

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G296	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/31/2015
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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 417 W WALNUT ST KOKOMO, IN 46901
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W 0000  Bldg. 00	<p>This visit was for the pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00173981.</p> <p>Complaint #IN00173981: Unsubstantiated, due to lack of evidence.</p> <p>Dates of Survey: 7/21, 7/22, 7/23, 7/24, 7/27, 7/28, and 7/31/2015.</p> <p>Facility Number: 000815 Provider Number: 15G296 AIM Number: 100249080</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0140  Bldg. 00	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>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 1 of 3 sampled clients (client A), the facility failed to implement its written policy in regard to client finances to ensure accountability of client A's funds.</p>	W 0140	<p><b>W140:</b> The facility currently has systems and policies in place to ensure accurate accounting of client financial records. The facility currently trains all employees and supervisors on client finance management policy and procedures</p>	08/30/2015

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

TITLE

(X6) DATE

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

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	<p>Findings include:</p> <p>On 7/21/15 at 1:50pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incidents of financial exploitation for client A:</p> <p>-A 5/31/15 BDDS report for an incident on 5/30/15 at 9:30am for client A. The report indicated "Staff was counting finances and signing off on [each client's financial record] (sic) and found that [client A] was missing \$10.00."</p> <p>On 7/28/15 at 11:10am, an interview was conducted with the Area Director (AD) and the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional). The PD/QIDP and the AD both indicated client A's missing money was not located, the facility had control of client A's personal fund money, and client A's missing money was reimbursed by the facility.</p> <p>On 7/21/15 at 3:00pm, a review of the 4/2011 "Management of An Individual Funds" indicated random audits completed by the agency's management personnel will be completed. The policy indicated the management of a client's personal funds must be completed on</p>		<p>to ensure client finances are safe and accurate as recorded.</p> <p>The Program Coordinator will train the staff in the home to ensure client funds are counted and signed off on each shift on a daily basis. The Program Coordinator was trained to monitor the client finances and document on the weekly checklist.</p> <p>In the future, the facility Program Coordinator will monitor the client finances three times for two weeks then weekly thereafter to ensure client accounting balances are accurate. The Program Director will review accounts weekly for one month, then monthly thereafter. The Program Director will balance the checkbooks monthly to ensure they are accurate according to bank records.</p> <p>Responsible Party: Area Director Completion Date: 8/30/15</p>		

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W 0149 Bldg. 00	<p>each shift and balanced.</p> <p>On 7/31/15 at 9:45am, an interview was conducted with the PD/QIDP. The PD/QIDP indicated client A's money was still missing and had been replaced by the facility. The PD/QIDP indicated it was not determined when client A's money became missing because client A's account was not reconciled until the end of the week.</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 1 of 3 sampled clients (client C) and 2 additional clients (clients E and F), the facility neglected to implement facility policy and procedures to prevent abuse, neglect, and/or exploitation by failing to complete effective corrective action for client C's continued client to client physical aggression toward clients E, F, and clients attending the day services workshop.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the</p>	W 0149	<p>W149: All new employees are trained on the policy and the procedure for endangered adult/abuse/neglect. The facility follows a protocol including assessment of client behavioral support plans, program goals and individual support plan to ensure the client needs and protection is met.</p> <p>The facility will train the staff/Program Coordinator, Program Director and Day Program supervisor on incident management of client behavioral incidents. Training will include the review all client incidents including client to client to determine what should occur for future prevention. The training</p>	08/30/2015

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	<p>Bureau of Developmental Disabilities Services (BDDS) from 1/1/15 through 7/21/15 were reviewed on 7/21/15 at 1:50pm and indicated the following:</p> <p>-A 7/12/15 BDDS report for an incident on 7/11/15 at 4:00pm indicated client C pinched client F twice on her right arm.</p> <p>-A 7/7/15 BDDS report for an incident on 7/6/15 at 12:00noon indicated client C "scratched" another client at the day services on the left arm, broke the skin, and resulted in "bruising."</p> <p>-A 6/5/15 BDDS report for an incident on 6/4/15 at 2:15pm indicated client C pinched another client at the day services on the left forearm and "broke the skin."</p> <p>-A 6/4/15 BDDS report for an incident on 6/4/15 at 9:35am indicated client C pinched another client at the day services three times on the arm.</p> <p>-A 5/29/15 BDDS report for an incident on 5/29/15 at 11:45am indicated client C pinched another client on the arm at the day services which resulted in a "red area" on the arm.</p> <p>-A 2/13/15 BDDS report for an incident on 2/12/15 at 2:38pm indicated while at the day services client C pinched client E</p>		<p>will include follow up on incidents to ensure corrective/protective measures are put in place to prevent reoccurrence of client aggression incidents. The team will discuss the client behavior plan to make revisions of the behavior plan as necessary to address client to client aggression.</p> <p>The facility will continue to train all employees to follow the reporting guidelines of behavior plans as written and initiation of behavioral intervention techniques, charting and calling supervisors per protocol as trained. The Area Director will review weekly all client incidents then develop a plan to follow up on recommendations to assess the effectiveness of the plans for the client behavior to ensure protection of all clients.</p> <p>Person responsible: Area Director Completion Date: 8/30/15</p>	

