

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G415	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/24/2014
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NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 8626 STANDRIDGE RUN FORT WAYNE, IN 46825
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W000000	<p>This visit was for the full recertification and state licensure survey. This visit included the investigations of complaint #IN00158839 and complaint #IN00159008.</p> <p>Complaint #IN00158839: SUBSTANTIATED, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W148, W149, W159, W186, W189, W214, W227, W242, W249, W252 and W287.</p> <p>Complaint #IN00159008: SUBSTANTIATED, Federal and state deficiencies related to the allegation(s) W102, W104, W122, W148, W149, W159, W186, W189, W214, W227, W242, W249, W252, W287, W460, W480, and W488.</p> <p>Dates of Survey: November 10, 12, 13, 14, 16, 17, 18, 19, 20, 21 and 24, 2014.</p> <p>Surveyor: Kathy J. Wanner, QIDP.</p> <p>Facility number: 000929 Provider number: 15G415 AIM number: 100244520</p> <p>The following federal deficiencies also reflect state findings in accordance with</p>	W000000		
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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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	460 IAC 9. Quality Review completed 12/8/14 by Ruth Shackelford, QIDP.			
W000102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review and interview, the Governing Body failed to meet the Condition of Participation:	W000102	See plans of corrections for W104 and W122	12/24/2014

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	<p>Governing Body for 3 of 3 sampled clients (clients A, B and C) and for 2 of 2 additional clients (clients D and E) by failing to schedule a sufficient number of competent staff to supervise the clients' needs at the group home; and by failing to ensure the staff were able to implement behavior interventions, provide safety and meet the clients' needs for 1 of 3 sampled clients (client B) which resulted in client B remaining on the van for over twenty hours.</p> <p>Findings include:</p> <p>Please refer to W122: The governing body neglected to meet the Condition of Participation: Client Protections. The governing body neglected to follow their abuse and neglect policy, failed to provide sufficient direct care staff to supervise and manage the individual needs for 3 of 3 sampled clients (clients A, B and C) and 2 of 2 additional clients (clients D and E); and failed to ensure direct care staff were trained sufficiently to implement the behavior plan to protect client B from his behavior of refusing to get off the van which resulted in client B being on the van for over twenty hours.</p> <p>Please refer to W104: The governing body failed to exercise operating direction over the facility to ensure a</p>			
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W000104	<p>sufficient number of trained competent staff were scheduled to work at the group home to implement behavior interventions, ensure safety and meet the individual needs of 3 of 3 sampled clients (clients A, B and C) and 2 of 2 additional clients (clients D and E).</p> <p>This federal tag relates to complaint #IN00158839. This federal tag relates to complaint #IN00159008.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over</p>			

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	<p>the facility.</p> <p>Based on observation, record review and interview, the governing body failed to exercise general policy, budget and operating direction over the facility by failing to ensure a sufficient number of trained staff were scheduled to work at the group home to implement behavior interventions, ensure safety and meet the individual needs of 3 of 3 sampled clients (clients A, B and C) and 2 of 2 additional clients (clients E and D); the governing body failed to ensure 3 of 3 sampled clients (client A, B and C) and 2 of 2 additional clients (clients D and E), were provided meals according to specialized diets, failed to ensure they were utilizing a menu formulated by a dietician which included portion sizes, failed to ensure clients ate in the dining area, and failed to ensure clients were supported in learning dining manners and etiquette; the governing body failed to ensure the group home was well maintained, clean, safe and that maintenance repair needs were met in a timely manner.</p> <p>Findings include:</p> <p>1. Facility records were reviewed on 11/12/2014 at 1:29 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 2/7/14 and 11/12/14. The</p>	W000104	<p>The group home will provide a minimum staffing ratio of 3:5 (3 staff to 5 clients) whenever all 5 clients are at the group home during waking hours. The house will have a staffing ratio of 2:3 (2 staff to 3 or 4 clients) during waking hours at times when client B or client E is not at the group home Person Responsible: Assistant Director Date Completed: 12/24/14 The schedulers and the on-call team will be trained on the staffing ratios for the group home to ensure that the minimum number of staff persons specified above are scheduled to work a shift Person Responsible: Assistant Director Date Completed: 12/24/14 Client B's BSP has been revised to include techniques and procedures to follow when he refuses to get out of the van Person Responsible: Behavior Consultant Date Completed: 12/15/14 All group home staff will be trained on Client B, Client C, and Client D's updated BSPs and on the lift/carry/transfer technique Person Responsible: Behavior Consultant Date Completed: 12/24/14 All group home staff will be retrained on Client E's BSP Person Responsible: Behavior Consultant Date Completed: 12/24/14 For the next three months the QIDP will complete a weekly checklist indicating that all staff that worked</p>	12/24/2014

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	<p>BDDS reports indicated the following:</p> <p>A BDDS report dated 10/28/14 for an incident on 10/26/14 at 10:00 A.M. indicated "On Monday morning, staff contacted on-call supervisor to report that [client B] had been in the van since the day before and was refusing to get out. The on-call supervisor sent over a staff person to assist with [client B]. That staff person promptly got [client B] off the van. The van was parked in the garage during this time. The Behavior Support Plan (BSP) requires that staff perform a 2 person lift-carry-transport if [client B] refuses to get out of the van for longer than an hour. Staff were suspended pending an investigation into neglect."</p> <p>The facility's internal investigation documentation dated 11/3/14 was reviewed on 11/10/14 at 2:55 P.M. The investigation indicated "Staffing ratio at time of incident 2:5 (two staff for five clients) and 1:5 (one staff for five clients). Required staffing ratio at time of incident 2:5. The investigation documentation indicated there were three clients at the group home on Sunday October 26, 2014 (clients A, B, and D). The investigation documentation indicated there was one staff working at the group home with clients A, B and D on October 26, 2014 from 2:00 P.M. until</p>		<p>at Standridge have completed the client specific training Person Responsible: QIDP Date Completed: 12/24/14 For the next three months the QIDP will complete a weekly checklist indicating that the house maintained the appropriate staffing ratio Person Responsible: QIDP Date Completed: 12/24/14 Menus formulated by a dietician have been posted in the group home. Additional menus indicating appropriate substitutions for different nutritional needs will be available in a binder in the kitchen Person Responsible: House supervisor Date Completed: 12/15/14 Staff and the supervisor will be trained on using the dietician menus including specialized diets and portion sizes Person Responsible: QIDP Date Completed: 12/24/14 The supervisor will be trained on how to appropriately grocery shop for the group home according to the menus formulated by a dietician and providing an appropriate food supply. This will include training on involving clients in the shopping. Person Responsible: QIDP Date Completed: 12/24/14 The group home staff and supervisor will be trained on the client's dining and choke risk plans Person Responsible: QIDP Date Completed: 12/24/14 The QIDP will complete an observation of the group home during a meal time three times a</p>	

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	<p>9:00 P.M. and on the overnight shift and morning shift of October 27, 2014 from 9:00 P.M. through 8:00 A.M.</p> <p>During this survey a series of confidential interviews (CI) were conducted between the dates of 11/2/14 and 11/20/14.</p> <p>CI #9 "There are many times the home is single staffed. Mornings and weekends are especially bad. If the manager leaves to go grocery shopping then there is only one staff at the home with five clients."</p> <p>CI #11 "Weekends are the worst. I come to help if I can. This house cannot be single staffed."</p> <p>CI #12 "If there is only one staff working, the needs of the clients are not being met. One person cannot be everywhere."</p> <p>A review of the schedule as worked for the past month was completed on 11/10/14 at 3:55 P.M. The schedule indicated the home was single staffed on the morning shift (5a-8a) on 10/22/14, 10/24/14, 10/27/14, 10/28/14 and 10/31/14. The home was single staffed on the weekend shifts (9a-9p) on 10/11/14 all day, 10/12/14 from 4:00 P.M.-9:00 P.M., 10/18/14 all day, 10/19/14 from 6:00 P.M.-9:00 P.M., 10/25/14 all day, 10/26/14 from 2:00 P.M. -9:00 P.M.</p>		<p>week for 3 months and then once a month ongoing checking for cleanliness of the home, maintenance issues, use of active treatment, use of dietician formulated menus, adequate food available for menus, minimum staffing ratios, implementation of ISP objectives, and adherence to BSPs and risk plans. The observations will be documented and any issues noted will be corrected. Person Responsible: QIDP Date Completed: 12/24/14 After the three month period, the QIDP will complete an observation of the group home during meal time once a month ongoing Person Responsible: QIDP Date Completed: 12/24/14 The living room carpet has been cleaned. The mini blinds and curtain in the living room and kitchen will be replaced. The refrigerator light has been replaced. Person Responsible: House Supervisor Date Completed: 12/15/14 The corner base-trim will be replaced and the dry wall will be repaired. The handrails and grab bars will be replaced. The toilet will be replaced Person Responsible: Maintenance Supervisor Date Completed: 12/24/14 The clutter in the bedrooms has been cleaned up. Staff will be trained on cleaning and laundry responsibilities Person Responsible: House Supervisor Date Completed: 12/24/14 Client C's BSP will be revised to include</p>		

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	<p>11/1/14 all day and 11/2/14 8:00 A.M. -12:00 P.M.</p> <p>During the morning shifts clients A, B, C, D and E are typically at the home requiring a 2.5- 5 (2 and 1/2 staff for 5 clients) ratio to meet the needs of the clients. On Sundays clients A, B and D are typically at home requiring at least a 2 -3 ratio (2 staff to 3 clients) to meet the needs of the clients.</p> <p>Client A's record was reviewed on 11/13/14 at 12:57 P.M. and indicated in her risk plan dated 5/16/14 "[Client A] is a high risk for falls. Keep areas clear of clutter. Keep rooms well lighted. Use gait belt and when walking or transferring [client A]. Use walker when [client A] is ambulating. Staff will check to make sure gait belt is on correctly before walking or transferring [client A]. Staff will remind [client A] not to loosen her gait belt." Client A's Individual Support Plan (ISP) dated 5/16/14 indicated "She also has a balance problem and requires a walker at all times and staff assistance to walk with her. She needs physical assistance with getting in/out of the bathtub. She is independent as can be with her daily living skills with the exception of her balance, staff need to assist her."</p> <p>Client B's record was reviewed on</p>		<p>her issues with hoarding and hygiene concerns during menses. Staff will be trained on client C's updated BSP Person Responsible: Behavior Consultant Date Completed: 12/24/14 The Assistant Director will do a weekly observation of the group home checking for one month and then once a month ongoing checking for cleanliness of the home, maintenance issues, use of active treatment, use of dietician formulated menus, adequate food available in the home for menus, minimum staffing ratios, adherence to BSPs and risk plans. The observations will be documented and any issues noted will be corrected. Person Responsible: Assistant Director Date Completed: 12/24/14 After the three month period, the Assistant Director will conduct a monthly observation of the group home ongoing Person Responsible: Assistant Director Date Completed: 12/24/14 Client B, C, D, and E's behavior consultants will conduct a weekly observation of the group home for three months checking for adherence to BSPs. The observations will be documented and any issues noted will be corrected Person Responsible: Supervising Behavior Consultant Completion Date: December 24, 2014</p>				

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	<p>11/13/14 at 1:21 P.M. His fall risk plan dated 10/24/14 indicated "[Client B] walks with a stagger gait, and has sudden seizures. Keep areas clear of clutter. Keep rooms well lighted. Staff will walk with [client B] when he walks long distances." Client B's Behavior Support Plan (BSP) dated 1/20/14 indicated "...targeted behaviors: physical aggression (hits, slaps, pushes, shoves and scratches others), resistive behaviors (uncooperativeness), AWOL (absent without leave)... Constantly monitor for safety. If no migraine is suspected offer an enticement for [client B] from the what works well list. Do not rush him. [Client B] refuses to leave the van when it is in the garage at the group home and he does not have a migraine, after one hour staff will use a two man lift carry transport."</p> <p>Client C's record was reviewed on 11/13/14 at 3:25 P.M. She had a BSP dated 5/12/14 which included the targeted behaviors of, "verbal aggression, physical aggression, active resisting, passive resisting and inappropriate touching." Interventions in the BSP indicated "Each staff person should spend a few periods each day interacting with [client C] (total of 10 minutes or so a day) and talk about things that interest her."</p>			

