STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G493	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA CORPORATION OF INDIANA	4160 N CAMPBELL AVE INDIANAPOLIS, IN 46226

(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	This visit was for an extended annual recertification and state licensure survey. Dates of Survey: 7/28/14, 7/29/14, 7/30/14, 8/1/14 and 8/4/14. Facility Number: 001007 Provider Number: 15G493 AIMS Number: 100245090 Surveyor: Keith Briner, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed August 8, 2014 By Dotty Walton, QIDP.	W000000		
W000130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation, record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1's privacy while dressing. Findings include: Observations were conducted at the	W000130	**CORRECTION:** *The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.* Specifically, direct support staff will be retrained regarding the need maintain privacy for all clients during active treatment.	09/03/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	group home on 7/28/14 from 4:50 PM through 6:15 PM. At 5:40 PM, client #1 (female) finished taking a shower. Client #1 with DSP (Direct Support Professional) #1 entered client #1's bedroom. Client #1 removed her shower towel, leaving her body exposed, while DSP #1 verbally coached client #1 to go to her dresser to pick undergarments and clothing to wear. Client #1's bedroom door remained opened as client #1 was naked and throughout the process of putting on her undergarments and clothing. At 5:42 PM, client #6 (male) walked past client #1's open door while she was dressing to enter his personal bedroom. At 5:43 PM, DSP #2 pushed client #5 in his wheelchair past client #1's bedroom while taking client #5 to the restroom. DSPs #1 and #2 did not encourage client #1 to cover her body, redirect clients #5 and #6's attention away from the client #1's bedroom area or close client #1's bedroom door to ensure privacy during her dressing activity. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/29/14 at 2:40 PM. QIDP #1 indicated client #1's privacy should be ensured while dressing in her room. QIDP #1 indicated DSP #1 should have closed client #1's bedroom door to protect her privacy while dressing.		Active treatment observations by administrative staff indicated that in addition to Client #1, this deficient practice affected Client #5. **PERVENTION:** The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week and the Team Leader will be required to observe and participate in active treatment sessions on varied shifts no less than five times per week. During Active Treatment observations, supervisors will assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring that privacy is maintained. Additionally, members of the Operations Team will maintain an increased presence at the facility, performing unscheduled observation of active treatment, no less than weekly for the next 30 days, no less than twice monthly for an additional 60 days providing hands-on coaching and training as needed. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. **RESPONSIBLE PARTIES:**	

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	9-3-2(a)		QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W000149	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 observation, record review and interview for 1 of 4 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed, the facility failed to implement its policy and procedures to ensure an injury of unknown origin regarding client #1 was reported to the BDDS (Bureau of Developmental Disabilities Services) within 24 hours and to ensure an investigation was completed with the findings reported to the facility administrator within 5 business days of the facility's knowledge of the injury of unknown origin regarding client #1. Findings include: The facility's BDDS reports and investigations were reviewed on 7/28/14 at 2:28 PM. The review did not indicate documentation of an injury of unknown origin/left bruised eye regarding client #1. Observations were conducted at the	W000149	**CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.* Specifically: Facility staff have been retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of weekly body assessments and incident documentation confirmed that this deficient practice did not affect other clients. The facility will provide documentation showing the date of investigation completion and a listing of appropriately notified parties for investigations for the sources of Client #1's injury discovered on 7/25/14. **PERVENTION:** Supervisory staff will review all facility documentation to assure incidents are reported as required. The governing body has	09/03/2014

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	group home on 7/28/14 from 4:50 PM through 6:15 PM. Client #1 was observed in the group home throughout the observation period. Client #1 had a blue and black to purple one inch circular bruise around her left eye. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/29/14 at 2:40 PM. QIDP #1 indicated client #1 had a blue and black to purple one inch circular bruise around her left eye. CS (Clinical Supervisor) #1 provided a 7/29/14 BDDS report regarding client #1's injury on 7/30/14 at 10:27 AM. The 7/29/14 BDDS report indicated on 7/25/14 "Staff looked at [client #1's] face while she was sitting in her rocking chair and noticed that she had a bruise under her left eye. Staff notified the RM (Residential Manager) and the QIDP. Staff also told the nurse." CS #1 did not provide documentation of an investigation regarding the 7/25/14 injury of unknown origin for client #1. LPN (Licensed Practical Nurse) #1 was interviewed on 7/29/14 at 12:39 PM. LPN #1 indicated she had not been notified regarding client #1's 7/25/14 eye injury of unknown origin.		added an additional layer of supervision at the facility which will enhance oversight of the incident reporting process. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation including but not limited to injuries of unknown origin, the governing body will administer written corrective action up to and including termination of employment. Professional staff will be retrained regarding the need to provide documentation of investigation result reporting to medical surveyors and other appropriate parties on request. Members of the Operations team will remain in communication with medical surveyors throughout the survey process to assure available documentation is provided upon request. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	

