

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/12/2013	
NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
W000000	<p>This visit was for a post certification revisit (PCR) to the investigation of complaint #IN00123819 investigated on 2/27/13.</p> <p>This visit was in conjunction with the predetermined full recertification and state licensure survey.</p> <p>Complaint #IN00123819: Not Corrected.</p> <p>Survey Dates: April 2, 3, 4 and 12, 2013</p> <p>Facility Number: 001193 Provider Number: 15G656 AIMS Number: 100446910</p> <p>Surveyor: Vickie Kolb, RN, BSN, Public Health Nurse Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/22/13 by Ruth Shackelford, Medical Surveyor III.</p>	W000000					

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

TITLE

(X6) DATE

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

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 3 sampled clients (clients #1, #2 and #3) and #2 additional clients (clients #5 and #6), the facility neglected to implement its policy and procedures to ensure:</p> <p>__ All allegations of neglect/abuse/mistreatment were immediately reported to the administrator and thoroughly investigated with a reproducible system of investigation for clients #1, #2, #3, #5 and #6.</p> <p>__ All allegations of neglect/abuse/mistreatment were reported to BDDS (Bureau of Developmental Disabilities Services) and to APS (Adult Protective Services) per state law for clients #1 and #2.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, BDDS (Bureau of Developmental Disabilities Services) reports and investigative records were reviewed on 4/2/13 at 1:30 PM and again on 4/4/13 at 10 AM. The facility's records indicated the following:</p> <p>__ Incident Report dated 2/16/13 at 12:30</p>	W000149	Now, and in the future, all allegations of incidents of abuse will be reported to DDARS and APS within 24 hours of the incident. Investigation of the allegations of incidents of abuse will be investigated by JRDS within 5 days of the alleged incidents of abuse, per our attached policy. Home Manager, Residential Department Head responsible. *The attached JRDS Procedures for Reporting Reportable Incidents to the State have been implemented. All investigations are reviewed by members of the JRDS Quality Review Team.	05/12/2013			

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	<p>PM indicated "[Client #2] was sitting on the couch and turned and grabbed [client #1] who was sitting in a recliner beside [client #2]." The facility records did not indicate BDDS and/or APS were notified of the client to client abuse in regard to clients #1 and #2. The facility records did not indicate an investigation was conducted.</p> <p>__ Incident Report dated 2/16/13 at 5 PM indicated "[Client #6] came out of her room and into the living room and grabbed [client #1] by the hair and started hitting her [client #1] in the face. Staff stopped her [client #6] and told her [client #6] to go to her room."</p> <p>__ BDDS report of 2/17/13 indicated on 2/16/13 at 5 PM client #2 "who is basically nonverbal, got upset that [client #1] was sitting in his chair. While grabbing at [client #1], [client #2] scratched [client #1's] left arm resulting in a 2 inch mark. [Client #2] had been resistive with staff throughout the day. It was decided to send [client #2] to the ER [Emergency Room] to rule out any medical issues. He [client #2] was taken to the ER at 5:30 PM. Within 10 minutes of [client #2] leaving, [client #6] walked over the (sic) [client #1] and hit her on the right side of her face. [Client #1's] right cheek is slightly swollen." A Follow Up BDDS report of 2/28/13 indicated "The</p>			

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	<p>incident occurred because [client #1] was sitting in the aggressor's chair. Staff rearranged the furniture and put [client #1's] rocker in the place where the aggressor's chair had been sitting." The facility records did not indicate an investigation was conducted.</p> <p>__ Incident Report dated 2/16/13 at 5:30 PM indicated "It was reported that when [client #6] became aggressive towards a housemate that a staff had taken [client #6] to her room and that another staff held [client #6's] door closed on at least 2 occasions not allowing [client #6] out of her room." The report indicated the house manager and the facility nurse were notified of the allegations of abuse. The facility records did not indicate the administrator was immediately notified and/or BDDS and APS were notified of the allegation of abuse/mistreatment. The facility records did not indicate an investigation was conducted in regard to the allegations of abuse/mistreatment.</p> <p>__ BDDS report of 2/20/13 indicated at 7 PM "The residents had just finished supper when [client #6] who was sitting at the table, reached over and slapped [client #3] on the right side of his face." The staff asked client #6 to leave the room and as client #6 was leaving, client #6 slapped client #5 on the left side of his</p>			