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	<p>on the right arm.</p> <p>-A 1/7/15 BDDS report for an incident on 1/6/15 at 10:15am indicated client C pinched another client at the workshop which resulted in a two and one half inch "red area" on the other client's arm.</p> <p>-A 1/6/15 BDDS report for an incident on 1/5/15 at 12:30pm indicated client C had pinched another client at the workshop which resulted in a bruise on the other client's arm.</p> <p>On 7/21/15 at 1:50pm, an interview was conducted with the AD (Area Director). The AD indicated there was no documented corrective action completed for client C's continued pinching behaviors. The AD stated client C's plans "probably should have at least been reviewed," revision made after the review, and there was no evidence that corrective action was completed after each incident. The AD indicated the agency's policy and procedure was not implemented because client C's behaviors continued</p> <p>The facility's Quality and Risk Management operating practices revised 4/11 was reviewed on 7/21/15 at 1:50pm and indicated it was agency policy to report to BDDS "Indiana Mentor is</p>			

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W 0157 Bldg. 00	<p>committed to ensuring the individuals we serve are provided with a safe and quality living environment. In order to ensure the highest standard of service delivery specific staff will be assigned to the monitoring and review of Quality Assurance. These staff will assist in providing Individual Support Teams with corporate supports, recommendations and resources for incident management and will review the effectiveness of the recommendations...The Area Director will review each incident and Quality Assurance recommendations monthly. This review will be completed with the Program Director and other appropriate staff to assess the effectiveness of each recommendation made per incident...."</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, for 1 of 3 sampled clients (client C) and 2 additional clients (clients E and F), the facility failed to initiate effective corrective action to prevent client to client physical aggression for client C's continued behaviors toward clients E, F, and clients attending the day services workshop.</p>	W 0157	<p>W157 The facility consistently monitors client treatment on a daily basis through review of documentation on all clients. The facility QMRP reviews client program plans including incident reports on a weekly basis and upon incident occurrence then makes revisions to the plans per team approval. The Area Director will retrain</p>	08/30/2015	

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	<p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) from 1/1/15 through 7/21/15 were reviewed on 7/21/15 at 1:50pm and indicated the following:</p> <p>-A 7/12/15 BDDS report for an incident on 7/11/15 at 4:00pm indicated client C pinched client F twice on her right arm.</p> <p>-A 7/7/15 BDDS report for an incident on 7/6/15 at 12:00noon indicated client C "scratched" another client at the day services on the left arm, broke the skin, and resulted in "bruising."</p> <p>-A 6/5/15 BDDS report for an incident on 6/4/15 at 2:15pm indicated client C pinched another client at the day services on the left forearm and "broke the skin."</p> <p>-A 6/4/15 BDDS report for an incident on 6/4/15 at 9:35am indicated client C pinched another client at the day services three times on the arm.</p> <p>-A 5/29/15 BDDS report for an incident on 5/29/15 at 11:45am indicated client C pinched another client on the arm at the day services which resulted in a "red area" on the arm.</p>		<p>the Program Director on the facility guidelines of incident report review and action plan to address reoccurring client behaviors. The facility has scheduled a meeting with the behavior specialist to establish intervention techniques for prevention of client C pinching behaviors. The staff will be trained on any changes to the client's program.</p> <p>The Program Director will continue to review client incident reports upon occurrence and weekly to monitor client behavior. The Program Director will initiate contact with the behavior specialist for client consultation if the client behaviors increase or remain continual for more than 2 consecutive months in the future.</p> <p>Responsible Staff: Area Director Completion Date: 8/30/15</p>		