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	<p>Client D's record was reviewed on 11/13/14 at 3:48 P.M. She had a BSP dated 7/2/14 which included the targeted behaviors of "talking constantly and interrupting others...staff were to keep her engaged in activities and tasks to keep her focused..explain activities of the day and what is expected of her, allow frequent breaks, and engage her in appropriate conversations about a topic of her choice, giving verbal praise when she displays appropriate behaviors."</p> <p>Client E's record was reviewed on 11/13/14 at 4:12 P.M. Her fall risk plan dated 1/15/14 indicated "[Client E] has a history of falls related to the diagnoses of cerebral palsy, seizures, left sided weakness, and being overweight...Wears a gait belt when awake, used to help transfer. Uses wheelchair for transportation. Staff to remind [client E] to ask for help. Make sure [client E] is wearing shoes when transferring and discourage distractions when transferring...." Client E's record indicated she had a BSP dated 5/1/14 with the targeted behaviors of: "self-injurious behaviors (SIB), verbal outbursts and physical aggression." Staff were to, "Give her one-on-one time, extra attention , laugh and tell jokes with her, verbal praise for her appearance,</p>			

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	<p>consistent with her routine and shower, complete her grooming and getting dressed first in the morning." If she displays SIB and can not be verbally redirected staff were to "gently move her wrist away from her mouth while complimenting her or talking about her family..." If she tried to "purposely fall out of her wheelchair staff were to make sure she was safe, and leave her on the ground until it was her idea to get back up into her chair."</p> <p>An interview was conducted with the Qualified Intellectual Disabilities Professional(QIDP) on 11/13/14 at 2:30 P.M. The QIDP stated, "No, staff did not follow his (client B's) BSP. His BSP says to use a transport carry technique should have been used. There was only one staff working, so staff could not do the transport carry technique and be with the other clients."</p> <p>An interview was conducted with the facility Quality Director (QD) on 11/13/14 at 1:12 P.M. The QD was asked if the group home should ever be single staffed. The QD stated, "Only during sleep hours, as [client B] is an elopement risk and [client A] and [client E] need assistance to ambulate safely."</p> <p>2). Observations were conducted at the</p>			

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	<p>group home where clients A, B, C, D and E lived on 11/12/14 from 3:40 P.M. through 6:17 P.M. Client A was in the kitchen assisting the group home supervisor (GHS) with preparing dinner. The food items prepared that evening were chicken fettuccine Alfredo, broccoli, dinner rolls, peach slices, milk, rice milk, water, fruit punch; ketchup and barbeque sauce were used by clients C and D. There was a handwritten menu posted for the week. It did not indicate portion sizes for each item. There was no menu available indicating how staff should assist the clients with their different dietary needs.</p> <p>Observations were conducted at the group home where clients A, B, C, D and E lived on 11/16/14 from 2:17 P.M. through 4:11 P.M. There was another hand written menu posted for the current week. None of the items on the menu was located in the home. The menu did not include Monday's meals. Tuesday's dinner meal consisted of breaded pork chops, rice pilaf, broccoli, fruited jello, bread with butter, milk, juice and pudding and juice for snack in the evening. Observations of the refrigerator, freezer, and freezer in the garage revealed no pork chops, milk, juice or pudding. The freezer in the garage had frozen vegetables, one roll of sausage, 5 loaves</p>			

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	<p>of high fiber bread, frozen potato patties and a few other small items. The freezer in the kitchen had a package of liver, frozen potato patties, and a stack of frozen pot pies. There was no milk, eggs or fresh vegetables or fruit observed to be in the refrigerator. There was a basket of oranges on the counter.</p> <p>Client A's record was reviewed on 11/13/14 at 12:57 P.M. Client A's nutrition assessment dated 5/22/14 indicated she was on a low cholesterol diet. Client A had a risk plan dated 5/6/14 indicating she was obese. Her current weight was 180 pounds and her height was 64 inches. Her ideal body weight range was 108-120 pounds.</p> <p>Client B's record was reviewed on 11/13/14 at 1:21 P.M. Client B's nutrition assessment dated 5/22/14 indicated he was to have a mechanical soft diet, additional portions, high fiber, avoid breaded products, no hot dogs, no milk, liberal snacks. His weight was 112 pounds and his height was 64.5 inches. His ideal body weight range was to be 120-146 pounds. The Registered Dietician (RD) indicated "...Staff report when menued meal item has food allergens, they will often provide a [Name] rice meal...It is recommended to continue to reintroduce the avoid food</p>						

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	<p>list slowly, a least restrictive diet would like be beneficial for overall nutritional health and may promote desired weight gain. Recommendations: 1) Continue current diet. 2) Encourage second portions at meals. 3) A nutritional supplement to be considered if weight drops below current weight of 112 or if client is leaving > 25% (more then 25%) uneaten at meals. 4) Continue to progress with reintroduction of foods with family's guidance and comfort. 5) Refer to RD when significant weight changes occur or as needed."</p> <p>Client C's record was reviewed on 11/13/14 at 3:25 P.M. Client C's nutrition assessment dated 5/22/14 indicated she was on a 1200 calorie diet with limit juice intake to 6oz per day. Her weight was 236 pounds and her height was 64 inches. Her ideal body weight range was 108-132 pounds. The RD indicated "Weight has shown a 21 pound or 10% weight gain over the past year. BMI (body mass index) now indicates morbid obesity. 1200 Calorie meal plan handout provided to staff."</p> <p>Client D's record was reviewed on 11/19/14 at 10:32 A.M. Client D's nutrition assessment dated 5/22/14 indicated she was on a low fat and low cholesterol diet. Her weight was 110</p>			

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	<p>pounds and her height was 62 inches. Her ideal body weight range was 99-121 pounds. The RD indicated "Weight has decreased 3.6 pounds over past year. Dining plan indicates 'maintain weight at least 115 pounds.'...Client presents at nutritional risk due to leaving food behind, weight loss with history of being self conscious in regards to her weight."</p> <p>Client E's record was reviewed on 11/19/14 at 10:31 A.M. Client E's nutrition assessment dated 5/22/14 indicated she was on a mechanical soft diet, reduced salt intake, portion control, limit one non-fruit dessert to 1 time weekly. Her weight was 230 pounds and her height was 64 inches. Her ideal body weight range was 108-132 pounds.</p> <p>The assistant residential director (ARD) was interviewed on 11/18/14 at 8:26 A.M. The ARD stated "The house supervisor was unaware there were dietician menus that she should be using. I have given her the menus and talked about making substitutions for... diet restrictions."</p> <p>The facility RN was interviewed on 11/20/14 at 10:37 A.M. The RN stated, "I am most concerned about [client C's] and [client D's] diets being followed. We like [client B] to eat so he can gain weight. I</p>			

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	<p>would be interested to know if he was sick after eating two servings of Alfredo sauce. His parents are willing for him to try small amounts of new and different foods."</p> <p>3). Observations were conducted at the group home where clients A, B, C, D and E lived on 11/12/14 from 3:40 P.M. through 6:17 P.M. The living room carpeting had a dark stain two feet by two feet irregular shaped splatter stain in front of the sofa. Two of the three mini blinds at the living room windows were missing and the only curtain there was a valance so the windows were not covered at night. The kitchen window curtain did not fit and was made of a sheer fabric which would be able to be seen through at night. The interior light on the refrigerator was missing or burned out. In client C and E's bathroom there was a corner of the base trim missing and the dry wall was chipping off. The hand rails around the commode consisted of plumbing pipes wrapped with black foam tape which was coming loose. This was on the left side next to the tub. On the right side there was a loose grab bar which could be lifted and shaken. There was a board above the tank of the commode which was at an angle and loose. Client B's room had clutter on the floor, and only a path for him to walk</p>			

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	<p>to/from his bed. Client C and D's room was cluttered, had an odor, both beds were unmade, and clothing was scattered across the floor and dressers.</p> <p>Confidential interviews (CI) were conducted between the dates of 11/12/14 and 11/24/14.</p> <p>CI #1 "Yes, I've come in and had to clean her (client C's) bedroom. I know she refuses and she needs to do it and it's hard to get her to do things, but it was out of control. She doesn't change her clothing or do her laundry or take showers like she should. Her room and she gets to smelling bad. She puts her clean clothing right back in with the dirty, or on the floor. Even her sanitary items are laying around. It didn't used to be this bad. I couldn't take it so I cleaned it when I came in."</p> <p>CI #2 " We have cleaned the bedroom a couple of times. We were concerned about dust and mold due to allergies. The whole house is really not clean. The carpet (living room) has a big stain on it. I don't know what happened. The house is a nice house and was clean at one time. I worry about someone falling on the clutter in the bedroom(s). The laundry is put away inside out, even hung up inside out. Why would someone not fix it?"</p>			

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	<p>CI #11 "The blinds and curtains have been messed up for awhile. Clearly the carpet is unclean. The grab bars in [client E's] bathroom are just wrong. [Client E] is scared she will fall when she showers anyway and then the grab bars are plumbing pipes and loose bars. This house is dirty. Every time I come in I notice how dirty it is...."</p> <p>An interview was conducted with the Assistant Residential Director (ARD) on 11/18/14 at 8:26 A.M. The ARD stated, "[Client C] has a hoarding issue and gets very upset when staff attempt to help her clean her room. I worked with the house supervisor on strategies for handling this and her new behavior consultant is adding this to her BSP. The client bedrooms should not be dirty and the clients should be assisting with cleaning. I created a training on active treatment and all the staff will be retrained. I am working with the house supervisor to create cleaning schedules for the staff."</p> <p>This federal tag relates to complaint #IN00158839. This federal tag relates to complaint #IN00159008.</p> <p>9-3-1(a)</p>				

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility neglected to meet the Condition of Participation: Client Protections for 3 of 3 sampled clients (client A, B and C) and for 2 of 2 additional clients (clients D and E). The facility neglected to follow their abuse and neglect policy by failing to schedule a sufficient number of competent staff to supervise the clients' needs at the group home; and by failing to ensure direct care staff were trained sufficiently, able to implement the behavior plan to protect client B from his behavior of refusing to get off the van, provide safety and meet the client's needs for 1 of 3 sampled clients (client B) which resulted in client B remaining on the van for over twenty hours; and failed to notify client B's guardians in a timely manner.</p> <p>Findings include:</p> <p>Please refer to W148: The facility failed to notify parents/guardians of significant incidents and seizures in a timely manner for 1 of 3 sampled clients (client B).</p> <p>Please refer to W149: The facility neglected to follow their policy and operating procedures by neglecting to</p>	W000122	See plans of corrections for W148, W149, W186, and W189	12/24/2014

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	<p>protect 1 of 3 sampled clients (client B) from his behavior of refusing to exit the van, which resulted in him remaining on the van for over twenty hours.</p> <p>Please refer to W186: The facility failed to ensure a sufficient number of trained staff were scheduled to work at the group home to implement behavior interventions, ensure safety and meet the individual needs of 3 of 3 sampled clients (clients A, B and C) and 2 of 2 additional clients (clients D and E).</p> <p>Please refer to W189: The facility failed to ensure staff were sufficiently and competently trained to work at the group home to implement behavior interventions, ensure safety and meet the individual needs of 2 of 3 sampled clients (clients A and client B) and 2 of 2 additional clients (clients D and E).</p> <p>This federal tag relates to complaint #IN00158839. This federal tag relates to complaint #IN00159008.</p> <p>9-3-2(a)</p>			

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W000148	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &</p> <p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview, the facility failed to notify parents/guardians of significant incidents and seizures in a timely manner for 1 of 3 sampled clients (client B).</p> <p>Findings include:</p> <p>Facility records were reviewed on 11/12/2014 at 1:29 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 2/7/14 and 11/12/14. The BDDS reports indicated the following:</p> <p>A BDDS report dated 10/28/14 for an incident on 10/26/14 at 10:00 A.M.</p>	W000148	<p>The QIDPs will be retrained on informing guardians and family members of significant events including allegations of neglect</p> <p>Person Responsible: Assistant Director</p> <p>Date Completed: 12/24/14</p> <p>The QIDPs will submit a checklist to the Assistant Director for every BDDs report that they complete indicating when and how the guardians or other family members were notified of the</p>	12/24/2014

