on all shifts to ensure staff understand the incident reporting</li> <li>· The QA for group homes will audit the home monthly to ensure proper incident reporting and documentation.</li> <li>· RPM will review all incident reports to ensure proper follow up and investigation</li> </ul>		

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	<p>table in their cups in front of each client for the clients to take their medications on their own and on the weekends staff #5 would take the clients' medications to their bedrooms instead of prompting them to get up and take their medications. ___ Clients #1, #2 and #6 indicated staff #5 slept at night while working.</p> <p>The BDDS report indicated the staff failed to report the allegations of abuse/neglect of clients #1, #2, #3, #4, #5 and #6 immediately upon knowledge of the abuse/neglect to the administrator.</p> <p>During interview with the Social Service Coordinator (SSC) on 12/4/15 at 11 AM, the SSC: ___ Indicated the staff failed to report allegations of abuse/neglect of clients #1, #2, #3, #4, #5 and #6 by staff #5 immediately to the administrator upon knowledge of the abuse/neglect. ___ Indicated she did not know how long the staff were aware of staff #5's abuse/neglect of the clients and stated, "But apparently for awhile." ___ Indicated all allegations of abuse/neglect were to be reported immediately to the administrator and to BDDS and APS within 24 hours of knowledge of the abuse/neglect.</p> <p>2. The 5/12/15 Incident Report from the</p>			

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W 0154  Bldg. 00	<p>day program indicated client #6 was sitting at a table when another client came up and hit client #6 twice on the arm. The facility records indicated the allegation of abuse was not reported immediately to the administrator and/or reported to the BDDS or APS.</p> <p>During interview with the SSC on 12/4/15 at 2 PM, the SSC:            ___ Indicated all allegations of abuse were to be reported immediately to the administrator and then to BDDS and APS within 24 hour of knowledge of the abuse/neglect.            ___ Indicated the incident on 5/12/15 happened at the day program and stated, "They (the day program staff) should have reported it."</p> <p>9-3-2(a) 9-3-1(b)(5)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 10 of 12 allegations of abuse/neglect and 2 of 5 injuries of unknown origin reviewed, the facility failed to ensure an</p>	W 0154	<p><b>Corrective actions taken:</b></p> <ul style="list-style-type: none"> <li>All county QIDPS were in-serviced on thorough</li> </ul>	01/10/2016			

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	<p>investigation was conducted for all allegations of abuse/neglect and injuries of unknown origin and to ensure all investigations conducted were thorough for clients #1, #2, #3, #4, #5 and #6.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 12/2/15 at 9 AM.</p> <p>The 9/27/15 Adverse Incident Report indicated on 9/27/15 at 5 PM the staff were cooking in the kitchen when a skillet began to "smoke from burning." The smoke alarms activated, clients #1, #2, #3, #4, #5 and #6 were evacuated from the home and the local fire department was called. Once the smoke was cleared the clients returned inside the home.</p> <p>__The facility investigative records indicated no investigation was conducted.</p> <p>The 7/24/15 Bureau of Developmental Disabilities Services (BDDS) report indicated on 7/23/15 at 7 PM client #3 grabbed client #5 around the neck and the upper right arm.</p> <p>__The 7/23/15 investigative records indicated no client interviews for the incident of 7/23/15. The investigative records failed to indicate a thorough</p>		<p>investigations, client rights, peer on peer aggression reporting &amp; unknown injury reporting on 12/23/15. ( Attachment J)</p> <ul style="list-style-type: none"> <li>Group home staff will be in-serviced on client rights, ANE policy, injuries of unknown origin incident reporting &amp; incident reporting.</li> <li>Day program staff were in-serviced on incident reporting and peer to peer aggression reporting on 12/22/15. ( Attachment E)</li> </ul> <p><b>How will we identify others:</b></p> <ul style="list-style-type: none"> <li>The regional program manager will receive all incident reports, BDDS reportable and internal, in order to ensure QIDPs conduct investigations when appropriate.</li> <li>The Quality assurance director will review all incidents to ensure proper reporting and investigations.</li> </ul> <p><b>Measures put in place:</b></p> <ul style="list-style-type: none"> <li>Group home observation sheet ( Attachment B)</li> <li>Group home monthly record review ( Attachment D)</li> </ul>				

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	<p>investigation was completed.</p> <p>The 7/7/15 Medical Incident Report indicated on 7/7/15 at 11:15 AM while away from the group home the staff noted an injury on client #1's left arm. After returning home the staff applied an antibiotic ointment and a bandage to the area. The report indicated the client and staff did not know how the client was injured. __The facility investigative records indicated no investigation was conducted.</p> <p>The 5/12/15 Incident Report from the day program indicated client #6 was sitting at a table when another client came up and hit client #6 twice on the arm. __The facility investigative records indicated no investigation was conducted in regard to the allegations of abuse.</p> <p>The 4/21/15 BDDS report indicated on 4/21/15 at 5 PM client #3 went into client #5's bedroom and had client #5's arm as if client #3 was going to bite client #5. The report indicated the staff had to get between the two clients and separate them because client #3 continued to try to bite client #5. __The facility investigative records indicated no investigation was conducted in regard to the allegations of abuse.</p>		<p><b>Monitoring of corrective action:</b></p> <ul style="list-style-type: none"> <li>Regional Program manager will review all investigations to ensure they address all issues and contain systemic changes.</li> <li>Quality assurance director will review all investigations to ensure proper client protections.</li> </ul>				