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	CS #1 was interviewed on 7/29/14 at 1:45 PM. CS #1 indicated injuries of unknown origin should be reported to the BDDS within 24 hours of knowledge of the incident. CS #1 indicated injuries of unknown origin should be investigated and the results reported to the administrator within 5 business days of the incident. CS #1 indicated the facility's abuse and neglect policy should be implemented. The facility's policy and procedures were reviewed on 8/4/14 at 5:14 PM. The facility's 9/14/07 policy and procedure entitled, "Investigations" indicated, "Practices: 3. (b) Ensure alleged incident of abuse, neglect, mistreatment, exploitation or injuries of unknown origin are fully investigated within 5 calendar days from the date the allegations were made and investigation was initiated." The facility's 9/14/07 policy and procedure entitled "Abuse, Neglect, Exploitation operating standard 1.26" indicated, "Following ResCare protocol for the exact process to report incidents, once the suspicion has been reported to the supervisor and/or PD (Program Director), the PD will report, within 24 hours, the suspected abuse, neglect or exploitation as follows...." 9-3-2(a)			

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W000153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on observation, record review and interview for 1 of 4 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed, the facility failed to ensure an injury of unknown origin regarding client #1 was reported to the BDDS (Bureau of Developmental Disabilities Services) within 24 hours. Findings include: The facility's BDDS reports and investigations were reviewed on 7/28/14 at 2:28 PM. The review did not indicate documentation of an injury of unknown origin/left bruised eye regarding client #1. Observations were conducted at the group home on 7/28/14 from 4:50 PM through 6:15 PM. Client #1 was observed in the group home throughout the observation period. Client #1 had a blue and black to purple one inch circular bruise around her left eye.	W000153	**CORRECTION:** *The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.* Specifically, facility staff have been retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of weekly body assessments and incident documentation confirmed that this deficient practice did not affect other clients. **PREVENTION:** Supervisory staff will review all facility documentation to assure incidents are reported as required. The governing body has added an additional layer of supervision at the facility which will enhance oversight of the incident reporting process.	09/03/2014

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	QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/29/14 at 2:40 PM. QIDP #1 indicated client #1 had a blue and black to purple one inch circular bruise around her left eye. CS (Clinical Supervisor) #1 provided a 7/29/14 BDDS report regarding client #1's injury on 7/30/14 at 10:27 AM. The 7/29/14 BDDS report indicated on 7/25/14 "Staff looked at [client #1's] face while she was sitting in her rocking chair and noticed that she had a bruise under her left eye. Staff notified the RM (Residential Manager) and the QIDP. Staff also told the nurse." CS #1 was interviewed on 7/29/14 at 1:45 PM. CS #1 indicated injuries of unknown origin should be reported to the BDDS within 24 hours of knowledge of the incident. 9-3-1(b)(5) 9-3-2(a)		Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation including but not limited to injuries of unknown origin, the governing body will administer written corrective action up to and including termination of employment. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W000156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.			

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	Based on observation, record review and interview for 1 of 4 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed, the facility failed to ensure an investigation was completed and reported to the facility administrator within 5 business days of the facility's knowledge of the injury of unknown origin regarding client #1. Findings include: The facility's BDDS reports and investigations were reviewed on 7/28/14 at 2:28 PM. The review did not indicate documentation of an investigation of an injury of unknown origin/left bruised eye regarding client #1. Observations were conducted at the group home on 7/28/14 from 4:50 PM through 6:15 PM. Client #1 was observed in the group home throughout the observation period. Client #1 had a blue and black to purple one inch circular bruise around her left eye. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/29/14 at 2:40 PM. QIDP #1 indicated client #1 had a blue and black to purple one inch circular bruise around her left eye.	W000156	**CORRECTION:** *The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.* Specifically, the facility will provide documentation showing the date of investigation completion and a listing of appropriately notified parties for investigations for the sources of Client #1's injury discovered on 7/25/14. **PREVENTION:** Professional staff will be retrained regarding the need to provide documentation of investigation result reporting to medical surveyors and other appropriate parties on request. Members of the Operations team will remain in communication with medical surveyors throughout the survey process to assure available documentation is provided upon request. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	09/03/2014