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	<p>indicated "On Monday morning, staff contacted on-call supervisor to report that [client B] had been in the van since the day before and was refusing to get out. The on-call supervisor sent over a staff person to assist with [client B]. That staff person promptly got [client B] off the van. The van was parked in the garage during this time. The Behavior Support Plan (BSP) requires that staff perform a 2 person lift-carry-transport if [client B] refuses to get out of the van for longer than an hour. Staff were suspended pending an investigation into neglect." The BDDS report indicated client B's parents/guardians were notified of this incident on 10/28/14.</p> <p>Client B's record was reviewed on 11/13/14 at 1:21 P.M. Client B's record indicated his parents were his guardians and assisted him with decision making.</p> <p>Client B's guardian was interviewed on 11/17/14 at 8:20 A.M. When asked if they had been informed about client B being on the van for more than twenty hours, the Guardian stated "I wasn't told until a couple of days ago, and I didn't know it was that long. I understand staff didn't notify anyone. We live 30 minutes away, but I would rather come in to help, then have him sit out there all night. We were notified on Monday about that fact</p>		<p>event</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>The house supervisor will be trained on parent/guardian communication</p> <p>Person Responsible: Assistant Director</p> <p>Date Completed: 12/24/14</p> <p>Staff will be retrained on following behavior support plans, using the on-call system, and on submitting reports when clients have seizures or exhibit maladaptive behaviors</p> <p>Person Responsible: House Supervisor</p> <p>Date Completed: 12/24/14</p> <p>When conducting scheduled observations, the QIDP and Assistant Director will ensure that</p>	

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	<p>he hadn't urinated in over 30 hours, and on Wednesday about him staying on the van all day and night. We have tried to help keep the staff updated on what things they can do to encourage him to get off the van. If you let [client B] make it his choice and don't push him it helps. We did not know they were not showering him every night. I asked if they showed them his shower caddy and they said 'no.' All you have to do is show him his caddy or set his shower soap beside him and let him think about it a little while and he will get right up and go shower. It is very unsettling when we are not notified about things. We want to know when he has seizures, we want to know that day. When he just went to the neurologist they didn't have any documentation to show the doctor. The day program will tell us, so we could tell the doctor that much. Sometimes the other clients at the house will tell us he had one. They need to call us and let us know. They should have called someone when he was on the van."</p> <p>An interview was conducted with the facility Behavior Consultant (BC) on 11/13/14 at 1:53 P.M. The BC stated, "I do not understand why staff did not call for assistance earlier. I was completely unaware this was happening daily."</p>		<p>any maladaptive behaviors or other significant events are appropriately reported</p> <p>Person Responsible: QIDP and Assistant Director</p> <p>Date Completed: 12/24/14</p>	

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W000149	<p>An interview was conducted with the facility Quality Director (QD) on 11/13/14 at 1:12 P.M. the QD stated, "It should never have been allowed to happen. The staff should have called on-call sooner and gotten someone over there to help who he responds better to."</p> <p>This federal tag relates to complaint #IN00158839. This federal tag relates to complaint #IN00159008.</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 observation, record review and interview, the facility neglected to follow their policy and operating procedures by neglecting to protect 3 of 3 sampled</p>	W000149	The facility has written procedures that prohibit mistreatment, neglect or abuse of the client	12/24/2014

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	<p>clients (clients A, B and C) and 2 of 2 additional clients (clients D and E) and by failing to protect 1 of 3 clients (client B) from his behavior of refusing to exit the van, which resulted in him remaining on the van for over twenty hours.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/12/14 from 3:40 P.M. through 6:18 P.M. Client A arrived home first on the city bus. She began to prepare the evening meal with the group home supervisor. At 4:43 P.M. clients C and D entered the group home and selected a movie to watch and watched the movie throughout the entire observation period even during the evening meal which they ate in the living room. Client C was observed to yell, howl and repeatedly attempt to hug and kiss client D. Client C grabbed and/or tickled direct support professional (DSP) #1. One time client C while laying and rolling around on the floor put her head between DSP #1's feet and grabbed on to her ankles. Client C also attempted to hug and kiss DSP #2 and the GHS. Verbal prompting to "remember personal space" was given. Client B had arrived home at the same time as clients C and D but remained on the van. DSP #1 and DSP #2 tried the techniques in client B's behavior support</p>		<p>Staff will be retrained on active treatment including taking advantage of all natural training opportunities</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>Client B and C's BSPs have been revised to provide clear direction for staff to follow when target behaviors are exhibited. Staff and supervisor will be retrained on the revised plans. Staff and house supervisor will be trained on client D, and E's BSPs. Staff will be trained on the lift/carry/transfer technique</p> <p>Person Responsible: Behavior Consultant</p> <p>Date Completed: 12/24/14</p> <p>Staff and house supervisor will be trained on avoiding abuse, neglect, and exploitation</p> <p>Person Responsible: QIDP</p>	

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	<p>plan (giving him his book bag, asking him to help them, asking if he wanted a ride in the wheelchair, offering him his DVD and toy car), but client B would not leave the van. When client B moved to the back seat of the van DSP #2 decided to take client B for a van ride. They returned home at 5:40 P.M. and client B and DSP #2 entered the house. Client B sat down at the table and began to eat his evening meal. His 4:00 P.M. medications were administered to him earlier while he was on the van. During the observation period client A was the only client involved in aggressive active treatment activities. There were two DSP staff on duty and the GHS and the Qualified Intellectual Disabilities Professional (QIDP) were in the home. Client E was on a family visit.</p> <p>Facility records were reviewed on 11/12/2014 at 1:29 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 2/7/14 and 11/12/14. The BDDS reports indicated the following:</p> <p>A BDDS report dated 10/28/14 for an incident on 10/26/14 at 10:00 A.M. indicated "On Monday morning, staff contacted on-call supervisor to report that [client B] had been in the van since the day before and was refusing to get out.</p>		<p>Date Completed: 12/24/14</p> <p>Client B's BSP has been revised to include techniques and procedures to follow when he refuses to get out of the van</p> <p>Person Responsible: Behavior Consultant</p> <p>Date Completed: 12/15/14</p> <p>Staff will be retrained on following behavior support plans, using the on-call system, and on submitting reports when clients have seizures or exhibit maladaptive behaviors</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>The QIDP will complete an observation of the group home during a meal time three times a week for 3 months and then once a month ongoing checking for cleanliness of the home, maintenance issues, use of active treatment, use of dietician</p>	

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NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 8626 STANDRIDGE RUN FORT WAYNE, IN 46825
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	<p>The on-call supervisor sent over a staff person to assist with [client B]. That staff person promptly got [client B] off the van. The van was parked in the garage during this time. The Behavior Support Plan (BSP) requires that staff perform a 2 person lift-carry-transport if [client B] refuses to get out of the van for longer than an hour. Staff were suspended pending an investigation into neglect."</p> <p>The facility's internal investigation documentation dated 11/3/14 was reviewed on 11/10/14 at 2:55 P.M. The investigation indicated "Staffing ratio at time of incident 2:5 (two staff for five clients) and 1:5 (one staff for five clients). Required staffing ratio at time of incident 2:5." The investigation documentation indicated there were three clients at the group home on Sunday October 26, 2014 (clients A, B, and D). The documentation indicated Direct Support Professional (DSP) #1 arrived to work on 10/26/14 at 9:00 A.M. "[client B] was sleep (sic) and eventually woke up on his own...He came out to the kitchen to eat breakfast...picked over his food...but had many cups of rice milk before staff asked him if he wanted to go for a ride." DSP #2 was also working at this time and attempted to get [client B] off the van after the ride before DSP #2 was scheduled to leave at 12:00 P. M.</p>		<p>formulated menus, adequate food available for menus, minimum staffing ratios, implementation of ISP objectives, and adherence to BSPs and risk plans. The observations will be documented and any issues noted will be corrected.</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>The Assistant Director will do a weekly observation of the group home checking for one month and then once a month ongoing checking for adherence to BSPs and risk plans. The observations will be documented and any issues noted will be corrected.</p> <p>Person Responsible: Assistant Director</p> <p>Date Completed: 12/24/14</p> <p>When conducting scheduled observations, the QIDP and Assistant Director will ensure that any maladaptive behaviors or other significant events are</p>	

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	<p>Client B stayed on the van. During the investigation DSP #2 was asked what time they got back from the outing, "It was about 15-20 minutes before he was to get off work."</p> <p>DSP #3 arrived at the group home at 12:00 P.M. "...I asked where [client B] was and was told he was in the van in the garage because he refused to get out even with a male staff (DSP #2)...I went to the garage to check to see if he had used the restroom and to see if maybe a new face for the day could get him out. I called his name, and tried to jingle my keys. He would not respond. It was time for his meds (medication) so me and another staff had to get on the van because he was swatting at her (DSP #1) and refusing. Since he did not get out of the van we decided to go for a ride around town. We went to the park. He still would not respond. I tried to see if he would get out by holding my hand, but he swatted at me. We went riding again to a shopping center. He did get out of the van for little bit because we asked him to help push [client A] in her wheelchair. I tried to get him to go to the restroom, but he refused. We decided to just go back home. We used his book bag and he pushed it away. I asked if he wanted to take a ride in the wheelchair and he just turned his head. In a situation like this we have had something similar and called the</p>		<p>appropriately reported</p> <p>Person Responsible: QIDP and Assistant Director</p> <p>Date Completed: 12/24/14</p> <p>The Assistant Director of Supported Living completed an audit of client records to ensure that maladaptive behavior reports are being submitted by staff and comprehensive functional behavior assessments are completed. The assistant director will complete quarterly audits of client records on an ongoing basis</p> <p>Person Responsible: Assistant Director</p> <p>Completion Date: December 24, 2014</p> <p>Client B, C, D, and E's behavior consultants will conduct a weekly observation of the group home for three months checking for adherence to BSPs. The observations will be documented and any issues noted will be corrected</p>	

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	<p>supervisor. She says to leave him in there until the overnight (staff) comes because sometimes he listens to them better. I asked him if he was hungry and he refused cooked food, but did eat some of his corn puffs. Before I left at 8:00 P.M. I had tried to get him out of the van. He swatted or refused almost everything. I didn't feel he was in danger but still tried to use the BSP. He took his meds on time, ate what he wanted to eat and even drank 2-3 glasses of rice milk and water. He just refused to go into the house that day. I came back the next morning which was Monday. I asked overnight staff is [client B] still in the van and he was...I went out to try to get him out and he had fallen asleep...he had not wet himself. I used his book bag again, but he would not get off the van. This was 5-5:30 A.M. and at that point I had to assist some of the other clients...A third staff came in. A male staff. He asked what he could do, so I said 'try to get [client B] off the van.' I was assisting [client E], [client D], [client A] and [client C]...the male staff walked into the house with [client B]." DPS #4 arrived for third shift on Sunday night and "[client B] was on the van...I went to the van to talk to him and encourage him to get to his room. He refused and was trying to hit me. I got him his bag and DVD...none of these things helped. I ensured the windows were down in the</p>		<p>Person Responsible: Supervising Behavior Consultant</p> <p>Completion Date: December 24, 2014</p> <p>The group home will provide a minimum staffing ratio of 3:5 (3 staff to 5 clients) whenever all 5 clients are at the group home during waking hours. The house will have a staffing ratio of 2:3 (2 staff to 3 or 4 clients) during waking hours at times when client B or client E is not at the group home</p> <p>Person Responsible: Assistant Director</p> <p>Date Completed: 12/24/14</p>	

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	<p>van and gave him a blanket. I checked on him at least hourly through the night. He was always dry....Staff called on-call around 5:30-6:30 A.M. to request a male staff to come help out."</p> <p>The investigation documentation indicated an interview was conducted with the group home supervisor (GHS) on 10/31/14. The documented interview with the GHS indicated "...they do leave him (client B) in the van longer than an hour, but have not left him overnight before. She said that the Monday through Friday overnight staff person is a male and [client B] will get out of the van and go in the house when the male staff asks him to. She stated she has told staff to leave him in the van until the third shift staff person gets there because it is more dangerous to [client B] and staff to attempt to carry him in the house than to leave him in the van. She also said it would not be possible to perform the two-person carry as described in his Individual Support Plan (ISP) when he is in the back of the van...she stated it occurs daily (his refusals to get out of the van)."</p> <p>The facility's Abuse, Neglect and Exploitation Committee summary of review of the investigation of the incident dated 11/3/14, found the staff who</p>			