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	<p>face. The HM (Home Manager) was called and instructed the staff to call the police. The police arrived and talked to client #6, telling her it was against the law to hit someone else and asked client #6 to apologize. The facility records did not indicate an investigation was conducted.</p> <p>__BDDS report of 2/23/13 indicated on 2/22/13 at 5:30 PM "Today at supper [client #2] turned his plate of food over on the table. [Name of staff] took [client #2] to his bedroom. She put items on his bed to keep him off his bed and closed his bedroom door. She [the staff] told the other working staff something like, "we can't let him have his way." Saturday [name of staff] phoned the QMRP [Qualified Mental Retardation Professional] (this reporter) and stated that [client #2] appeared to be in a bad mood and was noncompliant. As we discussed what had occurred this morning, [name of staff] told of the incident at supper last night. Also, during a later conversation another staff, [name of staff] stated that last Saturday when [client #6] became aggressive towards a housemate [name of staff] had taken [client #6] to her room and that [name of staff] held [client #6's] door closed on at least 2 occasions not allowing [client #6] out of her room. The Residential Department Head was contacted who</p>			
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	<p>suspended [name of staff] until an investigation is completed. [Name of staff] also suspended until an investigation is completed."</p> <p>__The follow up BDDS report of 3/5/13 indicated the Residential Department Head investigated the incident of 2/22/13. "The outcome from the investigation was that [name of staff] held [client #'s] door closed in an attempt to keep [client #6] from hurting someone else. As reported by staff [client #6] was upset that the door was held closed but did calm down within a few minutes. Restricting [client #6] to her room is not part of HRC [Human Rights Committee] approved plan. [Name of staff] received a written warning and was retrained on 2/28 by the Residential Department Head on the JRDS (Jay Randolph Developmental Services) Individual Protection Plan." The report indicated the staff did restrict client #2 to his room and from lying on his bed. "They (the report did not indicate who they was) also reported that [name of staff] also called him [client #2] an "a-----" and confirmed that she said "we can't let him have his way." [Name of staff's] employment was terminated on 2/25. Restricting [client #2] from his room is not part of his HRC approved plan."</p> <p>__The follow up BDDS report of 3/15/13 indicated "...After numerous interviews</p>			

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	<p>were completed, there were no findings/reports of other incidents of this type of seclusion...." The facility investigative records did not indicate staff/client interviews, record reviews, investigative results and/or actions taken in regard to the allegations of abuse in regard to clients #2 and #6.</p> <p>__ Incident report of 3/3/13 at 8:30 PM indicated client #6 was sitting in the living room on the couch beside client #3. Client #6 was "staring at people and gazing at the television." Client #6 was asked not to stare, "...it wasn't nice. When she [client #6] reached over and smacked [client #3] on the arm." The facility investigative records indicated one written statement from staff #4. The investigative records did not indicate staff/client interviews, record reviews, investigative results and/or actions taken in regard to the client to client abuse for clients #6 and #3.</p> <p>__ BDDS report of 3/12/13 indicated on 3/9/13 client #6 was asked to slow her pace of eating down. Client #6 put her spoon down and "smacked" client #3 on his right arm. The facility investigative records indicated one written statement from staff #4. The investigative records did not indicate staff/client interviews, record reviews, investigative results</p>						

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	<p>and/or actions taken in regard to the client to client abuse for clients #6 and #3.</p> <p>__BDDS report of 3/12/13 indicated on 3/11/13 while at the facility owned day program at 11:50 AM client #6 ran to the table client #1 was sitting at and hit client #1 on the right side of her face and in the back of the neck. The facility records did not indicate an investigation was conducted.</p> <p>__ Incident report of 3/12/13 at 5:40 PM indicated "Staff had prompted her [client #6] to sit up straight in her chair and not to lean over her plate per her dietary management plan.... [Client #6] looked up at the staff, then hit the housemate [client #3] sitting next to her with her open hand. Staff asked [client #6] to stop, she then hit the housemate [client #3] again with her open hand before the staff could get between them. Staff asked [client #6] to leave the area, she then hit another housemate [client #5] with her open hand on the way out of the dining room...." The facility records did not indicate an investigation was conducted.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 4/4/13 at 3 PM indicated all allegations of abuse/mistreatment and client to client abuse were to be immediately reported to</p>				