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	<p>The 4/18/15 BDDS report indicated on 4/18/15 at 7 AM the overnight shift staff gave client #2 150 mg (milligrams) of Primidone (a medication to control seizures). The report indicated client #2 was to receive Primidone 50 mg twice a day. The facility called the Emergency Room due to concern for client #2 taking a triple dose of the medication. The staff were informed by poison control a dosage above 500 mg would be toxic. The medication error was discovered at the 8 PM medication pass on 4/18/15 when the staff discovered the 8 PM Primidone was missing. The staff also noted the 7 AM dose for 4/19/15 was missing also. The report indicated "Staff will watch for signs and symptoms of illness from client throughout the night."            ___The facility investigative records indicated no investigation was conducted in regard to client #2 receiving three times the amount of Primidone she was prescribed to take.</p> <p>The 4/16/15 BDDS report indicated on 4/16/15 at 5:30 PM client #3 went into client #5's bedroom and attacked client #5. Client #3 placed her arms around client #5's neck and was trying to choke client #5.            ___The facility investigative records indicated no investigation was conducted in regard to the allegations of abuse.</p>			

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	<p>The 3/26/15 BDDS report indicated on 3/25/15 at 8:50 PM client #3 went into client #5's bedroom and attacked client #5. Client #3 shook client #5 by placing one hand on client #5's neck and the other on client #5's shoulder. __The facility investigative records indicated no investigation was conducted in regard to the allegations of abuse.</p> <p>The 3/17/15 BDDS report indicated on 3/16/15 at 8 PM client #3 went into client #5's bedroom and grabbed client #5's arms. Client #5 screamed and the staff got between the clients to break them up. __The facility investigative records indicated no investigation was conducted in regard to the allegations of abuse.</p> <p>The 3/16/15 BDDS report indicated on 3/15/15 at 5:30 PM client #3 grabbed client #5 by the neck. The report indicated it took staff "two - three minutes" to get client #3 to turn client #5 loose from her hold. Once client #5 was released from client #3's hold, client #3 grabbed client #5's arms. __The facility investigative records indicated no investigation was conducted in regard to the allegations of abuse.</p> <p>The 3/15/15 Adverse Incident Report indicated on 3/15/15 at 8 PM client #5</p>						

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	<p>was sweeping the floor in the dining room when client #3 "ripped the broom from [client #5]."</p> <p>__The facility investigative records indicated no investigation was conducted in regard to the allegations of abuse.</p> <p>The 2/22/15 BDDS report indicated on 2/20/15 the night shift noted a bruise the "size of a baseball" on client #5's right lower hip. The report indicated the injury to client #5's hip was unknown. The investigative records indicated an investigation was conducted and the cause for the injury remained unknown. The investigation indicated an interview with three staff and client #2. The investigative records failed to indicate interviews with clients #1, #3, #4, #5 and #6. The investigation failed to indicate a thorough investigation was conducted.</p> <p>During interview with the Social Services Coordinator (SSC) on 12/4/15 at 2 PM, the SSC:</p> <p>__ Indicated no investigation was conducted in regard to the incident on 9/27/15 requiring the response of the local fire department.</p> <p>__ Indicated no investigation was conducted in regard to the injury of unknown origin for client #1 on 7/7/15.</p> <p>__ Indicated no investigation was conducted in regard to the medication</p>			

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W 0230 Bldg. 00	<p>error discovered on 4/18/15 for client #2 resulting in client #2 receiving three times her normal dose of Primidone.            ___ Indicated no investigations were conducted in regard to the allegations of client to client abuse on March 15, 16, 25, April 16, 21, May 12 and July 23, 2015 for clients #3, #5 and #6.            ___ Indicated all allegations of abuse/neglect, misappropriation of client items and all injuries of unknown origin were to be investigated.            ___ Stated all investigations were to be conducted thoroughly and "should include" interviews from all clients in the home.</p> <p>9-3-2(a)</p> <p>483.440(c)(4)(ii) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be assigned projected completion dates. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to ensure the clients' objectives were assigned specific completion dates.</p> <p>Findings include:</p>	W 0230	<p><b>Corrective actions taken:</b></p> <ul style="list-style-type: none"> <li>All county QIDPs were in-serviced on TA completion dates on 12/23/15( Attachment J)</li> </ul> <p><b>How will we identify others:</b></p> <ul style="list-style-type: none"> <li>The quality assurance</li> </ul>	01/10/2016

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	<p>Client #1's record was reviewed on 12/2/15 at 1 PM.</p> <p>Client #1's TAS (Task Analysis Sheets) for 2015 indicated the staff were collecting data on the following objectives for client #1:</p> <ul style="list-style-type: none"> <li>To address people appropriately.</li> <li>To identify her Fish Oil (a dietary supplement).</li> <li>To identify coins.</li> <li>To use the washing machine to do her clothing.</li> <li>To prepare a meal with assistance once a week.</li> </ul> <p>Client #1's TAS indicated no completion dates for each objective.</p> <p>Client #1's ISP (Individualized Support Plan) dated 1/20/15 indicated no specific completion dates for each individual objective.</p> <p>Client #2's record was reviewed on 12/2/15 at 2 PM.</p> <p>Client #2's TAS for 2015 indicated the staff were collecting data on the following objectives for client #2:</p> <ul style="list-style-type: none"> <li>To identify paper money.</li> <li>To identify her PRN (as needed) medications and what they were used for.</li> <li>To prepare a meal with assistance.</li> <li>To exercise for at least 15 minutes three times a week.</li> </ul>		<p>manager will review all client individual program plans to ensure all goals have an appropriate completion date.</p> <p><b>Measures put in place:</b></p> <ul style="list-style-type: none"> <li>· Group home monthly record review ( Attachment D)</li> </ul> <p><b>Monitoring of corrective action:</b></p> <ul style="list-style-type: none"> <li>· The regional program manager will review all client monthly summaries to ensure client goals, or TAs, have appropriate completion dates.</li> </ul>				