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	<p>worked with [client B] during the incident to have not been neglectful in their care of client B according to their agency policy. The committee recommended that "[client B's] BSP be reviewed and revised."</p> <p>Client B's record was reviewed on 11/13/14 at 1:21 P.M. Client B's Behavior Support Plan (BSP) dated 1/20/14 indicated "Description of client: [Client B] is a 27 year old...with profound intellectual disabilities. He is ambulatory. He is essentially non-verbal. He has a diagnosis of profound MR, ADD (attention deficit disorder), mood disorder NOS (not otherwise specified), hyperthyroidism, heartburn, seizure disorder, migraine headaches, food and seasonal allergies. He is allergic to dairy products." His BSP indicated the following targeted behaviors: physical aggression (hits, slaps, pushes, shoves and scratches others), resistive behaviors (uncooperativeness), AWOL (absent without leave). Recommendations for resistive behaviors (refusing to exit the van, medications, participate in self-care, climbing on top of the van, laying flat on the ground): "Always check for signs of a possible migraine (dilated pupils, wrinkled forehead, sweating or swatting at staff). Offer PRN (as needed) pain relief medication. If giving a PRN for</p>			

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	<p>pain wait 20-30 minutes before making your request for compliance again. Constantly monitor for safety. If no migraine is unsuspected offer an enticement for [client B] from the what works well list. Do not rush him. [Client B] refuses to leave the van when it is in the garage at the group home and he does not have a migraine, after one hour staff will use a two man lift carry transport."</p> <p>The facility Standard Operating Procedures dated 3/23/11 and the Staff and Client Relationships policy dated 2014 were reviewed on 11/13/14 at 9:09 A.M. The policy indicated "...4. Staff are prohibited from denying to clients... appropriate supervision...care and training. 10. Client safety is of utmost importance to the staff of Easter Seals Arc. Abuse and neglect of clients will not be tolerated."</p> <p>An interview was conducted with the QIDP on 11/13/14 at 2:30 P.M. The QIDP stated, "No, staff did not follow his (client B's) BSP. His BSP says a transport carry technique should have been used. Staff thought it would be harmful if they attempted it with him at the back of the van. There was only one staff working, so staff could not do the transport carry technique."</p>			

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	<p>An interview was conducted with the facility Behavior Consultant (BC) on 11/13/14 at 1:53 P.M. The BC stated, "No they should have tried the lift-carry transport. The van has extra room in the center due to where the wheelchairs can be locked down. The staff have all been trained on the plan and the technique. I was very upset when I saw how long he had stayed on the van. I do not understand why staff did not call for assistance earlier. I was completely unaware this was happening daily. He has only had one ABC card (behavior reporting card) in the past year. They should be filling them out each time he refuses to exit the van or does any of his targeted behaviors." When asked about client C's observed inappropriate touching during the group home observations, the BC stated, "I don't have any data for those either. In fact I was just informed it wasn't needed in her BSP any longer."</p> <p>An interview was conducted with the instructor of CPI (Crisis Prevention Intervention) on 11/13/14 at 1:42 P.M. The CPI instructor stated, "We go over each technique in class and demonstrate how they are to be done." When asked about a collaboration between the QIDP, GH staff, the BC and himself regarding an individualized program for client B,</p>			

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	<p>the CPI instructor stated "We definitely could work one-on-one with staff on how best to work with a client."</p> <p>An interview was conducted with the facility Quality Director (QD) on 11/13/14 at 1:12 P.M. the QD stated, "The committee found that the BSP for [client B] needs to be revised. It should never have been allowed to happen. The staff should have called on-call sooner and gotten someone over there to help who he responds better to." The QD indicated it was not seen as neglect the way the policy was worded, but it is in no way the intent or mission of the facility. The QD was asked if the group home should ever be single staffed. The QD stated, "Only during sleep hours, as [client B] is an elopement risk and [client A] and [client E] have ambulation needs."</p> <p>This federal tag relates to complaint #IN00158839. This federal tag relates to complaint #IN00159008.</p> <p>9-3-2(a)</p>			

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based upon observation, record review and interview, the QIDP (Qualified Intellectual Disabilities Professional) failed for 2 of 3 sampled clients (clients B and C) to ensure the staff were trained to implement client plans, failed to ensure accurate behavior data was collected for clients B and C, failed to address client C's needs for her behaviors of inappropriate touching, hoarding, refusals to shower, wiping after toileting, and personal hygiene during her menses were addressed in her plan.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 11/12/14 from 3:40 P.M. through 6:18 P.M. At 4:43 P.M. client C entered the group home and selected a movie to watch and watched the movie throughout the entire observation period even during the evening meal which she ate in the living room. Client C was observed to yell, howl and repeatedly attempt to hug and kiss client D. Client C grabbed and or tickled direct support</p>	W000159	<p>Client B and client C's BSPs will be revised and staff will be trained on the revised BSPs and on the lift/carry/transfer technique</p> <p>Person Responsible: Assistant Director</p> <p>Date Completed: 12/24/14</p> <p>Staff and house supervisor will be trained on avoiding abuse, neglect, and exploitation and on providing active treatment</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>Staff will be retrained on following behavior support plans, using the on-call system, and on submitting reports when clients have seizures or exhibit maladaptive</p>	12/24/2014

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	<p>professional (DSP) #1. One time client C while laying and rolling around on the floor put her head between DSP #1's feet and grabbed on to her ankles. Client C also attempted to hug and kiss DSP #2 and the GHS. Verbal prompting to "remember personal space" was given. Client B had arrived home at the same time as clients C and D but remained on the van. DSP #1 and DSP #2 tried the techniques in client B's behavior support plan (giving him his book bag, asking him to help them, asking if he wanted a ride in the wheelchair, offering him his DVD and toy car), but client B would not leave the van. When client B moved to the back seat of the van DSP #2 decided to take client B for a van ride. They returned home at 5:40 P.M. and client B and DSP #2 entered the house. Client B sat down at the table and began to eat his evening meal. Clients B and C were not involved in aggressive active treatment activities. There were two DSP staff on duty, the GHS and the Qualified Intellectual Disabilities Professional (QIDP) in the home.</p> <p>Client A's record was reviewed on 11/13/14 at 12:57 P.M. and indicated in her risk plan dated 5/16/14 "[Client A] is a high risk for falls. Keep areas clear of clutter. Keep rooms well lighted. Use gait belt and when walking or transferring</p>		<p>behaviors</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>Comprehensive functional behavior assessments will be completed on client B and client C.</p> <p>Person Responsible: Behavior Consultant</p> <p>Date Completed: 12/24/14</p> <p>The behavior consultants will be retrained to complete comprehensive functional behavior assessments annually</p> <p>Person Responsible: Assistant Director</p> <p>Date Completed: 12/24/14</p> <p>The QIDP will be retrained on conducting observations of group homes, training staff, implementing plans, data</p>	

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	<p>[client A]. Use walker when [client A] is ambulating. Staff will check to make sure gait belt is on correctly before walking or transferring [client A]. Staff will remind [client A] not to loosen her gait belt." Client A's Individual Support Plan (ISP) dated 5/16/14 indicated "She also has a balance problem and requires a walker at all times and staff assistance to walk with her. She needs physical assistance with getting in/out of the bathtub. She is independent as can be with her daily living skills with the exception of her balance, staff need to assist her."</p> <p>Client B's record was reviewed on 11/13/14 at 1:21 P.M. His fall risk plan dated 10/24/14 indicated "[Client B] walks with a stagger gait, and has sudden seizures. Keep areas clear of clutter. Keep rooms well lighted. Staff will walk with [client B] when he walks long distances." Client B's Behavior Support Plan (BSP) dated 1/20/14 indicated "... targeted behaviors: physical aggression (hits, slaps, pushes, shoves and scratches others), resistive behaviors (uncooperativeness), AWOL (absent without leave)... Constantly monitor for safety. If no migraine is suspected offer an enticement for [client B] from the what works well list. Do not rush him. [Client B] refuses to leave the van when it is in the garage at the group home and</p>		<p>collection, and writing monthly reports</p> <p>Person Responsible: Assistant Director</p> <p>Date Completed: 12/24/14</p> <p>The Assistant Director of Supported Living completed an audit of client records to ensure that maladaptive behavior reports are being submitted by staff and comprehensive functional behavior assessments are completed. The assistant director will complete quarterly audits of client records on an ongoing basis</p> <p>Person Responsible: Assistant Director Supported Living</p> <p>Completion Date: December 24, 2014</p> <p>The Assistant Director will do a weekly observation of the group home checking for one month and then once a month ongoing checking for cleanliness of the home, maintenance issues, use of active treatment, use of dietician formulated menus,</p>	

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	<p>he does not have a migraine, after one hour staff will use a two man lift carry transport."</p> <p>Client C's record was reviewed on 11/13/14 at 3:25 P.M. She had a BSP dated 5/12/14 which included the targeted behaviors of, "verbal aggression, physical aggression, active resisting, passive resisting and inappropriate touching." Interventions in the BSP indicated "Each staff person should spend a few periods each day interacting with [client C] (total of 10 minutes or so a day) and talk about things that interest her."</p> <p>Client D's record was reviewed on 11/13/14 at 3:48 P.M. She had a BSP dated 7/2/14 which included the targeted behaviors of "talking constantly and interrupting others...staff were to keep her engaged in activities and tasks to keep her focused..explain activities of the day and what is expected of her, allow frequent breaks, and engage her in appropriate conversations about a topic of her choice, giving verbal praise when she displays appropriate behaviors."</p> <p>Client E's record was reviewed on 11/13/14 at 4:12 P.M. Her fall risk plan dated 1/15/14 indicated "[Client E] has a history of falls related to the diagnoses of</p>		<p>minimum staffing ratios, adherence to BSPs and risk plans</p> <p>Person Responsible: Assistant Director</p> <p>Date Completed: 12/24/14</p> <p>The carpet has been cleaned. The mini blinds and curtain in the living room and kitchen have been replaced. The refrigerator light has been replaced.</p> <p>Person Responsible: House Supervisor</p> <p>Date Completed: 12/15/14</p> <p>The corner base-trim will be replaced and the dry wall will be repaired. The handrails and grab bars will be replaced. The toilet will be replaced</p> <p>Person Responsible: Maintenance Supervisor</p> <p>Date Completed: 12/24/14</p>	

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	<p>cerebral palsy, seizures, left sided weakness, and being overweight...Wears a gait belt when awake, used to help transfer. Uses wheelchair for transportation. Staff to remind [client E] to ask for help. Make sure [client E] is wearing shoes when transferring and discourage distractions when transferring..." Client E's record indicated she had a BSP dated 5/1/14 with the targeted behaviors of: "self-injurious behaviors (SIB), verbal outbursts and physical aggression." Staff were to, "Give her one-on-one time, extra attention , laugh and tell jokes with her, verbal praise for her appearance, consistent with her routine and shower, complete her grooming and getting dressed first in the morning." If she displays SIB and can not be verbally redirected staff were to "gently move her wrist away from her mouth while complimenting her or talking about her family..." If she tried to "purposely fall out of her wheelchair staff were to make sure she was safe, and leave her on the ground until it was her idea to get back up into her chair."</p> <p>Confidential interviews (CI) were conducted between the dates of 11/12/14 and 11/24/14.</p> <p>CI #15 "I do not know how to do the transport carry technique. I have never</p>		<p>The clutter in the bedrooms has been cleaned up. Staff will be trained on cleaning and laundry responsibilities</p> <p>Person Responsible: House Supervisor</p> <p>Date Completed: 12/24/14</p> <p>Client C's BSP will be revised to include her issues with hoarding and hygiene concerns during menses. Staff will be trained on client C's updated BSP</p> <p>Person Responsible: Behavior Consultant</p> <p>Date Completed: 12/24/14</p> <p>ISPs for all clients will be reviewed to ensure that they include objectives to address the clients' needs. Any found to not include them will be revised and staff will be retrained on revised plans</p> <p>Person Responsible: QIDP</p> <p>Completion Date: December 24,</p>	