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	<p>the administrator at the time of the incident and/or when the allegation was made. The QIDP indicated BDDS and APS were to be notified within 24 hours of the incident and/or knowledge of the abuse/mistreatment. The QIDP indicated all allegations of abuse/mistreatment were to be thoroughly investigated. The QIDP indicated the RDH (Residential Department Head) conducted the facility investigations for the client to client abuse of 3/3/13 and 3/9/13 in regard to clients #3 and #6 and for the allegation of abuse made on 2/22/13 in regard to clients #2 and #6. The QIDP indicated the RDH had provided all of the facility investigative reports for review and the QIDP was unable to provide any additional documentation of investigative records. The QIDP indicated the facility investigative folder provided for review did not indicate staff/client interviews, records reviewed, investigative results and/or actions taken in regard to the investigative results. The QIDP indicated the results of the investigations were reported in the BDDS reports.</p> <p>Review of the revised facility policy "Individual Protection Policy" of 5/12 on 4/2/12 at 2 PM indicated "JRDS [Jay-Randolph Developmental Services] personnel are required to preserve an individual's rights, dignity, health, and</p>			

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	<p>safety. As such JRDS prohibits the abuse, neglect, exploitation, mistreatment of an individual served or the violation of the individual's rights." The policy defines abuse to be the "use of unreasonable physical force such as spanking, pinching, shoving, shaking and other punitive acts.... actions, verbal statements or commands, or other procedure that result in a detrimental outcome for the individual involved (i.e. tone of voice, derogatory statement, facial expressions, isolation, demeaning gestures, name calling, and other damaging acts.)" The policy indicated "Individuals served must not be subjected to abuse by anyone, including, but not limited to, JRDS staff, other consumers, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals." The facility policy indicated the staff were to report abuse/neglect/mistreatment immediately to the Executive Director or a designee. The policy indicated the Case Coordinator or designee was to file a report with BDDS within 24 hours of being made aware of an incident of abuse/neglect/mistreatment and then the Program Head or designee would initiate an investigation.</p> <p>This deficiency was cited on 2/27/13. The facility failed to implement a</p>			

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	systemic plan of correction to prevent recurrence. 9-3-2(a)				

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W000154	<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 interview and record review for 8 of 8 incidents of alleged abuse/neglect and/or client to client abuse reviewed, the facility failed to provide evidence of an investigation and/or evidence a thorough investigation was conducted for clients #1, #2, #3, #5 and #6.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, BDDS (Bureau of Developmental Disabilities Services) reports and investigative records were reviewed on 4/2/13 at 1:30 PM and again on 4/4/13 at 10 AM. The facility's records indicated the following:</p> <p>__ Incident Report dated 2/16/13 at 12:30 PM indicated "[Client #2] was sitting on the couch and turned and grabbed [client #1] who was sitting in a recliner beside [client #2]." The facility records indicated no investigation was conducted.</p> <p>__ Incident Report dated 2/16/13 at 5 PM indicated "[Client #6] came out of her room and into the living room and grabbed [client #1] by the hair and started hitting her [client #1] in the face. Staff</p>	W000154	Now, and in the future, there will be evidence that all alleged violations are thoroughly investigated. The Client Incident Report (see attached) contains a section for the Department Head or Health Care Coordinator's report. This report must be completed with in 24 hours of an incident. Residential Department Head Responsible. The attached JRDS Procedures for Reporting Reportable Incidents to the State have been implemented. All investigations are reviewed by members of the JRDS Quality Review Team.	05/12/2013			

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	<p>stopped her [client #6] and told her [client #6] to go to her room." The BDDS report of 2/17/13 indicated on 2/16/13 at 5 PM client #2 "who is basically nonverbal, got upset that [client #1] was sitting in his chair. While grabbing at [client #1], [client #2] scratched [client #1's] left arm resulting in a 2 inch mark. [Client #2] had been resistive with staff throughout the day. It was decided to send [client #2] to the ER [Emergency Room] to rule out any medical issues. He [client #2] was taken to the ER at 5:30 PM. Within 10 minutes of [client #2] leaving, [client #6] walked over the (sic) [client #1] and hit her on the right side of her face. [Client #1's] right cheek is slightly swollen. A Follow Up BDDS report of 2/28/13 indicated "The incident occurred because [client #1] was sitting in the aggressor's chair. Staff rearranged the furniture and put [client #1's] rocker in the place where the aggressor's chair had been sitting." The facility records indicated no investigative records in regard to the incident of 2/16/13.</p> <p>___ Incident Report dated 2/16/13 at 5:30 PM indicated "It was reported that when [client #6] became aggressive towards a housemate that a staff had taken [client #6] to her room and that another staff held [client #6's] door closed on at least 2 occasions not allowing [client #2] out of</p>						