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	<p>To identify what medications she took and why</p> <p>Client #2's TAS indicated no completion dates for each objective.</p> <p>Client #2's ISP dated 7/6/15 indicated no specific completion dates for each individual objective.</p> <p>Client #3's record was reviewed on 12/2/15 at 3 PM.</p> <p>Client #3's TAS for 2015 indicated the staff were collecting data on the following objectives for client #3:</p> <ul style="list-style-type: none"> <li>To independently take a shower.</li> <li>To wipe properly after going to the bathroom.</li> <li>To identify coins.</li> <li>To use the microwave.</li> <li>To use the washing machine to wash her clothing.</li> <li>To identify her medications and what she was the medications for.</li> </ul> <p>Client #3's TAS indicated no completion dates for each objective.</p> <p>Client #3's ISP dated 3/4/15 indicated no specific completion dates for each individual objective.</p> <p>Interview with the Qualified Intellectual Disabilities Professional and the Social Services Coordinator (SSC) on 12/4/15 at 2 PM indicated client #1's, #2's and #3's ISPs did not include completion dates for each individual objective. The SSC</p>			

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W 0249 Bldg. 00	<p>indicated the facility was in the process of rewriting all of the clients' objectives and the dates would be added upon revision.</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. Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to ensure the staff provided the clients medication training at every available opportunity.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/1/15 between 3:45 PM and 6:45 PM. During this observation period staff #3 was observed giving clients #1, #2 and #3 their PM medications. __At 4:43 PM staff #3 gave client #2</p>	W 0249	<p><b>Corrective actions taken:</b> · All county QIDPs were in-serviced upon the need for Medication training for clients at every medication pass on 12/23/15 ( Attachment J) · All QIDPs will in-service their staff during their house meetings concerning the need to provide each client with functioning level appropriate med trainings. <b>How will we identify others:</b> · The quality assurance manager will ensure, through her monthly audit of every group home, that every client has a med goal incorporated into their individual program plan accompanied with completion dates. <b>Measures put in place:</b></p>	01/10/2016

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	<p>received Primidone 50 mg (milligrams) for seizures and a PRN (as needed) Ibuprofen for pain.</p> <p>__At 4:49 PM staff #3 gave client #1 received Vitamin D (a dietary supplement) and an Antacid chew 500 mg.</p> <p>__At 4:53 PM staff #3 gave client #3 received Metformin 850 mg (for blood sugar control), Calcium 600 mg (a dietary supplement) and eye drops (Genteal and Ketotifen Fumarate).</p> <p>Staff #3 did not provide clients #1, #2 and #3 with any medication training during this observation period.</p> <p>Client #1's record was reviewed on 12/2/15 at 1 PM. Client #1's ISP dated 1/20/15 indicated client #1 was not independent in medication administration and required staff assistance and training. Client #1's ISP indicated client #1 had a training objective to identify her Fish Oil (a dietary supplement).</p> <p>Client #2's record was reviewed on 12/2/15 at 2 PM. Client #2's ISP dated 7/6/15 indicated client #2 was not independent in medication administration and required staff assistance and training. Client #2's ISP indicated client #2 had a training objective to learn to identify her PRN medications and what the</p>		<p>· Group home observation sheet ( Attachment B) · Group home monthly record review ( Attachment D) <b>Monitoring of corrective action:</b> · QIDP will monitor med pass through her monthly documented observations in order to ensure that staff are assisting the clients with their scheduled medication goals. · The regional program manager will review monthly summaries and the associated goal tracking to ensure medication goals are being documented on a daily basis.</p> <p>Addendum * The QIDP will monitor med pass 4 times a week for 2 months and document on a group home observation sheet ( Attachment B) the presence of proper medication goals initiated by staff and completed by clients. The QIDP will address any deficient practice immediately and submit the documented med pass observations to the regional manager.</p>	

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W 0250 Bldg. 00	<p>medications were for.</p> <p>Client #3's record was reviewed on 12/2/15 at 3 PM. Client #3's ISP dated 3/4/15 indicated client #3 was not independent in medication administration and required staff assistance and training. Client #3's ISP indicated client #3 had a training objective to learn to identify her medications and what the medications were for.</p> <p>Interview with the Qualified Intellectual Disabilities Professional and the Social Services Coordinator (SSC) on 12/4/15 at 2 PM indicated clients were to be provided training in medication administration at every available opportunity. The SSC stated, "Yes, they should have provided them (clients #1, #2 and #3) with some sort of training about their medications while passing the meds."</p> <p>9-3-4(a)</p> <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.</p>			
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	<p>Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and 3) and 3 additional clients (#5, #6 and #7), the facility failed to ensure an active treatment schedule was developed and implemented for the clients.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 12/2/15 at 1 PM and indicated no active treatment schedule.</p> <p>Client #2's record was reviewed on 12/2/15 at 2 PM and indicated no active treatment schedule.</p> <p>Client #3's record was reviewed on 12/2/15 at 3 PM and indicated no active treatment schedule.</p> <p>During interview with the Qualified Intellectual Disabilities Professional and the Social Services Coordinator (SSC) on 12/4/15 at 2 PM, the SSC indicated no active treatment schedules were available for review for clients #1, #2 and #3. The SSC stated, "I think we used to have them but I'm not sure what happened that we don't have them now."</p> <p>9-3-4(a)</p>	W 0250	<p><b>Corrective actions taken:</b></p> <ul style="list-style-type: none"> <li>· All county QIDPs were in-serviced upon the need for active treatment schedules for clients on 12/23/15 ( Attachment J)</li> <li>· QIDP created an active treatment schedule for the group home clients ( Attachment F)</li> <li>· Group home staff will be in-serviced upon the use and implementation of the active treatment schedule.</li> </ul> <p><b>How will we identify others:</b></p> <ul style="list-style-type: none"> <li>· The quality assurance manager will ensure through monthly audits that all homes have and implement active treatment schedules.</li> </ul> <p><b>Measures put in place:</b></p> <ul style="list-style-type: none"> <li>· Group home observation sheet ( Attachment B)</li> <li>· Group home monthly record review ( Attachment D)</li> <li>· Active treatment schedule ( Attachment F)</li> </ul> <p><b>Monitoring of corrective action:</b></p> <ul style="list-style-type: none"> <li>· QIDP will monitor for implementation of the active</li> </ul>	01/10/2016	