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	<p>-A 2/13/15 BDDS report for an incident on 2/12/15 at 2:38pm indicated while at the day services client C pinched client E on the right arm.</p> <p>-A 1/7/15 BDDS report for an incident on 1/6/15 at 10:15am indicated client C pinched another client at the workshop which resulted in a two and one half inch "red area" on the other client's arm.</p> <p>-A 1/6/15 BDDS report for an incident on 1/5/15 at 12:30pm indicated client C had pinched another client at the workshop which resulted in a bruise on the other client's arm.</p> <p>Client C's record was reviewed on 7/24/15 at 10:35am. Client C's 2/20/15 ISP (Individual Support Plan) and 6/2015 BSP (Behavior Support Plan) both indicated client C had targeted behaviors which included "Physical Aggression: Any purposeful attempt or successful act of hitting, slapping, kicking, spitting or otherwise intentionally injuring someone." Client C's plans did not indicate a program revision to include pinching behaviors. Client C's plan indicated staff "Do not take [client C] away from the person." Client C's plans indicated client C had a "history" of physical aggression to gain his (client</p>			

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W 0247 Bldg. 00	<p>C's) removal from a area which was "too hectic" or "noisy."</p> <p>On 7/21/15 at 1:50pm, an interview was conducted with the AD (Area Director). The AD indicated there was no documented corrective action completed for client C's continued pinching behaviors. The AD stated client C's plans "probably should have at least been reviewed," revision made after the review, and there was no evidence that corrective action was completed after each incident. The AD indicated the agency's policy and procedure was not implemented because client C's behaviors continued.</p> <p>9-3-2(a)</p> <p>483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management.</p> <p>Based on observation and interview, for 6 of 6 clients (clients A, B, C, D, E, and F), the facility failed to encourage choice of the facility menu cereal item at the breakfast meal.</p> <p>Findings include:  On 7/23/15 from 5:25am until 7:30am,</p>	W 0247	<p><b>W247:</b> The facility trains staff upon hire and reviews annually on the rights of the clients. The direct support professionals are trained to encourage choice, and ensure the client has the right to retain and use personal possessions and clothing. The Program Coordinator will retrain the staff to purchase and offer more than one breakfast cereal option to</p>	08/30/2015

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	<p>observation and interview were completed with clients A, B, C, D, E, and F at the group home. At 5:25am, clients C, D, E, and F consumed Lucky Charms (a cold cereal). Client A was provided a bowl of Oatmeal custodially made by GHS (Group Home Staff) #1 while client A was seated at the dining room table. GHS #1 indicated client B was in bed ill and had indicated he was not eating breakfast. From 5:45am until 6:00am, GHS #1 and clients C, D, E, and F indicated they had one choice of cereal which was Lucky Charms. At 5:55am, GHS #1 and client A stated client A was "always" given Oatmeal cereal because she had a choking risk. At 6:15am, clients E and F showed the kitchen cabinets and indicated there was one cereal available for clients to eat.</p> <p>On 7/23/15 at 7:30am, and on 7/24/15 at 8:35am, the facility's menu was requested for review and was not available.</p> <p>On 7/24/15 at 8:35am, an interview was conducted with the facility's Area Director (AD). The AD indicated clients A, B, C, D, E, and F should be given their choice of cereal to eat in the morning. The AD indicated the group home should have more than one kind of cereal to offer each client.</p>		<p>clients for meals. Training will include offering choices to ensure client rights.</p> <p>The Program Coordinator will formally observe the staff and clients for three times weekly for one month then once weekly thereafter to ensure choice is offered during meals. The Program Director will review the observations and follow up as needed to ensure client rights.</p> <p>Responsible Person: Program Director Completion Date: 8/30/15</p>				

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W 0289 Bldg. 00	<p>On 7/28/15 at 11:10am, an interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted. The PD/QIDP indicated more than one cereal should be available for clients A, B, C, D, E, and F to choose from to eat.</p> <p>9-3-4(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on observation, record review, and interview, for 1 of 3 sampled clients (client A), the facility failed to ensure client A's bedroom door alarms used as a behavioral intervention were incorporated into her ISP (Individual Support Plan) and BSP (Behavior Support Plan).</p> <p>Findings include:</p> <p>On 7/22/15 from 3:15pm until 4:35pm and on 7/23/15 from 5:25am until 7:30am, client A's upstairs bedroom door had an active alarm which sounded on the lower level (downstairs) when client A's upstairs bedroom door was</p>	W 0289	<p>W 289</p> <p>The facility currently ensures by means of an annual teaming and monthly review of client programming that the use of systematic interventions to manage inappropriate client behavior is incorporated into the clients Individual Program Plan. The Program Director will add the use of the bedroom door alarm to the behavior support and individual support plan for client A. The Program Director will ensure the Human Rights Committee and Individual Support Team approve the addition to the plans for client C.</p>	08/30/2015