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	<p>her room." The report indicated the house manager and the facility nurse were notified at the time of the allegations of abuse were made. The facility records indicated an investigation was initiated on 2/22/13. The facility investigative records indicated no staff/client interviews, record reviews, investigative results and/or actions taken in regard to the incident.</p> <p>__BDDS report of 2/20/13 indicated at 7 PM "The residents had just finished supper when [client #6] who was sitting at the table, reached over and slapped [client #3] on the right side of his face." The staff asked client #6 to leave the room and as client #6 was leaving, client #6 slapped client #5 on the left side of his face. The HM (Home Manager) was called and instructed the staff to call the police. The police arrived and talked to client #6, telling her it was against the law to hit someone else and asked client #6 to apologize. The facility records indicated no investigative records in regard to the incident of 2/20/13.</p> <p>__BDDS report of 2/23/13 indicated on 2/22/13 at 5:30 PM "Today at supper [client #2] turned his plate of food over on the table. [Name of staff] took [client #2] to his bedroom. She put items on his bed to keep him off his bed and closed his bedroom door. She [the staff] told the</p>						

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	<p>other working staff something like, "we can't let him have his way." Saturday [name of staff] phoned the QMRP [Qualified Mental Retardation Professional] (this reporter) and stated that [client #2] appeared to be in a bad mood and was noncompliant. As we discussed what had occurred this morning, [name of staff] told of the incident at supper last night. Also, during a later conversation another staff, [name of staff] stated that last Saturday when [client #6] became aggressive towards a housemate [name of staff] had taken [client #6] to her room and that [name of staff] held [client #6's] door closed on at least 2 occasions not allowing [client #6] out of her room. The Residential Department Head was contacted who suspended [name of staff] until an investigation is completed. [Name of staff] also suspended until an investigation is completed."</p> <p>__The follow up BDDS report of 3/5/13 indicated the Residential Department Head investigated the incident of 2/22/13. The outcome from the investigation was that [name of staff] held [client #6's] door closed in an attempt to keep [client #6] from "hurting" someone else. As reported by staff, [client #6] was upset that the door was held closed but did calm down within a few minutes. Restricting [client</p>			

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	<p>#6] to her room is not part of HRC [Human Rights Committee] approved plan. [Name of staff] received a written warning and was retrained on 2/28 by the Residential Department Head on the JRDS (Jay Randolph Developmental Services) Individual Protection Plan." The report indicated the staff did restrict client #2 to his room and from lying on his bed. "They (the report did not indicate who they was) also reported that [name of staff] also called him [client #2] an "a-----" and confirmed that she said "we can't let him have his way." [Name of staff's] employment was terminated on 2/25. Restricting [client #2] from his room is not part of his HRC approved plan."</p> <p>__The follow up BDDS report of 3/15/13 indicated "...After numerous interviews were completed, there were no findings/reports of other incidents of this type of seclusion..." The facility investigative records indicated no staff/client interviews, record reviews, investigative results and/or actions taken in regard to the allegations of abuse in regard to clients #2 and #6.</p> <p>__Incident report of 3/3/13 at 8:30 PM indicated client #6 was sitting in the living room on the couch beside client #3. Client #6 was "staring at people and gazing at the television." Client #6 was</p>						

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	<p>asked not to stare, "...it wasn't nice. When she [client #6] reached over and smacked [client #3] on the arm." The facility investigative records indicated one written statement from staff #4. The investigative records indicated no staff/client interviews, record reviews, investigative results and/or actions taken in regard to the client to client abuse for clients #6 and #3.</p> <p>__BDDS report of 3/12/13 indicated on 3/9/13 client #6 was asked to slow her pace of eating down. Client #6 put her spoon down and "smacked" client #3 on his right arm. The facility investigative records indicated one written statement from staff #4. The investigative records indicated no staff/client interviews, record reviews, investigative results and/or actions taken in regard to the client to client abuse for clients #6 and #3.</p> <p>__BDDS report of 3/12/13 indicated on 3/11/13 while at the facility owned day program at 11:50 AM client #6 ran to the table client #1 was sitting at and hit client #1 on the right side of her face and in the back of the neck. The facility records indicated no investigation was conducted.</p> <p>__ Incident report of 3/12/13 at 5:40 PM indicated "Staff had prompted her [client #6] to sit up straight in her chair and not</p>			