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W 0331  Bldg. 00	<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 2 of 3 sample clients (#1 and #3), the facility nursing services failed to ensure the staff properly disposed of medications that were dropped on the floor.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/1/15 between 3:45 PM and 6:45 PM. During this observation period staff #3 was observed giving clients #1 and #3 their PM medications. ___At 4:49 PM staff #3 prepared and gave client #1 her PM medications. While doing so, staff #3 dropped one of client #1's Vitamin D pills on the floor. The pill rolled beneath the medication cart. Staff #3 did not pick up the pill and continued with the medication pass. ___At 4:53 PM staff #3 prepared and gave client #3 her PM medications. While</p>	W 0331	<p>treatment schedule through her monthly documented observations in order to ensure that staff are assisting the clients through active treatment.</p> <p><b>Corrective actions taken:</b></p> <ul style="list-style-type: none"> <li>· All county QIDPs were in-serviced upon proper medication disposition procedures on 12/23/15. ( Attachment J)</li> <li>· QIDPs will in-service all group home staff on proper medication disposition</li> </ul> <p><b>How will we identify others:</b></p> <ul style="list-style-type: none"> <li>· QIDPs will audit group home medication supplies to ensure there are no expired medications on hand. If any expired medications are found, the QIDP will instruct staff to properly dispose of them.</li> </ul> <p><b>Measures put in place:</b></p> <ul style="list-style-type: none"> <li>· Medication disposition form ( Attachment G)</li> <li>· Group home monthly record review ( Attachment D)</li> </ul>	01/10/2016

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	<p>doing so, staff #3 dropped one of client #3's Calcium pills on the floor. The pill rolled into the middle of the floor. Staff #3 did not pick up the pill and continued with the medication pass. After giving client #3 her medications, client #3 leaned over and picked up the Calcium pill. Staff #3 stated, "Just throw it away." Client #3 threw the pill in the trash can.</p> <p>__At 4:55 PM after finishing the medication pass, staff #3 picked up the pill that rolled beneath the medication cart and threw it into the trash can.</p> <p>Interview with staff #3 at 5 PM on 12/1/15 indicated throwing the pills in the trash can was an acceptable method of disposing of dropped medications.</p> <p>Interview with the (Social Services Coordinator) SSC and the Team Lead (TL) on 12/4/15 at 11 AM indicated the staff were to follow the facility protocol for disposing of medications when dropped on the floor. The SSC indicated pills were to be placed in a plastic bag with hot water and coffee grounds and then thrown into the trash. The SSC stated medications were never to be "just thrown into the trash." The SSC indicated the staff would have been provided this training from the nurse along with the medication training that was provided to the staff upon hire.</p>		<p><b>Monitoring of corrective action:</b></p> <ul style="list-style-type: none"> <li>· The quality assurance manager will audit group home medication supplies, looking for expired medications. Upon discovery of expired medications, she will direct the staff to properly dispose of them.</li> <li>· The QIDPs will utilize documented monthly observations to ensure medications are destroyed properly.</li> <li>· All group home team leads will identify expired meds and properly dispose of them or instruct staff to dispose of them properly during their 5 shifts a week.</li> </ul>		