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	<p>seen it done. They talked about it in class, but we didn't practice it. I think the manager should show us what we are supposed to do to help get him off the van. She just has us wait until a male staff arrives; he will usually get off the van for a male staff."</p> <p>CI #16 "No I don't think any of us called the manager or anyone else. Why would we? He is left on the van all the time. It wasn't anything unusual."</p> <p>An interview was conducted with the Qualified Intellectual Disabilities Professional(QIDP) on 11/13/14 at 2:30 P.M. The QIDP stated, "No, staff did not follow his (client B's) BSP. His BSP says to use a transport carry technique should have been used... There was only one staff working, so staff could not do the transport carry technique and be with the other clients."</p> <p>An interview was conducted with the facility Behavior Consultant (BC) on 11/13/14 at 1:53 P.M. The BC stated, "No they should have tried the lift-carry transport. The van has extra room in the center due to where the wheelchairs can be locked down. The staff have all been trained on the plan and the technique. I was very upset when I saw how long he had stayed on the van. I do not</p>		<p>2014</p> <p>The QIDP will be trained on the responsibility to integrate, coordinate and monitor clients' active treatment programs. This will include ensuring staff supervision levels to address maladaptive behavior, ensure comprehensive functional behavior assessments are completed, addressing identified needs of clients, and ensuring behavior program data is documented</p> <p>Person Responsible: Assistant Director</p> <p>Completion Date: December 24, 2014</p>	

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	<p>understand why staff did not call for assistance earlier. I was completely unaware this was happening daily. He has only had one ABC card (behavior reporting card) in the past year. They should be filling them out each time he refuses to exit the van or does any of his targeted behaviors." When asked about client C's observed inappropriate touching during the group home observations, the BC stated, "I don't have any data for those either. In fact I was just informed it wasn't needed in her BSP any longer."</p> <p>2). Observations were conducted at the group home where clients A, B, C, D and E lived on 11/12/14 from 3:40 P.M. through 6:17 P.M. The living room carpeting had a dark stain two feet by two feet irregular shaped splatter stain in front of the sofa. Two of the three mini blinds at the living room windows were missing and the only curtain there was a valance so the windows were not covered at night. The kitchen window curtain did not fit and was made of a sheer fabric which would be able to be seen through at night. The interior light on the refrigerator was missing or burned out. In client C and E's bathroom there was a corner of the base trim missing and the dry wall was chipping off. The hand rails around the commode consisted of</p>			

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	<p>plumbing pipes wrapped with black foam tape which was coming loose. This was on the left side next to the tub. On the right side there was a loose grab bar which could be lifted and shaken. There was a board above the tank of the commode which was at an angle and loose. Client B's room had clutter on the floor, and only a path for him to walk to/from his bed. Client C and D's room was cluttered, had an odor, both beds were unmade, and clothing was scattered across the floor and dressers.</p> <p>Confidential interviews (CI) were conducted between the dates of 11/12/14 and 11/24/14.</p> <p>CI #1 "Yes, I've come in and had to clean her bedroom. I know she refuses and she needs to do it and it's hard to get her to do things, but it was out of control. She doesn't change her clothing or do her laundry or take showers like she should. Her room and she gets to smelling bad. She puts her clean clothing right back in with the dirty, or on the floor. Even her sanitary items are laying around. It didn't used to be this bad. I couldn't take it so I cleaned it when I came in."</p> <p>CI #2 " We have cleaned the bedroom a couple of times. We were concerned about dust and mold due to allergies. The</p>			

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	<p>whole house is really not clean. The carpet (living room) has a big stain on it. I don't know what happened. The house is a nice house and was clean at one time. I worry about someone falling on the clutter in the bedroom(s). The laundry is put away inside out, even hung up inside out. Why would someone not fix it?"</p> <p>CI #11 "The blinds and curtains have been messed up for awhile. Clearly the carpet is unclean. The grab bars in [client E's] bathroom are just wrong. [Client E] is scared she will fall when she showers anyway and then the grab bars are plumbing pipes and loose bars. This house is dirty. Every time I come in I notice how dirty it is...."</p> <p>An interview was conducted with the Assistant Residential Director (ARD) on 11/18/14 at 8:26 A.M. The ARD stated, "[Client C] has a hoarding issue and gets very upset when staff attempt to help her clean her room. I worked with the house supervisor on strategies for handling this and her new behavior consultant is adding this to her BSP. The client bedrooms should not be dirty and the clients should be assisting with cleaning. I created a training on active treatment and all the staff will be retrained. I am working with the house supervisor to create cleaning schedules for the staff."</p>			

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	<p>3. The QIDP failed to ensure staff demonstrated competency to implement 2 of 3 sampled clients' (clients B and C) supervision level to address maladaptive behavior. Please see W189.</p> <p>4. The QIDP failed for 2 of 3 sampled clients (clients B and C), to ensure comprehensive functional behavioral assessments were completed. Please see W214.</p> <p>5. The QIDP failed for 1 of 3 sampled clients (client C), to address her identified needs in inappropriate touching, hoarding, wiping after toileting, shower refusals and personal hygiene during her menses. Please see W227.</p> <p>6. The QIDP failed for 2 of 3 sampled clients (clients B and C) to ensure their behavior program data was documented. Please see W252.</p> <p>This federal tag relates to complaint #IN00158839. This federal tag relates to complaint #IN00159008.</p> <p>9-3-3(a)</p>				

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W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview, the facility failed to ensure a sufficient</p>	W000186	The group home will provide a minimum staffing ratio of 3:5 (3	12/24/2014

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	<p>number of trained staff were scheduled to work at the group home to implement behavior interventions, ensure safety and meet the individual needs of 2 of 3 sampled clients (clients A and client B); and 2 of 2 additional clients (clients D and E).</p> <p>Findings include:</p> <p>1. Facility records were reviewed on 11/12/2014 at 1:29 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 2/7/14 and 11/12/14. The BDDS reports indicated the following:</p> <p>A BDDS report dated 10/28/14 for an incident on 10/26/14 at 10:00 A.M. indicated "On Monday morning, staff contacted on-call supervisor to report that [client B] had been in the van since the day before and was refusing to get out. The on-call supervisor sent over a staff person to assist with [client B]. That staff person promptly got [client B] off the van. The van was parked in the garage during this time. The Behavior Support Plan (BSP) requires that staff perform a 2 person lift-carry-transport if [client B] refuses to get out of the van for longer than an hour. Staff were suspended pending an investigation into neglect."</p>		<p>staff to 5 clients) whenever all 5 clients are at the group home during waking hours. The house will have a staffing ratio of 2:3 (2 staff to 3 or 4 clients) during waking hours at times when client B or client E is not at the group home</p> <p>Person Responsible: Assistant Director</p> <p>Date Completed: 12/24/14</p> <p>The schedulers and the on-call team will be trained on the staffing ratios for the group home to ensure that the minimum number of staff persons specified above are schedule to work a shift</p> <p>Person Responsible: Assistant Director</p> <p>Date Completed: 12/24/14</p> <p>For the next three months the QIDP will complete a weekly checklist indicating that all staff that worked at Standridge have completed the client specific training</p>	

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	<p>The facility's internal investigation documentation dated 11/3/14 was reviewed on 11/10/14 at 2:55 P.M. The investigation indicated "Staffing ratio at time of incident 2:5 (two staff for five clients) and 1:5 (one staff for five clients). Required staffing ratio at time of incident 2:5. The investigation documentation indicated there were three clients at the group home on Sunday October 26, 2014 (clients A, B, and D). The investigation documentation indicated there was one staff working at the group home with clients A, B and D on October 26, 2014 from 2:00 P.M. until 9:00 P.M. and on the overnight shift and morning shift of October 27, 2014 from 9:00 P.M. through 8:00 A.M.</p> <p>A review of the schedule as worked for the past month was completed on 11/10/14 at 3:55 P.M. The schedule indicated the home was single staffed on the morning shift (5a-8a) on 10/22/14, 10/24/14, 10/27/14, 10/28/14 and 10/31/14. The home was single staffed on the weekend shifts (9a-9p) on 10/11/14 all day, 10/12/14 from 4:00 P.M.-9:00 P.M., 10/18/14 all day, 10/19/14 from 6:00 P.M.-9:00 P.M., 10/25/14 all day, 10/26/14 from 2:00 P.M. -9:00 P.M. 11/1/14 all day and 11/2/14 8:00 A.M. -12:00 P.M.</p>		<p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>For the next three months the QIDP will complete a weekly checklist indicating that the house maintained the sufficient number of trained staff.</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p>	

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	<p>During the morning shifts clients A, B, C, D and E are typically at the home requiring a 2.5- 5 (2 and 1/2 staff for 5 clients) ratio to meet the needs of the clients. On Sundays clients A, B and D are typically at home requiring at least a 2-3 ratio (2 staff to 3 clients) to meet the needs of the clients.</p> <p>Observations were conducted at the group home on 11/12/14 from 3:40 P.M. through 6:18 P.M. Client A arrived home first on the city bus. She began to prepare the evening meal with the group home supervisor. At 4:43 P.M. clients C and D entered the group home and selected a movie to watch and watched the movie throughout the entire observation period even during the evening meal which they ate in the living room. Client C was observed to yell, howl and repeatedly attempt to hug and kiss client D. Client C grabbed and or tickled direct support professional (DSP) #1. One time client C while laying and rolling around on the floor put her head between DSP #1's feet and grabbed on to her ankles. Client C also attempted to hug and kiss DSP #2 and the GHS. Verbal prompting to "remember personal space" was given. Client B had arrived home at the same time as clients C and D but remained on the van. DSP #1 and DSP #2 tried the techniques in client B's behavior support</p>			

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	<p>plan (giving him his book bag, asking him to help them, asking if he wanted a ride in the wheelchair, offering him his DVD and toy car), but client B would not leave the van. When client B moved to the back seat of the van DSP #2 decided to take client B for a van ride. They returned home at 5:40 P.M. and client B and DSP #2 entered the house. Client B sat down at the table and began to eat his evening meal. His 4:00 P.M. medications were administered to him earlier while he was on the van. During the observation period client A was the only client involved in aggressive active treatment activities. There were two DSP staff on duty, and the GHS and the Qualified Intellectual Disabilities Professional (QIDP) were in the home. Client E was on a family visit.</p> <p>Client A's record was reviewed on 11/13/14 at 12:57 P.M. and indicated in her risk plan dated 5/16/14 "[Client A] is a high risk for falls. Keep areas clear of clutter. Keep rooms well lighted. Use gait belt and when walking or transferring [client A]. Use walker when [client A] is ambulating. Staff will check to make sure gait belt is on correctly before walking or transferring [client A]. Staff will remind [client A] not to loosen her gait belt." Client A's Individual Support Plan (ISP) dated 5/16/14 indicated "She also has a</p>			

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	<p>balance problem and requires a walker at all times and staff assistance to walk with her. She needs physical assistance with getting in/out of the bathtub. She is independent as can be with her daily living skills with the exception of her balance, staff need to assist her."</p> <p>Client B's record was reviewed on 11/13/14 at 1:21 P.M. and indicated in his fall risk plan dated 10/24/14 "[Client B] walks with a stagger gait, and has sudden seizures. Keep areas clear of clutter. Keep rooms well lighted. Staff will walk with [client B] when he walks long distances." Client B's Behavior Support Plan (BSP) dated 1/20/14 indicated "... targeted behaviors: physical aggression (hits, slaps, pushes, shoves and scratches others), resistive behaviors (uncooperativeness), AWOL (absent without leave)... Constantly monitor for safety. If no migraine is suspected offer an enticement for [client B] from the what works well list. Do not rush him. [Client B] refuses to leave the van when it is in the garage at the group home and he does not have a migraine, after one hour staff will use a two man lift carry transport."</p> <p>Client C's record was reviewed on 11/13/14 at 3:25 P.M. and indicated she had a BSP dated 5/12/14 which included</p>			