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	CS (Clinical Supervisor) #1 provided a 7/29/14 BDDS report regarding client #1's injury on 7/30/14 at 10:27 AM. The 7/29/14 BDDS report indicated on 7/25/14 "Staff looked at [client #1's] face while she was sitting in her rocking chair and noticed that she had a bruise under her left eye. Staff notified the RM (Residential Manager) and the QIDP. Staff also told the nurse." CS #1 did not provide documentation of an investigation regarding the 7/25/14 injury of unknown origin for client #1. CS #1 was interviewed on 7/29/14 at 1:45 PM. CS #1 indicated injuries of unknown origin should be investigated and the results reported to the administrator within 5 business days of the incident. 9-3-2(a)			
W000159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 3 of 4 sampled clients (#1, #3 and #4) plus 4 additional clients (#5, #6 and #8), the QIDP (Qualified Intellectual Disabilities Professional)	W000159	**CORRECTION:** *Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.* Specifically	09/03/2014

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	failed to integrate, coordinate and monitor the clients' active treatment programs by failing to ensure client #3's CFA (Comprehensive Functional Assessment) was completed within 30 days of his admission to the facility, to ensure client #3's persistent refusals to participate in active treatment programming was addressed by the IDT (Interdisciplinary Team) and to ensure clients #1, #4, #5, #6 and #8 received training at each available opportunity and failed to promote client #1's independence, growth and dignity while dressing. Findings include: 1. The QIDP failed to ensure client #3's CFA was completed within 30 days of his admission to the facility. Please see W210. 2. The QIDP failed to ensure client #3's persistent refusals to participate in active treatment programming was addressed by the IDT and to ensure clients #1, #4, #5, #6 and #8 received training at each available opportunity. Please see W249. 3. The QIDP failed to promote client #1's independence, growth and dignity while dressing. Please see W268.		The QIDP has completed a Comprehensive Functional Assessment for Client #3. A review of facility support documents indicated this deficient practice did not affect any additional clients. For Client #3, the interdisciplinary team will meet to develop additional interventions to support and desensitize Client #3 to the new residential environment and encourage Client #3 to participate in active treatment. Additionally The QIDP has retrained direct support staff toward proper implementation of Client #1, #4, #5, #6 and #8's current learning objectives as well as the need to provide training to all clients during formal and informal opportunities. The QIDP will retrain direct support staff regarding the need maintain privacy for all clients during active treatment. Active treatment observations by administrative staff indicated that in addition to Client #1, this deficient practice affected Client #5. **PERVENTION:** The QIDP has been retrained regarding the need to assure that all relevant assessments are completed for clients within 30 days of admission. Members of the Operations Team will follow	

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	9-3-3(a)		up with the QIDP no less twice weekly when new clients are admitted to the facility to assure appropriate assessment occurs as required. The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week and the Team Leader will be required to observe and participate in active treatment sessions on varied shifts no less than five times per week. During Active Treatment observations, supervisors will assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff train toward learning objectives per the implementation schedule and provide choices of activities in which to participate at frequent intervals as well as assuring that privacy is maintained. Additionally, members of the Operations Team will maintain an increased presence at the facility, performing unscheduled observation of active treatment, no less than weekly for the next 30 days, no less than twice monthly for an additional 60 days providing hands-on coaching and training as needed. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the	