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W 0368  Bldg. 00	<p>Review of the facility Medication Policy dated 11/10/88 in regard to disposal of medications on 12/4/15 at 1:15 PM indicated "If the medication was dispensed from another pharmacy, the Program Manager needs to be notified of the medication to be destroyed. The medication will then be destroyed by placing in a plastic bag with hot water, coffee grounds, etc., sealing the bag and placing in trash. DO NOT FLUSH or pour down sink. Witnessed by two of the following persons: the Program Manager, a nurse or as staff person."</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 2 of 3 sampled clients (#1 and #2) and 2 additional client (#4 and #5), the facility failed to ensure all medications were administered to the clients in compliance with the clients' physician's orders.</p> <p>Findings include:</p>	W 0368	<p><b>Corrective actions taken:</b></p> <ul style="list-style-type: none"> <li>· All county QIDPs were in-serviced on the need for better communication with the pharmacy on 12/23/15. ( Attachment J)</li> <li>· Group home staff will be in-serviced on the procedure for alerting their supervisor when a</li> </ul>	01/10/2016
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	<p>The facility's reportable and investigative records were reviewed on 12/2/15 at 9 AM.</p> <p>The 10/23/15 BDDS report indicated when the facility pharmacy delivered the medications to the group home on the evening of 10/21/15 several medications were missing. The pharmacy was notified and the facility was told the medications would be called into a local pharmacy. The morning of 10/22/15 the medications were still not available. The report indicated after several phone calls the clients' medications were delivered 10/23/15 at 5:30 PM. The report indicated clients #1, #4 and #5 did not receive the following medications:          ___ Client #1 did not receive her daily dose of Tylenol PM (for pain relief and sleep aid) and Klor-Con, and Potassium Citrate (dietary supplements) as ordered by her physician on 10/22/15 and 10/23/15.          ___ Client #4 did not receive her daily dose of Tylenol PM on 10/22/15.          ___ Client #5 did not receive her daily dose of Namenda (for memory), Aspirin (for heart health) and Calcium Carb, Thera tab and Vitamin C (dietary supplements) as ordered by her physician on 10/22/15 and 10/23/15.</p> <p>The 7/11/15 BDDS report indicated the staff failed to give client #4 her weekly</p>		<p>medication is not available. They will also be instructed upon the proper Genoa pharmacy staff to contact.</p> <ul style="list-style-type: none"> <li>DSI group home management and Genoa pharmacy staff will meet on 1/4/16 in order to foster better lines of communication and understanding of policies and procedures in order to prevent future lapses in client medication administrations.</li> </ul> <p><b>How will we identify others:</b></p> <ul style="list-style-type: none"> <li>Night audit checklist requires the night auditor to check the medication supply to ensure clients have an ample supply of medications( Attachment A)</li> </ul> <p><b>Measures put in place:</b></p> <ul style="list-style-type: none"> <li>Night auditor checklist ( Attachment A)</li> </ul> <p><b>Monitoring of corrective action:</b></p> <ul style="list-style-type: none"> <li>QIDPs will follow up on the night auditor checklist and address any shortage of medication immediately.</li> </ul>		

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	<p>dose of Alendronate for bone health on 7/6/15 as ordered by her physician. The report indicated the staff was suspended and the staff that failed to double check the medication pass was disciplined.</p> <p>The 6/5/15 BDDS report indicated on 6/4/15 client #4 "had two missed medications from staff on 6/4/15." The report did not indicate the name of the medications missed.</p> <p>The 4/18/15 BDDS report indicated on 4/18/15 at 7 AM the overnight shift staff gave client #2 150 mg (milligrams) of Primidone (a medication to control seizures). The report indicated client #2 was to receive Primidone 50 mg twice a day. The facility called the Emergency Room due to concern for client #2 taking a triple dose of the medication. The staff were informed by poison control a dosage above 500 mg would be toxic. The medication error was discovered at the 8 PM medication pass on 4/18/15 when the staff discovered the 8 PM Primidone was missing. The staff also noted the 7 AM dose for 4/19/15 was missing also. The report indicated "Staff will watch for signs and symptoms of illness from client throughout the night." The report indicated the staff were to be retrained on the importance of giving the clients the exact dose of medication.</p>			

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W 0369 Bldg. 00	<p>The 4/9/15 BDDS report indicated client #5 did not receive her 7 AM dose of Kepra for seizure control on 4/8/15.</p> <p>Interview with the Qualified Intellectual Disabilities Professional and the Social Services Coordinator on 12/4/15 at 2 PM indicated all medications were to be given as prescribed by the clients' physicians without error.</p> <p>9-3-6(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 1 of 8 medications observed being administered, the facility failed to ensure all medications were administered without error to client #3.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/1/15 between 3:45 PM and 6:45 PM. __At 4:53 PM staff #3 placed one drop of</p>	W 0369	<p><b>Corrective actions taken:</b> · All county QIDPs were in-serviced on medication pass procedure and policy on 12/23/15 ( Attachment J) · Group home staff will be in-serviced upon proper medication pass policy</p> <p><b>How will we identify others:</b> · Night audit checklist requires the night auditor to check the MAR in order to determine if all medication had been passed( Attachment A) · The staff who do not pass meds will perform a buddy check after all meds have</p>	01/10/2016

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	<p>Genteal eye drops in both of client #3's eyes.</p> <p>__At 4:54 PM staff #3 placed one drop of Ketotifen Fumarate eye drops in both of client #3's eyes.</p> <p>Review of client #3's December 2015 Medication Administration Record (MAR) on 12/2/15 at 11:30 AM indicated:</p> <p>__Client #3 was to receive one drop of Genteal eye drops in each at 4 PM.</p> <p>__Client #3 received Ketotifen Fumarate eye drops at 7 AM and 8 PM.</p> <p>__Client #3 was not to receive Ketotifen Fumarate eye drops at 4 PM.</p> <p>Client #3's record was reviewed on 12/2/15 at 3 PM. Client #3's October 2015 quarterly physician's orders indicated:</p> <p>__Client #3 was to receive one drop of Genteal eye drops in each eye at 4 PM.</p> <p>__Client #3 was to receive one drop of Ketotifen Fumarate eye drops in each eye at 7 AM and 8 PM.</p> <p>__Client #3's physician's orders did not indicate client #3 was to receive Ketotifen Fumarate eye drops at 4 PM.</p> <p>Interview with the RN on 12/4/15 at 11 AM indicated all medications were to be given as ordered by the physician and as indicated on each client's MAR.</p>		<p>been passed in order to determine accuracy in the med pass ( Attachment H) <b>Measures put in place:</b> · Night auditor checklist ( Attachment A) · Group home observation sheet ( Attachment B) · Group home monthly record review ( Attachment D) · Medication pass buddy check ( Attachment H) <b>Monitoring of corrective action:</b> · QIDPs will use their monthly documented observations to observe medication passes ( Attachment B) · The quality assurance manager will review the medication administration record on a monthly basis in order to determine the accuracy of the med pass ( Attachment D) · House team leads will observe medication passes 3-5 times a week and document and report any adverse practices. Addendum * The QIDP will monitor med pass 4 times a week for 2 months and document on a group home observation sheet ( Attachment B) the presence of proper and accurate medication pass by staff. The QIDP will address any deficient practice immediately and submit the documented med pass observations to the regional manager.</p>	