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	<p>opened/closed. On 7/23/15 at 7:20am, client A and GHS (Group Home Staff) #2 both indicated client A's upstairs bedroom door had an alarm which sounded downstairs to alert staff client A's bedroom door either opened or closed. At 7:20am, GHS #2 stated client A "steals items from others" and "eats large" quantities of food. GHS #2 stated client A was at risk to choke while eating and was "compulsive."</p> <p>Client A's record was reviewed on 7/24/15 at 9:30am. Client A's 2/4/15 ISP and 5/2015 BSP both indicated client A had "targeted behaviors" which included: Inappropriate Touch, Stealing, Inappropriate Sexual Seduction, False Accusations, Physical Assault, Incontinence, and Spitting up food. Client A's ISP indicated she required twenty-four hour a day staff supervision. Client A's Plan did not include the use of a bedroom door alarm.</p> <p>On 7/28/15 at 11:10am, an interview was conducted with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director. The QIDP/PD stated client A did not recognize danger, "required" twenty-four hour staff supervision, and had an upstairs bedroom door alarm to alert staff when she left her upstairs bedroom. The</p>		<p>The Program Coordinator will re-train the direct support professionals on the changes made to the behavioral and individual support plans of client C.</p> <p>In the future, the facility will ensure that all changes and additions to the client active treatment and programming are updated in the client Individual Program Plan/Behavioral Plan as stated in the client regulatory guidelines. This will be accomplished by monthly review by the Program Director of the client programming and implementation of addendums as needed.</p> <p>Person responsible: Area Director Completion Date: 8/30/15</p>				

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W 0331 Bldg. 00	<p>QIDP/PD indicated client A's upstairs bedroom door alarm should have been defined and documented in client A's ISP and BSP. The QIDP/PD indicated client A's record did not include a documented desired outcome as the result from client A's bedroom door having the alarm.</p> <p>9-3-5(a)</p> <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 (client A), the facility's nursing services failed to develop protocols specific to client A to monitor and to manage client A's dining and client A's coughing while eating meals.</p> <p>Findings include:</p> <p>On 7/22/15 from 3:15pm until 4:35pm, on 7/22/15 from 4:45pm until 5:15pm, and on 7/23/15 from 5:25am until 7:30am, client A consumed food and drink and coughed continuously throughout each of the observation periods while eating and drinking.</p> <p>On 7/22/15 from 3:30pm until 3:50pm, client A selected a snack of a cereal bar.</p>	W 0331	<p><b>W331:</b> The facility provides nursing services for the clients in the group home on a daily basis to ensure medical needs of the clients are being met. The facility nurse trains staff upon hire and as needed on medical treatments and procedures necessary to ensure the client medical needs are being met. The nurse monitors the documentation of medical orders to weekly to ensure procedures are being carried out as ordered by the doctor. Client A was scheduled and attended another swallow study resulting in a change in diet and updated dining plan. The facility nurse has developed an aspiration protocol for client A. The Program Nurse will train the direct support staff to implement medical procedures and protocols as written. In the future, the facility nurse will monitor the staff</p>	08/30/2015

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	<p>At 3:40pm, client A and GHS (Group Home Staff) #6 mashed the cereal bar in a bowl and soaked the mashed bar with milk and poured a drink. At 3:40pm, client A sat next to GHS #6 at the dining room table. Client A took a half of spoonful of milk soaked cereal bar and began to cough while swallowing. GHS #6 prompted client A to slow her rate of eating. Client A slowed her rate and after another half of bite and a sip of drink, client A began to cough again. Client A coughed after each bite and after each sip of drink. GHS #6 prompted client A four (4) separate times after client A took a bite of food and coughing continuously to raise her arms above client A's head. Client A's eyes looked watery and her face was red.</p> <p>On 7/22/15 from 4:45pm until 5:15pm, client A was on a community outing for dinner. GHS #6 and GHS #8 sat at a table with client A. GHS #6 and GHS #8 provided client A a Mechanical Soft diet and ground client A's Pork Loin in a food processor they transported with them. Client A's foods were fork mashed and consisted of Green Beans, Cheesy Potatoes, and Cole Slaw. Client A's liquids were regular consistency. Client A coughed after she fed herself bites of food. Staff prompted client A to slow her rate of eating and drinking. Client A</p>		<p>medical documentation at least monthly. The Program Director will inform the nurse of client incidents as they occur. In addition the supervisors and nurse combined will monitor three times weekly for one month then once weekly thereafter to ensure all medical practices are being carried out correctly and documented as per doctor's orders. Responsible Person: Area Director Completion Date: 8/30/15</p>	