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	<p>to lean over her plate per her dietary management plan.... [Client #6] looked up at the staff, then hit the housemate [client #3] sitting next to her with her open hand. Staff asked [client #6] to stop, she then hit the housemate [client #3] again with her open hand before the staff could get between them. Staff asked [client #6] to leave the area, she then hit another housemate [client #5] with her open hand on the way out of the dining room...." The facility records indicated no investigation was conducted.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 4/4/13 at 3 PM indicated all allegations of abuse/mistreatment were to be thoroughly investigated. The QIDP indicated the RDH (Residential Department Head) conducted the facility investigations for the client to client abuse of 3/3/13 and 3/9/13 in regard to clients #3 and #6 and for the allegation of abuse made on 2/22/13 in regard to clients #2 and #6. The QIDP indicated the RDH had provided all of the facility investigative reports for review and the QIDP was unable to provide any additional documentation of investigative records. The QIDP indicated the facility investigative folder provided for review did not indicate staff/client interviews, records reviewed, investigative results</p>						

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	<p>and/or actions taken in regard to the investigative results. The QIDP indicated the results of the investigations were reported in the BDDS reports.</p> <p>This deficiency was cited on 2/27/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>			

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, interview, and record review for 3 of 3 sampled clients (#1, #2 and #3) and 2 additional clients (#5 and #6), the facility failed to ensure the Interdisciplinary Team (IDT) assessed/re-assessed:</p> <p>__ Client #3 in regard to the use of shoelaces and the client's ambulatory needs.</p> <p>__ Clients #1, #2, #3, #5 and #6 for the need for a clothing protector.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 4/2/13 between 3:30 PM and 6 PM.</p> <p>__ At 4:20 PM client #1 walked through the living room with an orange shoe lace in her mouth. The HM verbally and physically prompted client #1 to give up the shoe lace and throw it in the trash.</p> <p>__ At 4:22 PM client #3 was sitting in the dining room by the window, looking out the window and playing with a purple shoe lace. Client #3 was pulling the shoe lace through his hands and putting it in his mouth.</p>	W000210	<p>Now, and in the future, the Home Manager, LPN and QMRP will ensure all assessments are complete within 30 days after admission. Also all recommendations will be identified and addressed within 30 days. The IDT has re-evaluated each individual's need for a clothing protector and only those needing clothing protectors will wear them. * The QMRP and LPN will make random unannounced visits to ensure all plans are followed. The Dietician visits randomly and unannounced to ensure compliance.</p>	05/12/2013			

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	<p>__ At 5 PM client #3 had black, yellow and white shoe laces. The laces were tied together in a knot. Client #3 dropped the shoe laces on the floor in the kitchen, picked them up and put a portion of them in his mouth and then pulled them out.</p> <p>__ At 5:15 PM a pair of red shoe laces was lying on the floor in the dining room.</p> <p>During the morning observation on 4/3/13 between 5:30 AM and 8:30 AM, client #3 carried around a black and white shoe lace. Client #3 was observed to drop the shoe laces on the floor and put them in his mouth twice during the observation.</p> <p>Interview with staff #1 and #2 on 4/2/13 at 6:15 AM indicated client #3 carried shoe laces and played with them. Staff #2 stated, "I think his mom gives them to him to play with." When asked where are they stored, staff #2 stated "I think he keeps them in the dining room," and staff #1 indicated she did not know where client #3 stored the shoe laces. When asked how are the shoelaces monitored and cleaned, staff #2 indicated she had seen some of the shoelaces on top of the washer and sometimes they would throw them in the wash with the other clothes if they saw them.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) and</p>				

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	<p>the RM (Residential Manager) on 4/4/13 at 3 PM indicated client #3 liked to play with shoelaces. The QIDP indicated the IDT had not assessed and/or reviewed the practice of client #3's having and/or "playing with" shoe laces in regard to the client's safety and health issues.</p> <p>2. During observations at the group home on 4/2/13 between 3:30 PM and 6 PM and on 4/3/13 between 5:30 AM and 8:30 AM, clients #1, #2, #3, #5 and #6 wore clothing protectors over their clothes while eating their meals.</p> <p>Client #1's record was reviewed on 4/4/13 at 1 PM. Client #1's record did not indicate client #1 had been assessed for food spillage and the need to wear a clothing protector while dining.</p> <p>Client #2's record was reviewed on 4/3/13 at 12 PM. Client #2's record did not indicate client #2 had been assessed for food spillage and the need to wear a clothing protector while dining.</p> <p>Client #3's record was reviewed on 4/3/13 at 2 PM. Client #3's record did not indicate client #3 had been assessed for food spillage and the need to wear a clothing protector while dining.</p> <p>Client #5's record was reviewed on 4/4/13</p>						