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W 0440 Bldg. 00	<p>9-3-6(a)</p> <p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to ensure evacuation drills were conducted at least quarterly for the night shift (11 PM to 7 AM) of personnel for the first quarter (January, February and March) of 2015 and the second quarter (April, May and June) of 2015.</p> <p>Findings include:</p> <p>Review of the facility's evacuation drills on 12/4/15 at 1 PM indicated no evacuation drills were conducted for the night shift of personnel for the first quarter and the second quarter of 2015 for clients #1, #2, #3, #4, #5 and #6.</p> <p>During interview with the Social Services Coordinator (SSC) on 12/4/15 at 2 PM, the SSC</p> <p>__ Indicated evacuation drills were to be conducted quarterly for each shift of</p>	W 0440	<p><b>Corrective actions taken:</b></p> <ul style="list-style-type: none"> <li>· All county QIDPs were in-serviced on the requirement for quarterly fire drills that are to be held on 1st, 2nd and 3rd shifts on 12/23/15 ( Attachment J)</li> <li>· Group home staff will be in-serviced upon the need for holding fire drills on every shift, including 3rds shift drills.</li> </ul> <p><b>How will we identify others:</b></p> <ul style="list-style-type: none"> <li>· Night audit checklist requires the night auditor to check the drill book and document if a drill has been missed ( Attachment A)</li> <li>· The quality assurance manager will audit drills on a monthly basis to ensure all drill are being held on their designated shift ( Attachment D)</li> </ul> <p><b>Measures put in place:</b></p> <ul style="list-style-type: none"> <li>· Night auditor checklist (</li> </ul>	01/10/2016	

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W 0441 Bldg. 00	<p>personnel. __ Indicated she could not locate an evacuation drill for the night shift of personnel for the first quarter or the second quarter of 2015.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to ensure the evacuation drills were conducted at various times throughout the day.</p> <p>Findings include:</p> <p>Review of the facility's evacuation drills on 12/4/15 at 1 PM for clients #1, #2, #3, #4, #5, and #6 indicated the staff</p>	W 0441	<p>Attachment A)</p> <ul style="list-style-type: none"> <li>Group home monthly record review ( Attachment D)</li> </ul> <p><b>Monitoring of corrective action:</b></p> <ul style="list-style-type: none"> <li>QIDPs submit copies of drills to the regional program manager on a monthly basis. The RPM will ensure that all drills are being completed on all designated shifts.</li> <li>The agency safety coordinator will receive all group home drills in order to ensure all drills are being completed on their designated shift.</li> </ul> <p><b>Corrective actions taken:</b></p> <ul style="list-style-type: none"> <li>All county QIDPs were in-serviced on the requirement for evacuation drills that are to be held on varied shifts on 12/23/15 ( Attachment J)</li> <li>Group home staff will be in-serviced upon the need for holding evacuation drills on varied shifts.</li> </ul> <p><b>How will we identify others:</b></p>	01/10/2016
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W 0454 Bldg. 00	<p>conducted the day shift (7 AM to 3 PM) and the night shift drills between 6 AM and 7 AM. The evacuation records indicated the staff failed to vary the times of the evacuation drills throughout the day. The evacuation records indicated no evacuation drills between the hours of 9 PM and 6 AM.</p> <p>Interview with the Social Services Coordinator on 12/4/15 at 2 PM indicated evacuation drills were to be held at various times throughout the night hours while the clients were sleeping and at various times throughout the day while the clients were awake and at home.</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and</p>		<ul style="list-style-type: none"> <li>· Night audit checklist requires the night auditor to check the drill book and document if a drill has been missed ( Attachment A)</li> <li>· The quality assurance manager will audit drills on a monthly basis to ensure all drills are being held on their designated shift ( Attachment D)</li> </ul> <p><b>Measures put in place:</b></p> <ul style="list-style-type: none"> <li>· Night auditor checklist ( Attachment A)</li> <li>· Group home monthly record review ( Attachment D)</li> </ul> <p><b>Monitoring of corrective action:</b></p> <ul style="list-style-type: none"> <li>· QIDPs submit copies of drills to the regional program manager on a monthly basis. The RPM will ensure that all drills are being completed on all designated shifts.</li> <li>· The agency safety coordinator will receive all group home drills in order to ensure all drills are being completed on their designated shift.</li> </ul>		