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			home to no less than monthly. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W000210	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. Based on record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure client #3's CFA (Comprehensive Functional Assessment) was completed within 30 days of his admission to the facility. Findings include: Client #3's record was reviewed on 7/29/14 at 9:05 AM. Client #3's record did not indicate documentation of a CFA. Client #3's ISP (Individual Support Plan) dated 5/26/14 indicated client #3's date of admission to the facility was 4/27/14. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/29/14 at 7:30 AM. QIDP #1 indicated client #3 had been admitted to the group home on 4/27/14. QIDP #1 indicated client #3's CFA had not been completed.	W000210	**CORRECTION:** *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.* Specifically, the QIDP has completed a Comprehensive Functional Assessment for Client #3. A review of facility support documents indicated this deficient practice did not affect any additional clients. **PERVENTION:** The QIDP has been retrained regarding the need to assure that all relevant assessments are completed for clients within 30 days of admission. Members of the Operations Team will follow up with the QIDP no less twice weekly when new clients are admitted to the facility to assure appropriate assessment occurs as required.	09/03/2014

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	9-3-4(a)		**RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W000249	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 4 sampled clients (#1, #3 and #4) plus 3 additional clients (#5, #6 and #8), the facility failed to ensure client #3's persistent refusals to participate in active treatment programming were addressed by the IDT (Interdisciplinary Team) and to ensure clients #1, #4, #5, #6 and #8 received training at each available opportunity. Findings include: 1. Observations were conducted at the group home on 7/28/14 from 4:50 PM through 6:15 PM. Client #3 was observed in the group home throughout the observation period. Client #3 was seated on the group home living room's couch	W000249	**CORRECTION:** *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.* Specifically for Client #3, the interdisciplinary team will meet to develop additional interventions to support and desensitize Client #3 to the new residential environment and encourage Client #3 to participate in active treatment. Additionally direct support staff have been retrained toward proper implementation of Client #1, #4, #5, #6 and #8's current learning objectives as well	09/03/2014

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	with his feet/legs crossed under his body in a lying position on the couch. Client #3 remained in this seated/lying position throughout the observation period. At 5:15 PM, client #3 was encouraged to come to the group home's dining room area to eat the evening meal. Client #3 refused to leave the living room couch. DSP (Direct Support Professional) #1 brought client #3 a plate of food and client #3 ate while seated on the living room couch. Observations were conducted at the group home on 7/29/14 from 6:08 AM through 8:00 AM. Client #3 was observed in the group home throughout the observation period. At 6:30 AM, client #3 entered the group home living room area from his bedroom and was seated on the group home living room's couch with his feet/legs crossed under his body in a lying position on the couch. Client #3 remained in this seated/lying position throughout the observation period. At 6:45 AM, client #3 was encouraged to join his housemates at the dining room table to eat the morning meal. Client #3 refused to participate in the group home's family style dining. Client #3 remained seated/lying on the couch. DSP #2 brought client #3 a plate of food and client #3 ate while seated on the living room couch. At 7:00 AM,		as the need to provide training to all clients during formal and informal opportunities. **PERVENTION:** The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week and the Team Leader will be required to observe and participate in active treatment sessions on varied shifts no less than five times per week. During Active Treatment observations, supervisors will assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff train toward learning objectives per the implementation schedule and provide choices of activities in which to participate at frequent intervals. Additionally, members of the Operations Team will maintain an increased presence at the facility, performing unscheduled observation of active treatment no less than weekly for the next 30 days, no less than twice monthly for an additional 60 days providing hands-on coaching and training as needed. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly.	

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	client #3 was encouraged to come to the medication administration room to receive his morning medications. Client #3 refused and began making grunting/yelling sounds. DSP #3 continued the morning medication administration with client #3's housemates and continued to offer client #3 coaching to come to the medication administration area at 7:05 AM and 7:10 AM. At 7:15 AM, DSP #3 took client #3's medications to client #3 and administered client #3's medications to him while seated/lying on the living room couch. At 7:30 AM, QIDP (Qualified Intellectual Disabilities Professional) #1 prompted client #3 to get up from the couch and use the restroom, clean his room or do an activity. Client #3 refused to participate in the offered activities. QIDP #1 was interviewed on 7/29/14 at 7:30 AM. QIDP #1 indicated client #3 had been admitted to the group home on 4/27/14. QIDP #1 indicated client #3 refused to participate in active treatment programming, attend medical/dental appointments or attend a day service provider. QIDP #1 indicated client #3's daily routine was centered around him being seated/lying on the couch. QIDP #1 stated, "We were only just recently able to get him to go to his bed to sleep at night. He was refused to leave the couch		**RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	