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	<p>the targeted behaviors of, "verbal aggression, physical aggression, active resisting, passive resisting and inappropriate touching." Interventions in the BSP indicated "Each staff person should spend a few periods each day interacting with [client C] (total of 10 minutes or so a day) and talk about things that interest her."</p> <p>Client D's record was reviewed on 11/13/14 at 3:48 P.M. and indicated she had a BSP dated 7/2/14 which included the targeted behaviors of "talking constantly and interrupting others...staff were to keep her engaged in activities and tasks to keep her focused..explain activities of the day and what is expected of her, allow frequent breaks, and engage her in appropriate conversations about a topic of her choice, giving verbal praise when she displays appropriate behaviors."</p> <p>Client E's record was reviewed on 11/13/14 at 4:12 P.M. and indicated in her fall risk plan dated 1/15/14 "[Client E] has a history of falls related to the diagnoses of cerebral palsy, seizures, left sided weakness, and being overweight...Wears a gait belt when awake, used to help transfer. Uses wheelchair for transportation. Staff to remind [client E] to ask for help. Make</p>			

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	<p>sure [client E] is wearing shoes when transferring and discourage distractions when transferring..." Client E's record indicated she had a BSP dated 5/1/14 with the targeted behaviors of: self-injurious behaviors (SIB), verbal outbursts and physical aggression." Staff were to, "Give her one-on-one time, extra attention , laugh and tell jokes with her, verbal praise for her appearance, consistent with her routine and shower, complete her grooming and getting dressed first in the morning." If she displays SIB and can not be verbally redirected staff were to gently move her wrist away from her mouth while complimenting her or talking about her family... If she tried to purposely fall out of her wheelchair staff were to make sure she was safe, and leave her on the ground until it was her idea to get back up into her chair."</p> <p>Confidential interviews (CI) were conducted between the dates of 11/12/14 and 11/20/14.</p> <p>CI #9 "There are many times the home is single staffed. Mornings and weekends are especially bad. If the manager leaves to go grocery shopping then there is only one staff at the home with five clients."</p> <p>CI #11 "Weekends are the worst. I come</p>			

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	<p>to help if I can. This house cannot be single staffed."</p> <p>CI #12 "If the there is only one staff working the needs of the clients are not being met. One person cannot be everywhere."</p> <p>CI #15 "I do not know how to do the transport carry technique. I have never seen it done. They talked about it in class, but we didn't practice it. I think the manager should show us what we are supposed to do to help get him off the van. She just has us wait until a male staff arrives; he will usually get off the van for a male staff."</p> <p>An interview was conducted with the Qualified Intellectual Disabilities Professional(QIDP) on 11/13/14 at 2:30 P.M. The QIDP stated, "No, staff did not follow his (client B's) BSP. His BSP (behavior support plan) says to use a transport carry technique should have been used... There was only one staff working, so staff could not do the transport carry technique."</p> <p>An interview was conducted with the Assistant Residential Director (ARD) on 11/13/14 at 2:30 P.M. The ARD stated, "At a minimum it (the group home) should be double staffed."</p>			

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	<p>An interview was conducted with the facility Quality Director (QD) on 11/13/14 at 1:12 P.M. The QD was asked if the group home should ever be single staffed. The QD stated, "Only during sleep hours, as [client B] is an elopement risk and [client A] and [client E] need assistance to ambulate safely." The QD indicated the incident with client B should never have occurred, staff should have called for assistance.</p> <p>This federal tag relates to complaint #IN00158839. This federal tag relates to complaint #IN00159008.</p> <p>9-3-3(a)</p>			

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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview, the facility failed to ensure staff were sufficiently and competently trained to work at the group home to implement behavior interventions, ensure safety and meet the individual needs of 2 of 3 sampled clients (clients B and C).</p> <p>Findings include:</p> <p>Facility records were reviewed on 11/12/2014 at 1:29 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 2/7/14 and 11/12/14. The BDDS reports indicated the following:</p>	W000189	<p>Staff will be retrained on all the clients' risk plans and dining plans. Staff will be retrained on active treatment including taking advantage of all natural training opportunities</p> <p>and using the on-call system and on documenting maladaptive behaviors</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>All group home staff will be</p>	12/24/2014

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	<p>A BDDS report dated 10/28/14 for an incident on 10/26/14 at 10:00 A.M. indicated "On Monday morning, staff contacted on-call supervisor to report that [client B] had been in the van since the day before and was refusing to get out. The on-call supervisor sent over a staff person to assist with [client B]. That staff person promptly got [client B] off the van. The van was parked in the garage during this time. The Behavior Support Plan (BSP) requires that staff perform a 2 person lift-carry-transport if [client B] refuses to get out of the van for longer than an hour. Staff were suspended pending an investigation into neglect."</p> <p>The facility's internal investigation documentation dated 11/3/14 was reviewed on 11/10/14 at 2:55 P.M. The investigation indicated "Staffing ratio at time of incident 2:5 (two staff for five clients) and 1:5 (one staff for five clients). Required staffing ratio at time of incident 2:5. The investigation documentation indicated there were three clients at the group home on Sunday October 26, 2014 (clients A, B, and D)." The investigation documentation indicated direct support professional (DSP) #1 indicated, "In a situation like this we have had something similar and called the supervisor. She says to leave him in there until the overnight (staff)</p>		<p>trained on Client B, Client C, and Client D's updated BSPs and on the lift/carry/transfer technique</p> <p>Person Responsible: Behavior Consultant</p> <p>Date Completed: 12/24/14</p> <p>All group home staff will be retrained on Client E's BSP</p> <p>Person Responsible: Behavior Consultant</p> <p>Date Completed: 12/24/14</p> <p>The group home will provide a minimum staffing ratio of 3:5 (3 staff to 5 clients) whenever all 5 clients are at the group home during waking hours. The house will have a staffing ratio of 2:3 (2 staff to 3 or 4 clients) during waking hours at times when client B or client E is not at the group home</p> <p>Person Responsible: Assistant Director</p>	

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	<p>comes because sometimes he listens to them better."</p> <p>The investigation documentation indicated an interview was conducted with the group home supervisor (GHS) on 10/31/14. The documented interview with the GHS indicated "...they do leave him (client B) in the van longer than an hour, but have not left him overnight before. She said that the Monday through Friday overnight staff person is a male and [client B] will get out of the van and go in the house when the male staff asks him to. She stated she has told staff to leave him in the van until the third shift staff person gets there because it is more dangerous to [client B] and staff to attempt to carry him in the house than to leave him in the van. She also said it would not be possible to perform the two-person carry as described in his Individual Support Plan (ISP) when he is in the back of the van...she stated it occurs daily (his refusals to get out of the van)."</p> <p>Observations were conducted at the group home on 11/12/14 from 3:40 P.M. through 6:18 P.M. Client A arrived home first on the city bus. She began to prepare the evening meal with the group home supervisor. At 4:43 P.M. clients C and D entered the group home and selected a</p>		<p>Date Completed: 12/24/14</p> <p>The QIDP will complete an observation of the group home during a meal time three times a week for 3 months and then once a month ongoing checking for cleanliness of the home, maintenance issues, use of active treatment, use of dietician formulated menus, minimum staffing ratios, implementation of ISP objectives, and adherence to BSPs and risk plans. The observations will be documented and any issues noted will be corrected.</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>The Assistant Director will do a weekly observation of the group home checking for one month and then once a month ongoing checking for cleanliness of the home, maintenance issues, use of active treatment, use of dietician formulated menus, minimum staffing ratios, adherence to BSPs and risk plans. The observations will be documented and any issues noted will be corrected.</p>	

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	<p>movie to watch and watched the movie throughout the entire observation period even during the evening meal which they ate in the living room. Client C was observed to yell, howl and repeatedly attempt to hug and kiss client D. Client C grabbed and or tickled direct support professional (DSP) #1. One time client C while laying and rolling around on the floor put her head between DSP #1's feet and grabbed on to her ankles. Client C also attempted to hug and kiss DSP #2 and the GHS. Verbal prompting to "remember personal space" was given. Client B had arrived home at the same time as clients C and D but remained on the van. DSP #1 and DSP #2 tried the techniques in client B's behavior support plan (giving him his book bag, asking him to help them, asking if he wanted a ride in the wheelchair, offering him his DVD and toy car), but client B would not leave the van. When client B moved to the back seat of the van DSP #2 decided to take client B for a van ride. They returned home at 5:40 P.M. and client B and DSP #2 entered the house. Client B sat down at the table and began to eat his evening meal. His 4:00 P.M. medications were administered to him earlier while he was on the van. During the observation period client A was the only client involved in aggressive active treatment activities. There were two DSP staff on</p>		<p>Person Responsible: Assistant Director</p> <p>Date Completed: 12/24/14</p> <p>Client B, C, D, and E's behavior consultants will conduct a weekly observation of the group home for three months checking for adherence to BSPs. The observations will be documented and any issues noted will be corrected</p> <p>Person Responsible: Supervising Behavior Consultant</p> <p>Completion Date: December 24, 2014</p>	

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	<p>duty, and the GHS and the Qualified Intellectual Disabilities Professional (QIDP) were in the home. Client E was on a family visit.</p> <p>Client B's record was reviewed on 11/13/14 at 1:21 P.M. Client B's Behavior Support Plan (BSP) dated 1/20/14 indicated "Description of client: [Client B] is a 27 year old...with profound intellectual disabilities. He is ambulatory. He is essentially non-verbal. He has a diagnosis of profound MR, ADD (attention deficit disorder), mood disorder NOS (not otherwise specified), hyperthyroidism, heartburn, seizure disorder, migraine headaches, food and seasonal allergies. He is allergic to dairy products." His BSP indicated the following targeted behaviors: physical aggression (hits, slaps, pushes, shoves and scratches others), resistive behaviors (uncooperativeness), AWOL (absent without leave). Recommendations for resistive behaviors (refusing to exit the van, medications, participate in self-care, climbing on top of the van, laying flat on the ground): "Always check for signs of a possible migraine (dilated pupils, wrinkled forehead, sweating or swatting at staff). Offer PRN (as needed) pain relief medication. If giving a PRN for pain wait 20-30 minutes before making your request for compliance again.</p>			

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	<p>Constantly monitor for safety. If no migraine is suspected offer an enticement for [client B] from the what works well list. Do not rush him. [Client B] refuses to leave the van when it is in the garage at the group home and he does not have a migraine, after one hour staff will use a two man lift carry transport."</p> <p>Client C's record was reviewed on 11/13/14 at 3:25 P.M. She had a BSP dated 5/12/14 which included the targeted behaviors of, "verbal aggression, physical aggression, active resisting, passive resisting and inappropriate touching." Interventions in the BSP indicated "Each staff person should spend a few periods each day interacting with [client C] (total of 10 minutes or so a day) and talk about things that interest her."</p> <p>CI #15 "I do not know how to do the transport carry technique. I have never seen it done. They talked about it in class, but we didn't practice it. I think the manager should show us what we are supposed to do to help get him off the van. She just has us wait until a male staff arrives; he will usually get off the van for a male staff."</p> <p>CI #16 "There are many times I am scheduled alone at the house. I just do the</p>			

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	<p>best I can do to keep the clients safe."</p> <p>CI #18 "The house is always short staffed, has been that way for years. Staff don't want to work here because they don't get the support they need. The manager and QIDP are rarely here. They need to be in the house to see what is going on."</p> <p>An interview was conducted with the QIDP on 11/13/14 at 2:30 P.M. The QIDP stated, "No, staff did not follow his (client B's) BSP. His BSP says a transport carry technique should have been used. Staff thought it would be harmful if they attempted it with him at the back of the van. There was only one staff working, so staff could not do the transport carry technique."</p> <p>An interview was conducted with the facility Behavior Consultant (BC) on 11/13/14 at 1:53 P.M. The BC stated, "No they should have tried the lift-carry transport. The van has extra room in the center due to where the wheelchairs can be locked down. The staff have all been trained on the plan and the technique. I was very upset when I saw how long he had stayed on the van. I do not understand why staff did not call for assistance earlier. I was completely unaware this was happening daily. He has</p>			

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	<p>only had one ABC card (behavior reporting card) in the past year. They should be filling them out each time he refuses to exit the van or does any of his targeted behaviors." When asked about client C's observed inappropriate touching during the group home observations, the BC stated, "I don't have any data for those either. In fact I was just informed it wasn't needed in her BSP any longer."</p> <p>An interview was conducted with the instructor of CPI (Crisis Prevention Intervention) on 11/13/14 at 1:42 P.M. The CPI instructor stated, "We go over each technique in class and demonstrate how they are to be done." When asked about a collaboration between the QIDP, GH staff, the BC and himself regarding an individualized program for client B, the CPI instructor stated "we definitely could work one-on-one with staff on how best to work with a client."</p> <p>An interview was conducted with the facility Quality Director (QD) on 11/13/14 at 1:12 P.M. the QD stated, "The committee found that the BSP for [client B] needs to be revised. It should never have been allowed to happen. The staff should have called on-call sooner and gotten someone over there to help who he responds better to." The QD</p>			