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	<p>transmission of infections.</p> <p>Based on observation and interview for 6 of 6 clients living in the group home (clients #1, #2, #3, #4, #5 and #6), the facility failed to implement and follow universal precautions to prevent the spread of infection in regard to the clients' hairbrushes.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/1/15 between 3:45 PM and 6:45 PM and on 12/2/15 between 6 AM and 7:45 AM.</p> <p>__ During both observation periods all of the clients' hairbrushes were stored together in an open small plastic basket that was stored on top of the toilet tank in the bathroom off of the medication room.</p> <p>__ Clients #4 and #5 took their hairbrush from the basket, brushed their hair and returned the brush to the basket.</p> <p>Interview with staff #3 on 12/1/15 at 4:30 PM indicated all of the clients (clients #1, #2, #3, #4, #5 and #6) kept their hairbrushes in the same place. Staff #3 indicated she did not know why the clients didn't keep their hairbrushes in their own rooms. Staff #3 stated, "I guess it's so we can watch them brush their hair to make sure they do it."</p>	W 0454	<p><b>Corrective actions taken:</b></p> <ul style="list-style-type: none"> <li>· All county QIDPs were in-serviced on the need for clients to have their hairbrushes stored in caddies that are to be stored in their rooms when not in use on 12/23/15 ( Attachment J)</li> <li>· Group home staff will be in-serviced upon the need for clients to store their hairbrushes in caddies in their bedrooms when not in use.</li> </ul> <p><b>How will we identify others:</b></p> <ul style="list-style-type: none"> <li>· The quality assurance manager will audit homes in order to ensure that sanitary practices are being followed at all homes( Attachment D)</li> <li>· QIDPs will use their monthly documented observations to ensure staff are following sanitary practices at all homes</li> </ul> <p><b>Measures put in place:</b></p> <ul style="list-style-type: none"> <li>· Night auditor checklist ( Attachment A)</li> <li>· Group home observation sheet ( Attachment B)</li> </ul>	01/10/2016			

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W 0455 Bldg. 00	<p>Interview with the Qualified Intellectual Disabilities Professional and the Social Services Coordinator on 12/4/15 at 2 PM indicated the clients should keep their hair brushes in their own rooms and the hair brushes should not be stored in a communal basket shared by all clients.</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 6 of 6 clients living in the group home (clients #1, #2, #3, #4, #5 and #6), the facility failed to maintain proper hygiene practices to prevent cross contamination of germs by not prompting the clients to wash their hands prior to eating their meals.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/1/15 between 3:45 PM and 6:45 PM. During this observation period clients #1, #2, #3, #4, #5 and #6 did not wash their hands prior to sitting</p>	W 0455	<ul style="list-style-type: none"> <li>· Group home monthly record review ( Attachment D)</li> </ul> <p><b>Monitoring of corrective action:</b></p> <ul style="list-style-type: none"> <li>· Quality assurance manager will audit all homes monthly in order to ensure clients are storing their personal hairbrushes in their rooms. ( Attachment D)</li> </ul> <p><b>Corrective actions taken:</b></p> <ul style="list-style-type: none"> <li>· All county QIDPs were in-serviced on the need for clients to wash their hands prior to med pass and meals on 12/23/15 ( Attachment J)</li> <li>· Group home staff will be in-serviced upon the need for clients to wash their hands before med pass and meals.</li> <li>· Active treatment schedules will include time slots for staff to encourage clients to wash their hands.</li> </ul>	01/10/2016

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W 0488 Bldg. 00	<p>down to eat their evening meal. Facility staff #1, #2 and #3 did not encourage the clients to wash their hands before sitting down to eat.</p> <p>Interview with the Qualified Intellectual Disabilities Professional and the Social Services Coordinator on 12/4/15 at 2 PM indicated the facility staff should have encouraged clients #1, #2, #3, #4, #5 and #6 to wash their hands prior to eating to prevent the spread of germs.</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p>		<p><b>How will we identify others:</b></p> <ul style="list-style-type: none"> <li>· The quality assurance manager will audit homes in order to ensure that sanitary practices are being followed at all homes( Attachment D)</li> <li>· QIDPs will use their monthly documented observations to ensure staff are following sanitary practices at all homes</li> </ul> <p><b>Measures put in place:</b></p> <ul style="list-style-type: none"> <li>· Group home observation sheet ( Attachment B)</li> <li>· Group home monthly record review ( Attachment D)</li> <li>· Active treatment schedule ( Attachment F)</li> </ul> <p><b>Monitoring of corrective action:</b></p> <ul style="list-style-type: none"> <li>· Home team leads will monitor med passes and meal times 3-5 times a week and ensure staff are encouraging clients to wash their hands.</li> </ul>	

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	<p>Based on observation, record review and interview for 1 additional client (client #4), the facility failed to ensure the staff implemented client #4's dining plan and encouraged client #4 to use utensils while eating.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/1/15 between 3:45 PM and 6:45 PM. During this observation period the following was observed:</p> <p>__ Client #4 was provided a taco meat mixture served over a flour tortilla with cheese and sour cream, mixed vegetables, rice, water, milk and a sugar free liquid.</p> <p>__ Client #4 wore wrist weights on both wrists to reduce the tremors while eating and was provided a partitioned plate to assist with food spillage.</p> <p>__ Client #4 ate at a fast pace and took large bites of food throughout her evening meal.</p> <p>__ Client #4 dropped food on the table around her plate and picked it up with her fingers and ate it.</p> <p>__ Client #4 used her fingers to periodically scoop and pick up her food.</p> <p>__ Staff #1 and #3 sat at one end of the table with staff #2 sitting at the opposite end of the table.</p> <p>__ Staff #3 sat beside client #4.</p> <p>__ Staff #1 and #3 got up and left the</p>	W 0488	<p><b>Corrective actions taken:</b></p> <ul style="list-style-type: none"> <li>Group home staff will be in-serviced upon the need to follow dining plans. They will also be in-serviced upon client #4's dining plan.</li> <li>All county QIDPs were in-serviced on the need to train staff to follow client dining plans on 12/23/15 ( Attachment J)</li> </ul> <p><b>How will we identify others:</b></p> <ul style="list-style-type: none"> <li>The quality assurance manager will audit homes in order to ensure that dining plans are current, in place and appropriate for the client ( Attachment D)</li> <li>QIDPs will use their monthly documented observations to ensure staff are following client specific dining plans ( Attachment B)</li> </ul> <p><b>Measures put in place:</b></p> <ul style="list-style-type: none"> <li>Group home observation sheet ( Attachment B)</li> <li>Group home monthly record review ( Attachment D)</li> </ul> <p><b>Monitoring of corrective action:</b></p> <ul style="list-style-type: none"> <li>Home team leads will monitor meal times 3-5 times a week and ensure staff are following client dining plans</li> <li>Addendum* The QIDP will monitor meal times 4 times a week for 2 months and document on a group home observation sheet ( Attachment B). The QIDP will ensure staff are following all client dining plans. The QIDP will address any deficient practice immediately and submit the documented med pass observations to the regional manager.</li> </ul>	01/10/2016	