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	at night too." Client #3's record was reviewed on 7/29/14 at 9:05 AM. Client #3's Daily Progress Narrative Notes (DPNN) dated from 5/1/14 through 7/28/14 indicated daily refusals to participate in active treatment programming and refusal to leave the group home's living room couch. Client #3's record did not indicate documentation of the facility's IDT addressing client #3's persistent refusal to participate in active treatment. Client #3's ISP (Individual Support Plan) dated 5/26/14 indicated client #3 had the following formal training objectives: -"Given skills training, 2 VPs (Verbal Prompts) and 3 PMs (Physical Models), [client #3] will write 3 words to communicate a want, need or emotion...." -"Given skills training, 3 VPs and 3 PPs (Physical Prompts), [client #3] will do daily hygiene...." -"Given skills training, 3 VPs and 1 PP, [client #3] will assist with meal preparation...." -"Given skills training, 3 VPs and 1 PP, [client #3] will brush his teeth...." -"Given skills training, 3 VPs and 1 PP,			

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	[client #3] will learn the purpose of his medication...." -"Given skills training, 3 VPs and 1 PP, [client #3] will make (an) independent purchase...." CS #2 (Clinical Supervisor) was interviewed on 7/29/14 at 2:40 PM. CS #2 indicated no formal IDT meetings had been convened to address client #3's refusals to participate in active treatment. CS #2 indicated client #3 had refused active treatment programming on a daily basis since his admission to the group home on 4/27/14. 2. Observations were conducted at the group home on 7/29/14 from 6:08 AM through 8:00 AM. At 6:35 AM, client #8 was prompted to the medication administration area by DSP #3. DSP #3 administered client #8's morning medications. Client #8 was not encouraged or coached to participate in the administration of his morning medications. At 6:50 AM, client #6 was prompted to the medication administration area by DSP #3. DSP #3 administered client #6's morning medications. Client #6 was not encouraged or coached to participate in the administration of his morning medications. At 7:00 AM, client #5 was			

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	prompted to the medication administration area by DSP #3. DSP #3 administered client #5's morning medications. Client #5 was not encouraged or coached to participate in the administration of his morning medications. At 7:10 AM, client 4 was prompted by DSP #3 to come to the medication administration area. DSP #3 administered client #4's morning medications. Client #4 was not encouraged or coached to participate in the administration of his morning medications. At 7:15 AM, client #1 was prompted by DSP #3 to come to the medication administration area. DSP #3 administered client #1's morning medications. Client #1 was not encouraged or coached to participate in the administration of her morning medications. 3. Client #1's record was reviewed on 7/29/14 at 11:20 AM. Client #1's ISP dated 3/23/14 indicated client #1 should be prompted to identify her medications at each medication administration. 4. Client #4's record was reviewed on 7/29/14 at 9:51 AM. Client #4's ISP dated 4/6/14 indicated client #4 should be encouraged to state the reasons he takes medications for seizures.			

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	5. Client #5's record was reviewed on 7/29/14 at 12:11 PM. Client #5's ISP dated 11/22/13 indicated client #5 should be encouraged to point to his Lipitor medication (cholesterol). 6. Client #6's record was reviewed on 7/29/14 at 12:17 PM. Client #6's ISP dated 8/29/13 indicated client #6 should be encouraged to point to his Seroquel tablet (bipolar). 7. Client #8's record was reviewed on 7/29/14 at 12:13 PM. Client #8's ISP dated 7/9/14 indicated client #8 should be encouraged to state the reason he takes Claritin (allergies). DSP #3 was interviewed on 7/29/14 at 7:20 AM. DSP #3 stated, "Yes, they do have medication goals. But they can't do them." QIDP #1 was interviewed on 7/29/14 at 7:30 AM. QIDP #1 indicated active treatment program implementation should occur at each available opportunity. 9-3-4(a)			