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W000214	<p>indicated staff did not use their best judgement in handling the situation.</p> <p>This federal tag relates to complaint #IN00158839.</p> <p>This federal tag relates to complaint #IN00159008.</p> <p>9-3-3(a)</p> <p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management</p>			

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	<p>needs.</p> <p>Based upon record review and interview, the facility failed to ensure comprehensive functional behavioral assessments were completed for 2 of 3 sampled clients (clients B and C).</p> <p>Findings include:</p> <p>1. Client B's records were reviewed on 11/13/14 at 1:21 P.M. Client B's Behavior Support Plan (BSP) dated 1/20/14 indicated "His BSP indicated the following targeted behaviors: physical aggression (hits, slaps, pushes, shoves and scratches others), resistive behaviors (uncooperativeness), AWOL (absent without leave). Recommendations for resistive behaviors (refusing to exit the van, medications, participate in self-care, climbing on top of the van, laying flat on the ground): The plan included the use of CPI (Crisis Prevention Institute) techniques including the use a two man lift carry transport. The plan included the use of Inderal LA, Sinequan and Seroquel for anxiety, insomnia and autism. Client B's comprehensive functional assessment (CFA) dated 10/24/2014 did not include a functional assessment of his behavior.</p> <p>2. Client C's record was reviewed on 11/13/14 at 3:25 P.M. Client C had a BSP dated 5/12/14 which included the</p>	W000214	<p>Comprehensive functional behavior assessments will be completed on client B and client C.</p> <p>Person Responsible: Behavior Consultant</p> <p>Date Completed: 12/24/14</p> <p>The behavior consultants will be retrained to complete comprehensive functional behavior assessments annually</p> <p>Person Responsible: Assistant Director</p> <p>Date Completed: 12/24/14</p> <p>The Assistant Director of Supported Living completed an audit of client records to ensure that maladaptive behavior reports are being submitted by staff and comprehensive functional behavior assessments are completed. The assistant director will complete quarterly audits of client records on an ongoing basis</p>	12/24/2014

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	<p>targeted behaviors of, "verbal aggression, physical aggression, active resisting, passive resisting and inappropriate touching. The plan included the use of Adderall XR Tenex, and Paxil for ADHD (attention deficit hyperactivity disorder) and oppositional defiant disorder. Client C's comprehensive functional assessment (CFA) dated 5/12/2014 did not include a functional assessment of her behavior.</p> <p>The Behavior Consultant (BC) was interviewed on 11/13/14 at 1:53 P.M. The BC indicated clients B and C were going to be having new BSPs written. She indicated there was not a functional assessment completed of client B's or C's behavior.</p> <p>This federal tag relates to complaint #IN00158839. This federal tag relates to complaint #IN00159008.</p> <p>9-3-4(a)</p>		<p>Person Responsible: Assistant Director</p> <p>Completion Date: December 24, 2014</p>	

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based upon record review and interview, for 1 of 3 sampled clients (client C), the facility failed to address her identified needs of inappropriate touching (hugging, grabbing, tickling and kissing) and hoarding dirty clothing and used menses products.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/12/14 from 3:40 P.M. through 6:18 P.M. At 4:43 P.M. client C entered the group home and selected a movie to watch and watched the movie throughout the entire observation period even during the evening meal which she ate in the living room. Client C was</p>	W000227	<p>Client C's BSP will be updated to include her issues with hoarding and hygiene during menses</p> <p>Person Responsible: Behavior Consultant</p> <p>Completion Date: December 24, 2014</p> <p>A new comprehensive functional assessment will be completed on client C and an addendum added to her plan with goals for hygiene, grooming, toileting, and social skills. Staff will be trained on implementation of the revised</p>	12/24/2014

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	<p>observed to yell, howl and repeatedly attempt to hug and kiss client D. Client C grabbed and/or tickled direct support professional (DSP) #1. One time client C while laying and rolling around on the floor put her head between DSP #1's feet and grabbed on to her ankles. Client C also attempted to hug and kiss DSP #2 and the GHS. Verbal prompting to "remember personal space" was given. There were two DSP staff on duty, and the GHS and the Qualified Intellectual Disabilities Professional (QIDP) were in the home.</p> <p>Observations were conducted at the group home where clients A, B, C, D and E lived on 11/12/14 from 3:40 P.M. through 6:17 P.M. Client C and D's room was cluttered, had an odor, both beds were unmade, and clothing was scattered across the floor and dressers.</p> <p>Client C's record was reviewed on was reviewed on 11/13/14 at 3:25 P.M. and indicated she had an ISP dated 5/12/14 which included the following objectives: swipe her debit card, identify one of her medications, start washing machine, brush her teeth, exercise for 20 minutes, and prep a side dish. Her Transition goals were to research a recipe, participate in a scheduled activity and clean her area. Client C's behavior support plan (BSP)</p>		<p>plan</p> <p>Person Responsible: QIDP</p> <p>Completion Date: December 24, 2014</p> <p>ISPs for all clients will be reviewed to ensure that they include objectives to address the clients' needs. Any found to not include them will be revised and staff will be retrained on revised plans</p> <p>Person Responsible: QIDP</p> <p>Completion Date: December 24, 2014</p> <p>The QIDP will conduct a weekly observation of the group home once a week for three months and then monthly ongoing checking for cleanliness of the home, maintenance issues, use of active treatment, use of dietician formulated menus, minimum staffing ratios, implementation of ISP objectives, and adherence to BSPs and risk plans. The observations will be documented and any issues noted will be corrected.</p>	

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	<p>dated 5/12/14 which included the targeted behaviors of, "verbal aggression, physical aggression, active resisting, passive resisting and inappropriate touching." Interventions in the BSP indicated "Each staff person should spend a few periods each day interacting with [client C] (total of 10 minutes or so a day) and talk about things that interest her."</p> <p>Confidential interviews (CI) were conducted between the dates of 11/12/14 and 11/24/14.</p> <p>CI #1 "Yes, I've come in and had to clean her bedroom. I know she refuses and she needs to do it and it's hard to get her to do things, but it was out of control. She doesn't change her clothing or do her laundry or take showers like she should. Her room and she gets to smelling bad. She puts her clean clothing right back in with the dirty, or on the floor. Even her sanitary items are laying around. It didn't used to be this bad. I couldn't take it so I cleaned it when I came in."</p> <p>CI #2 "We have cleaned the bedroom a couple of times. We were concerned about dust and mold due to allergies. The whole house is really not clean. The carpet (living room) has a big stain on it. I don't know what happened. The house</p>		<p>Person Responsible: QIDP</p> <p>Completion Date: December 2014</p> <p>The Assistant Director will do a weekly observation of the group home checking for one month and then once a month ongoing checking for cleanliness of the home, maintenance issues, use of active treatment, use of dietician formulated menus, minimum staffing ratios, adherence to BSPs and risk plans. The observations will be documented and any issues noted will be corrected.</p> <p>Person Responsible: Assistant Director</p> <p>Completion Date: December 2014</p>	

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	<p>is a nice house and was clean at one time. I worry about someone falling on the clutter in the bedroom(s). The laundry is put away inside out, even hung up inside out. Why would someone not fix it?"</p> <p>CI #13 "She refuses to take showers/baths and wears her clothing too long. It has to be washed twice to get it clean due to feces and blood when she has her periods. It makes her room smell really bad and she shares the room with another person. She has a goal to start the washer, but she needs a goal and behavior interventions for grooming and changing her clothing. She will sometimes take her clothing off in the living room and throw the dirty items (clothing and sanitary products) around the house."</p> <p>CI #17 "She doesn't do her laundry. She wears her clothing for long periods of time and there will be feces and blood on them. They are so dirty they have to be washed twice. They don't make her shower or change her clothing."</p> <p>CI #18 "I try to tell her to not grab me or kiss me, but she doesn't listen. She has no consequences for her actions."</p> <p>An interview was conducted with the Assistant Residential Director (ARD) on</p>			

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	<p>11/18/14 at 8:26 A.M. The ARD stated, "[Client C] has a hoarding issue and gets very upset when staff attempt to help her clean her room. I worked with the house supervisor on strategies for handling this and her new behavior consultant is adding this to her BSP."</p> <p>This federal tag relates to complaint #IN00158839.</p> <p>This federal tag relates to complaint #IN00159008.</p> <p>9-3-4(a)</p>			

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W000242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based upon record review and interview, the facility failed to include training methods for the identified needs of toileting care, bathing, grooming and personal hygiene skills in the Individual Support Plan (ISP) for 1 of 3 sampled clients (client C).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/12/14 from 3:40 P.M. through 6:18 P.M. At 4:43 P.M. Client C was observed to have uncombed hair. She was wearing a pair of large gray sweat pants and a tee shirt which was tight and she had to continue to pull it down. Client C was not dressed in a manner to enhance her appearance. After client C ate her evening meal she was prompted to wipe the barbeque sauce off</p>	W000242	<p>ISPs for all clients will be reviewed to ensure that they include objectives to address the clients' needs. Any found to not include them will be revised and staff will be retrained on revised plans</p> <p>Person Responsible: QIDP</p> <p>Completion Date: December 24, 2014</p> <p>Client C's BSP will be updated to include her issues with hoarding and hygiene during menses</p> <p>Person Responsible: Behavior Consultant</p>	12/24/2014

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	<p>her chin. She had three streaks of sauce on her chin. Client C refused to wash her face or even use a napkin.</p> <p>Client C's record was reviewed on was reviewed on 11/13/14 at 3:25 P.M. and indicated she was a 22 year old female. Client C had an ISP dated 5/12/14 which included the following objectives: swipe her debit card, identify one of her medications, start washing machine, brush her teeth, exercise for 20 minutes, and prep a side dish. Her Transition goals were to research a recipe, participate in a scheduled activity and clean her area. Client C's behavior support plan (BSP) dated 5/12/14 included the targeted behaviors of, "verbal aggression, physical aggression, active resisting, passive resisting and inappropriate touching." Interventions in the BSP indicated "Each staff person should spend a few periods each day interacting with [client C] (total of 10 minutes or so a day) and talk about things that interest her." Client C's ABAS dated 5/2014 was reviewed on 11/13/14 at 3:25 P.M. and indicated Client C needed to work on self care skills.</p> <p>Client D was interviewed on 11/16/14 at 3:10 P.M. Client D stated, "She (client C) doesn't wash her hands very often, so I don't want her to touch me."</p>		<p>Completion Date: December 24, 2014</p> <p>A new comprehensive functional assessment will be completed on client C and an addendum added to her plan with goals for hygiene, grooming, toileting, and social skills</p> <p>Person Responsible: QIDP</p> <p>Completion Date: December 24, 2014</p> <p>The QIDP will document progress with hygiene, grooming, toileting, and social skills on the monthly report</p> <p>Person Responsible: QIDP</p> <p>Completion Date: December 24, 2014</p> <p>The QIDP will conduct an observation of the group home once a week for three months and then monthly ongoing</p>	

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	<p>Confidential interviews (CI) were conducted between the dates of 11/12/14 and 11/20/14.</p> <p>CI #1 "She doesn't change her clothing or do her laundry or take showers like she should. The room and she gets to smelling bad. She puts her clean clothing right back in with the dirty or on the floor. Even her sanitary items are laying around. It didn't used to be this bad. I couldn't take it so I cleaned it when I came in."</p> <p>CI #12 "She wore a beautiful dress to the prom, and danced. After dancing for awhile her scent filled the whole room. You could tell she had not taken a bath before she came."</p> <p>CI #13 "She refuses to take showers/baths and wears her clothing too long it has to be washed twice to get it clean due to feces and blood when she has her periods. It makes her room smell really bad and shares rooms with another person. She has a goal to start the washer, but she needs a goal and behavior interventions for grooming and changing her clothing."</p> <p>An interview was conducted with the Assistant Residential Director (ARD) on 11/18/14 at 8:26 A.M. The ARD stated,</p>		<p>Person Responsible: QIDP</p> <p>Completion Date: December 2014</p> <p>The Assistant Director will do a weekly observation of the group home checking for one month and then once a month ongoing checking for cleanliness of the home, maintenance issues, use of active treatment, use of dietician formulated menus, minimum staffing ratios, adherence to BSPs and risk plans. The observations will be documented and any issues noted will be corrected.</p> <p>Person Responsible: Assistant Director</p> <p>Completion Date: December 2014</p>	
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W000249	<p>"I worked with the house supervisor on strategies for handling this (refusals to shower) and her new behavior consultant is adding this to her BSP." The ARD indicated the only hygiene goal client C had was to brush her teeth.</p> <p>This federal tag relates to complaint #IN00158839.</p> <p>This federal tag relates to complaint #IN00159008.</p> <p>9-3-4(a)</p>			
	483.440(d)(1)			