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	<p>dining room table to retrieve items from the kitchen and then returned to the table several times during the evening meal.</p> <p>__ Client #4 was prompted twice during the meal to slow her rate of food consumption, once by staff #3 and once by staff #2. Client #4 continued to eat at a fast pace after both times of verbal prompting to slow down.</p> <p>During the evening meal staff #1, staff #2 and staff #3 did not verbally or physically prompt client #4 to take smaller bites of food, to slow her rate of eating when needed and/or to take a drink while eating. The staff did not prompt client #4 to use her fork/spoon when appropriate and not to use her fingers.</p> <p>Client #4's record was reviewed on 12/3/15 at 1 PM. Client #4's 10/8/15 dining plan indicated client #4 was at risk of choking. The plan indicated "Staff should be seated at eye level and monitor client during all food intakes. Verbal and physical prompts should be offered as needed during the meal to remind [client #4] to slow down while eating."</p> <p>Interview with the Qualified Intellectual Disabilities Professional and the Social Services Coordinator (SSC) on 12/4/15 at 2 PM indicated the staff were to implement client #4's dining plan</p>			

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W 9999 Bldg. 00	<p>whenever client #4 was eating. The SSC indicated the staff should have prompted client #4 to slow down, to take small bites, to take a drink of liquid between bites and to use her utensils throughout the meal.</p> <p>9-3-8(a)</p> <p>1. 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 (c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: (3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum,... three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p>	W 9999	<p><b>Corrective actions taken:</b></p> <ul style="list-style-type: none"> <li>· All DSI staff who are involved with obtaining references for possible employees will be in-serviced upon the practice of obtaining references that are substantive and refer to the employee's character and work history, not just dates of work.</li> <li>· All county QIDPs were in-serviced on 12/23/15 upon the need to file a BDDS report for any situation that poses a possible risk to client welfare, including the event that requires fire department intervention. ( Attachment J)</li> </ul> <p><b>How will we identify others:</b></p> <ul style="list-style-type: none"> <li>· The group home secretary</li> </ul>	01/10/2016	

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	<p>Based on record review and interview for 1 of 3 staff persons reviewed, the facility failed to ensure three references were provided for staff #3.</p> <p>Findings include:</p> <p>The facility personnel records were reviewed on 12/4/15 at 1 PM. Staff #3's employee file indicated two references. The references indicated verification of employment only.</p> <p>Interview with the Social Services Coordinator on 12/4/15 at 2 PM indicated no additional references were available for review for staff #3.</p> <p>9-3-2(c)(3)</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 9-3-1 Governing Body (b) 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 division.</p>		<p>will review all staff references and obtain proper references in the event that the required 3 references are not complete.</p> <ul style="list-style-type: none"> <li>· The regional program manager will review all internal incident reports and ensure the proper BDDS report was filed if client welfare was ever in question.</li> </ul> <p><b>Measures put in place:</b></p> <ul style="list-style-type: none"> <li>· Group home monthly record review ( Attachment D)</li> </ul> <p><b>Monitoring of corrective action:</b></p> <ul style="list-style-type: none"> <li>· The quality assurance manager will review new staff references during her monthly audit to ensure compliance with references.</li> <li>· Recruiters will ensure that future new hires will have 3 references that provide substantive work history and character references.</li> </ul>		

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	<p>"Incidents to be reported to Bureau of Quality Improvement Services (BQIS) include any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual including but not limited to: 7. A fire at a service delivery site that jeopardizes or compromises the health or welfare of an individual."</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 6 of 6 clients living in the group home (clients #1, #2, #3, #4, #5 and #6), the facility failed to notify the Bureau of Developmental Disabilities Services (BDDS) within 24 hours in accordance with state law regarding an incident requiring the response of the local fire department due to the home filling with smoke.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records and Adverse Incident Reports (AIRs) were reviewed on 12/2/15 at 9 AM.</p> <p>The 9/27/15 AIR indicated the staff were cooking in the kitchen when a skillet</p>			

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	<p>began to smoke and burn. The smoke alarms activated, clients #1, #2, #3, #4, #5 and #6 were evacuated from the home and the local fire department was called. Once the smoke was cleared the clients returned inside the home.</p> <p>Interview with the Social Services Coordinator (SSC) on 12/4/15 at 2 PM indicated no report was filed with BDDS in regard to the AIR of 9/27/15 for clients #1, #2, #3, #4, #5 and #6. The SSC stated, "Since there was no actual fire, I didn't even think about it."</p> <p>9-3-1(b)</p>				