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	<p>at 12 PM. Client #5's record did not indicate client #5 had been assessed for food spillage and the need to wear a clothing protector while dining.</p> <p>Client #6's record was reviewed on 4/4/13 at 12:15 PM. Client #6's record did not indicate client #6 had been assessed for food spillage and the need to wear a clothing protector while dining.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM, the RM indicated the clients wore clothing protectors to keep their clothes clean. When asked if the clients had been assessed for the need for the use of clothing protectors, the QIDP stated, "No, not that I'm aware of." The QIDP indicated clients #1, #2, #3, #5 and #6 had not been assessed for excessive food spillage and the need to wear a clothing protector while dining.</p> <p>3. During observations at the group home on 4/2/13 between 3:30 PM and 6 PM and on 4/3/13 between 5:30 AM and 8:30 AM and at the facility owned DP (Day Program) on 4/3/13 between 11:15 AM and 11:45 AM, client #3 walked with an unsteady gait.</p>			

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	<p>Client #3's record was reviewed on 4/3/13 at 2 PM. Client #3's record indicated a diagnosis of, but not limited to, CP (Cerebral Palsy). Client #3's March 2013 Monthly/Quarterly Health Summary notes indicated client #3 "Has awkward gait with flexed knees bilat (bilateral)." Client #3's nursing note of 3/15/13 indicated "Observed [client #3] in the group home environment. [Client #3] ambulating unassisted with his flexed knee awkward gait." Client #3's ISP of 4/13/12 indicated client #3 was at risk for "falls, slips and trips: potentially, due to CP dx. (diagnosis)." Client #3's record indicated client #3 had a PT (Physical Therapy) evaluation on 12/30/08 with recommendations for client #3 to use the stairs when available, to incorporate walking often into his regular activities and to perform the provided exercises of seated hamstring stretch, seated stretch and heel cord stretches. Client #3's record indicated no further PT evaluations since 12/30/08.</p> <p>Interview with the facility LPN on 4/4/13 at 11 AM indicated client #3 had CP and was at risk for falls due to his uneven gait. The LPN indicated client #3's most current PT evaluation and/or ambulatory assessment was 12/30/08.</p> <p>This deficiency was cited on 2/27/13.</p>			

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	The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)				

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility nursing services failed:</p> <p>__ To ensure client #1 received physical therapy exercises as prescribed by the physician.</p> <p>__ To ensure client #1's, #2's, #3's, #5's and #6's medications instructions on the clients' pill packs from the pharmacist, the MARs (Medication Administration Records) and the physician's orders were reconciled to indicate the same instructions for the clients' medications.</p> <p>__ To ensure the staff thickened all of client #6's liquids.</p> <p>Findings include:</p> <p>1. During observations at the group home on 4/2/13 between 3:30 PM and 6 PM and on 4/3/13 between 5:30 AM and 8:30 AM, client #1 ambulated with an uneven gait.</p> <p>Client #1's record was reviewed on 4/4/13 at 1 PM. Client #1's record indicated client #1 had a diagnosis of, but not limited to, Osteoporosis. Client #1's Monthly/Quarterly Health Summary for March 2013 indicated client #1 "Walks with an uneven gait." Client #1's</p>	W000331	<p>Now, and in the future, nursing services will assess and monitor client specific medical needs. The IDT will determine need for necessary evaluations for ensuring all clients' medical needs are recognized and met.</p> <p>The Residential Nurse and Home Manager will reconcile each pill pack and MAR as new meds arrive and monthly to ensure all instructions are the same. Staff have been retrained on specific diet orders.</p> <p>IDT and Residential Nurse responsible.</p>	05/12/2013			

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	<p>Appointment Form of 8/27/12 indicated client #1 saw her physician for "Unsteady gait" and "Bruised frontal left knee." Client #1 received a diagnosis of, but not limited to, "Mild gait disturbance associated with behaviors." The form indicated physician's orders for physical therapy to include "generalized strengthening of bilateral lower extremities, quadriceps, gluteal muscles and calf muscles." The client's record indicated the physician's orders for physical therapy were not addressed.</p> <p>Interview with the facility LPN on 4/4/13 at 11 AM indicated she was not aware of orders for physical therapy in regards to client #1.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM, the RM stated she had taken client #1 to the appointment and client #1's physician told the RM client #1 would "more than likely" not cooperate with doing the exercises. The RM indicated the physician demonstrated the type of exercises the client should be doing. The RM indicated she was the one that made medical appointments for the clients in the group home and she did not schedule client #1 to go to physical therapy because</p>			