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W000268	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, record review and interview for 1 of 4 sampled clients (#1), the facility failed to promote client #1's independence, growth and dignity while dressing. Findings include: Observations were conducted at the group home on 7/28/14 from 4:50 PM through 6:15 PM. At 5:40 PM, client #1 (female) finished taking a shower. Client #1 with DSP (Direct Support Professional) #1 entered client #1's bedroom. Client #1 removed her shower towel, leaving her body exposed, while DSP #1 verbally coached client #1 to go to her dresser to pick undergarments and clothing to wear. Client #1's bedroom door remained opened as client #1 was naked and throughout the process of putting on her undergarments and clothing. At 5:42 PM, client #6 (male) walked past client #1's open door while she was dressing to enter his personal bedroom. At 5:43 PM, DSP #2 pushed client #5 in his wheelchair past client #1's bedroom while taking client #5 to the restroom. DSPs #1 and #2 did not encourage client #1 to cover her body,	W000268	**CORRECTION:** *These policies and procedures must promote the growth, development and independence of the client.* Specifically, direct support staff will be retrained regarding the need maintain privacy for all clients during active treatment. Active treatment observations by administrative staff indicated that in addition to Client #1, this deficient practice affected Client #5. **PERVENTION:** The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week and the Team Leader will be required to observe and participate in active treatment sessions on varied shifts no less than five times per week. During Active Treatment observations, supervisors will assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring that privacy is maintained. Additionally, members of the Operations Team will maintain an increased presence at the facility, performing unscheduled observation of active treatment,	09/03/2014

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	redirect clients #5 and #6's attention away from the client #1's bedroom area or close client #1's bedroom door to ensure privacy/dignity during her dressing activity. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/29/14 at 2:40 PM. QIDP #1 indicated client #1's privacy should be ensured while dressing in her room. QIDP #1 indicated DSP #1 should have closed client #1's bedroom door to protect her dignity while dressing. 9-3-5(a)		no less than weekly for the next 30 days, no less than twice monthly for an additional 60 days providing hands-on coaching and training as needed. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W000323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 4 sampled clients (#3), the facility failed to provide an annual physical examination for client #3. Findings include: Client #3's record was reviewed on 7/29/14 at 9:05 AM. Client #3's record did not indicate documentation of an annual physical examination.	W000323	**CORRECTION:** *The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.* Specifically, the facility will obtain visual and hearing screenings for Client #3. The facility is working with a visiting physician service to obtain screenings when Client #3 is unwilling to leave the house. An audit of facility medical charts	09/03/2014

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	LPN (Licensed Practical Nurse) #1 was interviewed on 7/29/14 at 12:39 PM. LPN #1 indicated client #3 had refused to participate in medical appointments. LPN #1 indicated a physician had been identified to come to the group home to provide services to client #3. LPN #1 indicated there was not documentation of an annual physical examination for client #3. CS (Clinical Supervisor) #2 provided via electronic media, a form dated 6/12/14 which indicated a physician had seen client #3 at the group home. The 6/12/14 form did not specify what services were provided. The 6/12/14 form did not document a physical examination or evaluation of client #3's vision and/or hearing. 9-3-6(a)		indicated this deficient practice did not affect any additional clients. **PREVENTION:** The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to visual and Audiological screening, occur within required time frames. Supervisory staff will review medical charts on an ongoing basis but no less than monthly to assure medical follow-along occurs as required. Members of the Operations Team and nursing staff will incorporate medical chart reviews into their formal audit process, which will occur no less than quarterly to assure that examinations including but not limited to visual and hearing evaluations take place as required. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team	
W000327	483.460(a)(3)(iv) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both.			

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	Based on record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure an annual/yearly TB (Tuberculosis) testing, x-ray or symptom screening checklist was completed for client #3. Findings include: Client #3's record was reviewed on 7/29/14 at 9:05 AM. Client #3's record did not indicate documentation of an annual/yearly TB testing, x-ray or symptom screening checklist was completed. LPN (Licensed Practical Nurse) #1 was interviewed on 7/29/14 at 12:39 PM. LPN #1 indicated client #3 had refused to participate in medical appointments. LPN #1 indicated there was not documentation of an annual/yearly TB testing, x-ray or symptom screening checklist completed for client #3. 9-3-6(a)	W000327	**CORRECTION:** *The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both.* Specifically, Client #3's visiting physician brought a portable X-ray machine to the facility and performed a tuberculosis screening. **PERVENTION:** The interdisciplinary team will continue to develop additional supports to desensitize Client #3 to attending medical procedures outside of his home and will continue to access at home medical care as needed. Members of the Operations Team and nursing staff will review facility medical charts no less than monthly to assure appropriate medical follow-along occurs. The facility nurse will provide the Operations and Health Services Teams with follow-up regarding Client #3's medical care at the weekly Nurse Meeting. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team	09/03/2014