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	<p>slowed her rate of bites of food and sips of liquid and continued to cough. At one point during the meal client A was coughing and staff excused client A from the table then accompanied client A to an out of sight area while client A continued to cough away from the crowd of people.</p> <p>On 7/23/15 from 5:25am until 6:15am, client A fed herself milk soaked Oatmeal and bread, and coughed after putting more than one bite of food into her mouth at one time. Client A coughed after putting sips of regular liquids into her mouth. At 5:45am, GHS #1 stated client A coughed "all the tame." Client A continued to cough. GHS #1 prompted client A to raise one arm above her head. Client A did and continued to cough. Client A's eyes looked watery. GHS #1 prompted client A to raise both arms over her head. Client A did until she did not cough and then continued eating. Client A began to cough again and GHS #1 prompted client A to raise client A's arms again. This continued until client A had consumed her meal.</p> <p>Client A's record was reviewed on 7/24/15 at 9:30am. Client A's 2/4/15 ISP and 5/2015 BSP both did not indicate client A had a behavior of coughing during dining. Client A's 7/21/15, 4/28/15, 1/15/15, and 10/21/14 Nursing</p>			

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	<p>Quarterly assessments did not indicate client A coughed during dining. Client A's 5/8/14 "Dysphagia/Dining Plan" indicated client A received a Mechanical Soft diet, ground meat, and thin liquids. Client A's Dining Plan indicated "Eating...Prompts to put utensil down and prompts to take a drink...Staff supervision." Client A's Dining Plan indicated "Triggers to notify Nursing Staff Coughing with signs of struggle watery eyes, drooling, facial redness." Client A's undated "Risk Assessment for Choking" indicated client A was at the choking risk of "Mild...Level 5: Coughing during meals, snacks, or on Saliva." Client A's 5/21/13 "Aspiration Protocol" indicated client A had an "Aperistaltic Esophagus (an Esophagus in which the muscle will not allow food to be moved down the esophagus) ...Eating or drinking instructions (no documenting), keep upright for 30 minutes after eating...Person temp. (temperature) above 100 or below 95 (degrees)." No specific instructions were documented on client A's Aspiration Protocol. Client A's 3/20/14 "Aperistaltic Esophagus" Protocol indicated "Notify: Supervisor or On Call...Crush meds (medications) and put in food...eat slowly, chew very well, drink plenty of water. Signs and Symptoms of difficulty in swallowing (sic);</p>			

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	<p>regurgitating/vomiting of undigested food...sit up for 1 hour after eating, avoid large meals...." Client A's 7/8/15 Nutritional Assessment did not include client A coughing during meals.</p> <p>On 7/28/15 at 11:50am, an interview was conducted with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director and the agency LPN (Licensed Practical Nurse). The QIDP/PD indicated client A had not been seen by the Registered Dietician (RD) during dining to assess client A coughing during and throughout eating and drinking. The QIDP/PD stated client A's coughing was "thought to be a behavior and not a medical issue." The LPN stated the RD had completed client A's nutritional assessment during the day while client A was gone to the workshop. The LPN stated the RD reviewed the documents in client A's record and had not "actually" observed client A consume food or drink. The LPN indicated client A's physician was addressing her Aperistaltic Esophagus with treatments on 3/25/15. The LPN indicated client A's nursing quarterly assessments failed to include the treatments. The LPN indicated there was no plan/protocol which included how staff were to assist client A. The LPN and QIDP/PD both indicated no staff training was available</p>			