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	<p>of what the doctor had told her.</p> <p>2. During observations of the medication pass at the group home on 4/3/13 between 5:30 AM and 8:30 AM the following was observed:</p> <p>_____ At 5:34 AM, staff #4 placed a Multi-Vitamin in 30 ml (milliliters) of applesauce and approached client #1 in the living room and said, "Here, take this" and fed client #1 the applesauce with the medication in it. The medication package indicated client #1 was to take the Multi-Vitamin on an empty stomach and with lots of water.</p> <p>_____ At 5:37 AM staff #4 placed a Doxycycline (an antibiotic) 100 mg (milligrams) in 30 ml of applesauce and walked to client #3's bedroom, woke client #3 and fed him the applesauce with the medication in it with a disposable plastic spoon. The medication package indicated client #3 was to take the Doxycycline on an empty stomach.</p> <p>_____ At 5:42 AM, staff #4 placed a Multi-Vitamin and Levothyroxine (for hypothyroidism) 25 mcg (micrograms) in 30 ml of applesauce and walked to client #6's bedroom, woke client #6 by pulling back her covers and prompting her to sit up to take her medications. Client #6 sat up on the side of her bed, the staff handed her the medication cup with applesauce</p>			

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	<p>and medication and stated, "Here, take this." Client #6 proceeded to feed herself the applesauce/medication. The medication package indicated client #6 was to take the Multi-Vitamin on an empty stomach.</p> <p>_____ At 5:45 AM, staff #4 placed a Multi-Vitamin and Levothyroxine 100 mcg in 30 ml of applesauce, walked to client #2 in the living room and said, "Here, take this" and fed client #2 the applesauce with the medication in it. The medication package indicated client #2 was to take the Multi-Vitamin and Levothyroxine on an empty stomach.</p> <p>_____ At 7:35 AM, staff #1 gave client #1 the remainder of her AM medications in 30 ml of applesauce with a plastic disposable spoon. Client #1 fed herself the applesauce, taking large bites.</p> <p>_____ At 7:45 AM, staff #1 gave client #3 the remainder of his AM medications in 30 ml of applesauce with a plastic disposable spoon.</p> <p>_____ At 7:50 AM, staff #1 gave client #5 his AM medications in 30 ml of applesauce with a plastic disposable spoon.</p> <p>_____ At 8 AM, staff #1 gave client #6 her AM medications with water. The water was not thickened.</p> <p>_____ At 8:10 AM, staff #1 gave client #2 the remainder of his AM medications in 30 ml of applesauce with a plastic</p>						

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	<p>disposable spoon.</p> <p>Client #1's record was reviewed on 4/4/13 at 1 PM. Client #1's April 2012 MAR indicated client #1 was to take her Multi-Vitamin on an empty stomach, 1 hour prior to meals and/or 2 - 3 hours after a meal. Client #1's 2012/2013 Physician orders indicated no specific orders for client #2 to take her Multi-Vitamin with or without food. Client #1's Quarterly Nutritional Review of 1/7/13 indicated client #1 was to use a "small spoon" to decrease the size of bites she takes.</p> <p>Client #2's record was reviewed on 4/3/13 at 12 PM. Client #2's April 2012 MAR indicated client #2 was to take his Multi-Vitamin on an empty stomach, 1 hour prior to meals and/or 2 - 3 hours after a meal. Client #2's MAR indicated client #2 was to take his Levothyroxine on an empty stomach. Client #2's 2012/2013 Physician orders indicated no specific orders for client #2 to take his Multi-Vitamin and/or his Levothyroxine with or without food and/or on an empty stomach.</p> <p>Client #3's record was reviewed on 4/3/13 at 2 PM. Client #3's MAR indicated client #3 was to take his Doxycycline 2 hours before a meal or 2 hours after antacids,</p>				