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W000368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 3 of 4 sampled clients (#1, #2 and #3) plus one additional client (#8), the facility failed to ensure clients #1, #2, #3 and #8 received their medications as ordered by the physician. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 7/28/14 at 2:28 PM. The review indicated the following: -BDDS report dated 6/13/14 indicated client #1 was not administered her bedtime dose of Klonopin 0.5 milligrams (seizures). -BDDS report dated 7/9/14 indicated client #1 was not administered her morning dose of Tylenol 325 milligram tablet (pain management). -BDDS report dated 7/9/14 indicated client #2 had missed doses of Oyster Shell Calcium 500 milligrams (supplement) and Metformin (diabetes)on 7/8/14.	W000368	**CORRECTION:** *The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.* Specifically, the staff members responsible for the pattern of medication errors no longer work at the facility. Current staff members have received training toward proper implementation of the agency's medication administration procedures to assure that all medications are administered as prescribed. **PREVENTION:** The QIDP will be expected to observe no less than two morning and two evening active treatment sessions per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer medication as prescribed. Members of the Operations Team will maintain an increased presence at the facility, performing unscheduled observation of active treatment, including medication administration no less than weekly for the next 30 days, no less than twice monthly for an additional 60 days to assure that medications are administered per physician's orders. After three months the administrative team	09/03/2014

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	-Investigative Summary dated 7/11/14 indicated, "On the evening of 7/1/14 [client #3] received a prescription for antibiotics to treat a respiratory infection. The order was faxed to the ResCare contracted pharmacy on the morning of 7/2/14. At the weekly nurses (sic) meeting on 7/7/14 [LPN (Licensed Practical Nurse) #1] reported that she had followed up with the house and that the medication had not been picked up." The investigative summary indicated client #3's 7/1/14 prescription for antibiotic was not started until 7/7/14. -BDDS report dated 7/18/14 indicated client #2's Primidone 50 milligrams (seizures) had not been administered on 7/16/14. -BDDS report dated 7/20/14 indicated client #1 missed her 9:00 PM doses of Olanzapine (antipsychotic) 20 milligrams, Olanzapine 10 milligrams and Trazodone 100 milligrams (insomnia). -BDDS report dated 7/22/14 indicated client #8 had missed his 9:00 PM dose of Advair Inhaler (asthma). 1. Client #1's record was reviewed on 7/29/14 at 11:20 AM. Client #1's		will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team	

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	Physician's Order Form (POF) dated 6/12/14 indicated client #1 had a physician's order to receive Acetaminophen/Tylenol 325 milligrams, take two tablets three times daily at 7:00 AM, 12:00 PM and 9:00 PM. Client #1 had a physicians order to receive Clonazepam/Klonopin 0.5 milligram tablet, take one tablet twice daily at 7:00 AM and 9:00 PM. Client #1 had a physician's order to receive Olanzapine 10 milligram tablet at 9:00 PM, Olanzapine 20 milligram tablet at 9:00 PM and Trazodone 100 milligram tablet at 9:00 PM. 2. Client #2's record was reviewed on 7/29/14 at 10:40 AM. Client #2's POF dated 6/12/14 indicated client #2 had a physician's order to receive Oyster Shell Calcium 500 milligrams three times a day at 7:00 AM, 5:00 PM and 9:00 PM. Client #2 had a physician's order to receive Primidone 50 milligrams tablet, take 5 tablets twice daily at 7:00 AM and 9:00 PM. 3. Client #3's record was reviewed on 7/29/14 at 9:05 AM. Client #3's 7/1/14 Record of Visit form indicated client #3 received a physician's order for Avelox (antibiotic) 400 milligrams three times a day for 7 days.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G493	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/04/2014
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	4. Client #8's record was reviewed on 7/29/14 at 12:13 PM. Client #8's POF dated 6/12/14 indicated client #8 had a physician's order to receive Advair Diskus Inhaler at 7:00 AM and 9:00 PM. LPN (Licensed Practical Nurse) #1 was interviewed on 7/29/14 at 12:39 PM. LPN #1 indicated medications should be administered as prescribed by the physician. 9-3-6(a)			