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W 0368 Bldg. 00	<p>for review for assisting client A during eating and drinking.</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 (clients A and C) and 2 additional clients (clients D and F), the facility failed to administer medications without error and as prescribed by client A, C, D, and F's physician.</p> <p>Findings include:</p> <p>On 7/21/15 at 1:50pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 1/1/2015 through 7/21/15 were reviewed and indicated the following medication errors for clients A, C, D, and F.</p> <p>-A 6/7/15 BDDS report for an incident on 6/5/15 at 8:00pm indicated the facility "staff did not pass any 8p (8:00pm) meds. (medications). When asked about it [the staff member] said that she was sorry and had just overlooked passing meds at 8pm (sic). [The staff member] said she got</p>	W 0368	<p><b>W368</b></p> <p>The facility utilizes a medication administration format that all direct support are trained to follow and implement upon hire. This training includes following the Medication Administration Record orders as written including special instructions. The medication procedures are monitored in the home by the Program Director and the facility nurse on a routine basis to ensure the medications are given to the client as ordered by the doctor. The staff will be re-trained by the Program Nurse to follow the facility policy for administration of all client medications. The training will include staff will read the client doctor's orders when administrating the client medication. In addition, the individual staff will be trained by the nurse and the next medication passing by the staff will be monitored by the nurse to ensure the staff maintains the knowledge to ensure safe medication practices for the clients.</p> <p>The Program Coordinator and</p>	08/30/2015	

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	<p>sidetracked with something and just forgot." The report indicated "The errors were not noticed until the 8pm med pass on 6/6/15, so after not receiving the meds for 24 hours [the staff] could not give the missed meds to the clients." The reports did not include what medications clients A, C, D, and F did not receive on 6/5/15.</p> <p>On 7/28/15 at 11:50am, an interview with PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) and LPN (Licensed Practical Nurse) was conducted. The LPN and the PD/QIDP indicated staff should administer medications according to physician's orders. The LPN and the PD/QIDP indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders.</p> <p>On 7/28/15 at 11:50am, an interview with the agency LPN (Licensed Practical Nurse) was conducted. The LPN indicated staff should follow Core A/Core B Living in the Community medication administration training when administering medications. The LPN indicated staff should follow physician's orders to administer medications.</p> <p>On 7/28/15 at 11:50am, a review of the</p>		<p>nurse combined will observe a medication pass by staff on a weekly visit for one month to monitor the medication administration procedure to eliminate possible future error by staff. In the future, the facility will continue to train all staff on the medication administration policy to ensure the client's medication is given in a means to ensure optimal safety.</p> <p>Person responsible: Program Director Completion Date: 8/30/15</p>	

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W 0383 Bldg. 00	<p>facility's 4/2011 Medication Administration Policy and Procedure was conducted. The policy and procedure indicated staff should administer client medications according to physician's orders.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation, record review, and interview, the facility failed to secure the medication cabinet keys for 3 of 3 sampled clients (A, B, and C) and three additional clients (clients D, E, and F) who resided in the home.</p> <p>Findings include:</p> <p>On 7/22/15 from 3:15pm until 4:35pm and on 7/23/15 from 5:25am until 7:30am. observations were conducted and clients A, B, C, D, E, and F walked and/or accessed each room throughout the group home independently. During both observation periods, the medication administration office door was open and/or not locked with the medication cabinet keys laying at eye level on the table in the room. During both observation periods Group Home Staff</p>	W 0383	<p><b>W383:</b> The facility trains all staff upon hire to administer medication per the core A and B medication policy. The facility training teaches the staff to follow the facility policy and procedures for medication administration including secure storage of medications</p> <p>The Program Director will retrain the staff to properly store and lock all client medication when not being used per policy. The training will include storing the keys to the medications in a secure location away from client access.</p> <p>The Program Coordinator will monitor the medication supply to ensure that the client medications are locked and stored properly in the future. The Program Coordinator will complete weekly observations to include medication administration for 4 weeks to ensure staff are correctly storing medications.</p>	08/30/2015	

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	<p>(GHS) #1, #2, #3, #4, #6, #8, and the Residential Manager (RM) were present. During both observation periods when the medication cabinet keys were moved from the table inside the medication room the keys were laid unsecured on top of the activity table in the living room area of the facility. On 7/23/15 at 7:30am, the RM indicated the facility kept the keys either on the activity table or on the table inside the medication room. The RM indicated the medication cabinet keys should be secure and the staff should know where the keys were kept.</p> <p>An interview was conducted on 7/28/15 at 11:50am, with the agency LPN (Licensed Practical Nurse). The LPN indicated the medication keys should be kept secured when medications were not administered and the keys were not secured. The LPN indicated clients A, B, C, D, E, and F had access to the medication keys to the medication cabinet. The LPN indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>On 7/28/15 at 11:50am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in</p>		<p>Person responsible: Program Director Completion Date: 8/30/15</p>		

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	"Core Lesson 3: Principles of Administering Medication" medication cabinet keys should be kept secure.  9-3-6(a)				