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	<p>iron, vitamins and minerals. Client #3's 2012/2013 Physician orders indicated no orders for client #3 to take his Doxycycline 2 hours before a meal or 2 hours after antacids, iron, vitamins and minerals.</p> <p>Client #6's record was reviewed on 4/4/13 at 1 PM. Client #6's MAR indicated client #6 could take her Mult-Vitamin with or without food. Client #6's MAR indicated client #6 was to take the Levothyroxine on an empty stomach. Client #6's 2012/2013 Physician orders indicated no orders for client #6 to take her Mult-Vitamin with or without food and her Levothyroxine on an empty stomach. Client #6's Quarterly Nutritional Review of 1/7/13 indicated client #6 was to have all her liquids thickened to honey consistency.</p> <p>Interview with staff #1 and #2 on 4/4/13 at 8:15 AM indicated it was staffs' choice to give the clients their medications with applesauce. Staff #2 stated, "We just do because they are all on special diets so we just thought it would be better for them." Staff #1 indicated client #6's liquids should be thickened prior to her getting them.</p> <p>Interview with the facility LPN on 4/4/13 at 11 AM indicated the staff were to give</p>				

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	<p>the medications as ordered by the physician, as indicated on the MAR and as instructed by the pharmacist on the clients' individual pill packs. The LPN stated, "They should all be the same and I'm working on that." The LPN indicated the group home staff "should notify me" if there is a discrepancy in the physician's orders, the MAR and/or the directions on the label from the pharmacist. The LPN indicated staff were not to give the clients their medication in applesauce unless the nurse and/or physician instructs the staff to do so and it would be designated on the MAR if the client was to get their medications in applesauce. When asked how client #3 was to get his Sorbitol, the LPN indicated the staff were to pour the 30 ml of Sorbitol into a medication cup and give it to the client. The LPN indicated the staff were never to give a client medication and then walk away from the client. The LPN indicated the staff were to stay with the clients until they took their medications. The LPN indicated all of client #6's liquids were to be thickened to honey consistency. The LPN indicated that included liquids given at medication time.</p> <p>This deficiency was cited on 2/27/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>						

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	9-3-6(a)			

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W000488	<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>Based on observation and interview for 3 of 3 sample clients (#1, #2 and #3) and 2 additional clients (#5 and #6), the facility failed to provide the clients training in family style dining.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/2/13 between 3:30 PM and 6 PM. The evening meal consisted of barbeque chicken, macaroni and cheese, cooked cabbage, baked apple and bread. Once the food was prepared, staff #1 pureed the food and placed each item into plastic high sided divided plates, one for client #3 and one for client #5. Staff #1 then began cutting up bread slices into cubes and placing the cubes into individual plastic high sided plates for clients #1, #2 and #6. Staff #2 placed a serving of food into the divided dishes and began setting out glasses and filling them with liquids. Once all the food was dipped up and the plates were filled, clients #1, #2, #3, #5 and #6 were prompted to come to the kitchen to wash their hands and to pick up their plates. The HM (Home Manager) escorted clients #1 and #5 to the dining room with</p>	W000488	<p>Now, and in the future, each client will eat in a manner consistent with his or her developmental level per the functional assessment. A staff training re individual developmental levels and needs will be conducted. If appropriate, eating programs will be implemented in accordance with an individual's needs and family style dining will be implemented. Home Manager, DSP and QMRP responsible.</p>	05/12/2013			

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	<p>their plates. Clients #1 and #5 sat down and immediately started eating. The HM returned to the kitchen to assist other clients to the dining room, leaving clients #1 and #5 unsupervised while they ate. Individually with staff assistance, each client washed their hands, picked up their plate, walked to the dining room and sat down and began eating their food. The staff stood behind them as they ate.</p> <p>Observations were conducted on 4/3/13 between 5:30 AM and 8:30 AM. The morning meal consisted of cooked cereal, cottage cheese, toast, milk, juice and coffee. Staff #1 pureed client #3's and #5's food and placed it into a divided plate. Client #1's, #2's and #6's food was also prepared and dipped into the dishes. Staff #2 filled the glasses and placed them on the dining room table for the clients. Clients were prompted to come to the kitchen to wash their hands. and to pick up their pre-filled plates and take it to the dining room.</p> <p>During both observations the staff did not provide the clients with training in regard to family style dining.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM stated what was seen in</p>			

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	<p>observation was how the clients "usually" had their meals. The HM indicated food was not brought to the table and the clients did not assist and/or serve themselves, the plates were filled in the kitchen and the clients carried their plates to the dining room with assistance from the staff. The QIDP indicated the clients were to be provided training in regard to family style dining.</p> <p>This deficiency was cited on 2/27/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-8(a)</p>			