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	<p>PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview, the facility failed to ensure 2 of 3 sampled clients (clients B and C) received continuous and aggressive active treatment at all formal and informal opportunities.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/12/14 from 3:40 P.M. through 6:18 P.M. At 4:43 P.M. clients C and D entered the group home and selected a movie to watch and watched the movie throughout the entire observation period even during the evening meal which they ate in the living room. Client C was observed to yell, howl and repeatedly attempt to hug and kiss client D. Client C grabbed and/or tickled direct support professional (DSP) #1. One time client C while laying and rolling around on the floor put her head between DSP #1's feet and grabbed on to her ankles. Client C also attempted to hug and kiss DSP #2 and the GHS. Verbal prompting to "remember personal</p>	W000249	<p>Staff will be retrained on active treatment including training on client objectives and on taking advantage of all natural training opportunities</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>The QIDP will conduct an observation of the group home once a week for three months and then monthly ongoing checking to ensure that any maladaptive behaviors that occur are documented</p> <p>Person Responsible: QIDP</p> <p>Completion Date: December 2014</p>	12/24/2014

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	<p>space" was given. Client B had arrived home at the same time as clients C and D but remained on the van. DSP #1 and DSP #2 tried the techniques in client B's behavior support plan (giving him his book bag, asking him to help them, asking if he wanted a ride in the wheelchair, offering him his DVD and toy car), but client B would not leave the van. When client B moved to the back seat of the van DSP #2 decided to take client #2 for a van ride. They returned home at 5:40 P.M. and client B and DSP #2 entered the house. Client B sat down at the table and began to eat his evening meal. His 4:00 P.M. medications were administered to him earlier while he was on the van. There were two DSP staff on duty, and the GHS and the Qualified Intellectual Disabilities Professional (QIDP) were in the home.</p> <p>Client B's record was reviewed on 11/13/14 at 1:21 P.M. and indicated he had an Individual Support Plan (ISP) dated 1/17/14 which included the following objectives: cross street safely, use debit card, go to medication area at med time, brush teeth, use wash cloth, sit on toilet, sign three words, hold dental tools. Client B did not work on any of his objectives during the observation period.</p> <p>Client C's record was reviewed on was</p>		<p>The Assistant Director will do a weekly observation of the group home checking for one month and then once a month ongoing checking to ensure that any maladaptive behaviors that occur are documented</p> <p>Person Responsible: Assistant Director</p> <p>Completion Date: December 2014</p> <p>Client B, C, D, and E's behavior consultants will conduct a weekly observation of the group home for three months checking for adherence to BSPs. The observations will be documented and any issues noted will be corrected</p> <p>Person Responsible: Supervising Behavior Consultant</p> <p>Completion Date: December 24, 2014</p>	

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	<p>reviewed on 11/13/14 at 3:25 P.M. and indicated she had an ISP dated 5/12/14 which included the following objectives: swipe her debit card, identify one of her medications, start washing machine, brush her teeth, exercise for 20 minutes, and prep a side dish. Client C did not work on exercising, preparing a side dish or starting the washing machine.</p> <p>An interview was conducted with the Assistant Residential Director (ARD) on 11/18/14 at 8:26 A.M. The ARD stated, "The client bedrooms should not be dirty and the clients should be assisting with cleaning. I created a training on active treatment and all the staff will be retrained." The ARD stated "Goals/objectives should be worked on at all formal and informal opportunities."</p> <p>This federal tag relates to complaint #IN00158839. This federal tag relates to complaint #IN00159008.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G415	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/24/2014
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NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 8626 STANDRIDGE RUN FORT WAYNE, IN 46825
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W000252	<p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on observation, record review and interview, the facility failed to keep accurate documentation of behavior data for 2 of 3 sampled clients (clients B and C).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/12/14 from 3:40 P.M. through 6:18 P.M. At 4:43 P.M. clients C and D entered the group home and selected a movie to watch and watched the movie throughout the entire observation period even during the evening meal which they ate in the living room. Client C was observed to yell, howl and repeatedly attempt to hug and kiss client D. Client C grabbed and/or tickled direct support professional (DSP) #1. One time client C while laying and rolling around on the floor put her head between DSP #1's feet and grabbed her ankles. Client C also attempted to hug and kiss DSP #2 and the GHS. Verbal</p>	W000252	<p>Client B has had 24 behavior reports from group home staff in the last year. They will be available when the surveyor returns.</p> <p>Staff will be retrained on following behavior support plans, using the on-call system, and on submitting reports when clients have seizures or exhibit maladaptive behaviors</p> <p>Person Responsible: House Supervisor</p> <p>Date Completed: 12/24/14</p> <p>All group home staff will be trained on Client B, Client C, and Client D's updated BSPs and on the lift/carry/transfer technique</p>	12/24/2014

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	<p>prompting to "remember personal space" was given. Client B had arrived home at the same time as clients C and D but remained on the van. DSP #1 and DSP #2 tried the techniques in client B's behavior support plan (giving him his book bag, asking him to help them, asking if he wanted a ride in the wheelchair, offering him his DVD and toy car), but client B would not leave the van, even though DSP #2 is a male staff and client B reported works better with males. When client B moved to the back seat of the van DSP #2 decided to take client B for a van ride. They returned home at 5:40 P.M. and client B and DSP #2 entered the house.</p> <p>Client B's record was reviewed on 11/13/14 at 1:21 P.M. Client B's Behavior Support Plan (BSP) dated 1/20/14 indicated "... targeted behaviors: physical aggression (hits, slaps, pushes, shoves and scratches others), resistive behaviors (uncooperativeness), AWOL (absent without leave)... Constantly monitor for safety... Do not rush him. If [Client B] refuses to leave the van when it is in the garage at the group home and he does not have a migraine, after one hour staff will use a two man lift carry transport." Client B's record indicated he had 1 ABC (antecedent/behavior/consequence) card</p>		<p>Person Responsible: Behavior Consultant</p> <p>Date Completed: 12/24/14</p> <p>All group home staff will be retrained on Client E's BSP</p> <p>Person Responsible: Behavior Consultant</p> <p>Date Completed: 12/24/14</p> <p>The QIDP will conduct a weekly observation of the group home once a week for three months and then monthly ongoing checking for cleanliness of the home, maintenance issues, use of active treatment, use of dietician formulated menus, minimum staffing ratios, implementation of ISP objectives, and adherence to BSPs and risk plans. The observations will be documented and any issues noted will be corrected.</p> <p>Person Responsible: QIDP</p> <p>Completion Date: December 2014</p>	

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	<p>for the past year. ABC cards are filled out when a behavior occurs and are utilized as the method of tracking behavior data frequency, intensity and cause and effect of behaviors. There was not an ABC card available for review for client B's behavior of refusing to exit the van during the observation period on 11/12/14.</p> <p>Client C's record was reviewed on 11/13/14 at 3:25 P.M. She had a BSP dated 5/12/14 which included the targeted behaviors of, "verbal aggression, physical aggression, active resisting, passive resisting and inappropriate touching." Interventions in the BSP indicated "Each staff person should spend a few periods each day interacting with [client C] (total of 10 minutes or so a day) and talk about things that interest her." Client C had 2 ABC cards filled out for the past year. There was not an ABC card available for review for client C's behaviors of yelling and inappropriate touching during the observation period on 11/12/14.</p> <p>Client D was interviewed on 11/16/14 at 3:10 P.M. Client D stated, "I ask her (client C) to stop, but she doesn't. She doesn't wash her hands very often, so I don't want her to touch me. I don't want her to kiss me. I only want my boyfriend</p>		<p>The Assistant Director will do a weekly observation of the group home checking for one month and then once a month ongoing checking for cleanliness of the home, maintenance issues, use of active treatment, use of dietician formulated menus, minimum staffing ratios, adherence to BSPs and risk plans. The observations will be documented and any issues noted will be corrected.</p> <p>Person Responsible: Assistant Director</p> <p>Completion Date: December 2014</p>	

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	<p>to kiss me. I tell her to stop, but she just doesn't listen. I wish someone would work on that with her."</p> <p>An interview was conducted with the facility Behavior Consultant (BC) on 11/13/14 at 1:53 P.M. The BC stated, "No they should have tried the lift-carry transport. The van has extra room in the center due to where the wheelchairs can be locked down. The staff have all been trained on the plan and the technique. I was very upset when I saw how long he had stayed on the van. I do not understand why staff did not call for assistance earlier. I was completely unaware this was happening daily. He has only had one ABC card (behavior reporting card) in the past year. They should be filling them out each time he refuses to exit the van or does any of his targeted behaviors." When asked about client C's observed inappropriate touching during the group home observations, the BC stated, "I don't have any data for those either. In fact I was just informed it wasn't needed in her BSP any longer."</p> <p>An interview was conducted with the Assistant Residential Director (ARD) on 11/18/14 at 8:26 A.M. The ARD stated, "Staff should be filling out the ABC cards. I have asked the BC to forward any</p>			

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W000287	<p>electronic ABC cards to the house supervisor so she can follow up with individual staff to ensure all behaviors are being reported."</p> <p>This federal tag relates to complaint #IN00158839. This federal tag relates to complaint #IN00159008.</p> <p>9-3-4(a)</p> <p>483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used for the convenience of staff. Based on record review and interview, the facility staff allowed 1 of 3 sampled clients (client B) to repeatedly remain on the van if he refused to exit when he arrived home from day program until the</p>	W000287	Client B's BSP has been revised to provide clear direction for staff to follow when target behaviors are exhibited. Staff and supervisor will be retrained on the	12/24/2014

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	<p>third shift staff arrived to work due to lack of competency and/or staffing presence.</p> <p>Findings include:</p> <p>Facility records were reviewed on 11/12/2014 at 1:29 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 2/7/14 and 11/12/14. The BDDS reports indicated the following:</p> <p>A BDDS report dated 10/28/14 for an incident on 10/26/14 at 10:00 A.M. indicated "On Monday morning, staff contacted on-call supervisor to report that [client B] had been in the van since the day before and was refusing to get out. The on-call supervisor sent over a staff person to assist with [client B]. That staff person promptly got [client B] off the van. The van was parked in the garage during this time. The Behavior Support Plan (BSP) requires that staff perform a 2 person lift-carry-transport if [client B] refuses to get out of the van for longer than an hour. Staff were suspended pending an investigation into neglect."</p> <p>The facility's internal investigation documentation dated 11/3/14 was reviewed on 11/10/14 at 2:55 P.M. The investigation indicated "Staffing ratio at</p>		<p>revised plan. Staff and house supervisor will be trained on client C, D, and E's BSPs. Staff will be trained on the lift/carry/transfer technique</p> <p>Person Responsible: Behavior Consultant</p> <p>Date Completed: 12/24/14</p> <p>Staff will be retrained on following behavior support plans and on using the on-call system</p> <p>Person Responsible: House Supervisor</p> <p>Date Completed: 12/24/14</p> <p>The QIDP will conduct a weekly observation of the group home once a week for three months and then monthly ongoing checking for adherence to BSPs. The observations will be documented and any issues noted will be corrected.</p> <p>Person Responsible: QIDP</p> <p>Completion Date: December</p>		

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	<p>time of incident 2:5 (two staff for five clients) and 1:5 (one staff for five clients). Required staffing ratio at time of incident 2:5. The investigation documentation indicated there were three clients at the group home on Sunday October 26, 2014 (clients A, B, and D)...Staff called on-call around 5:30-6:30 A.M. to request a male staff to come help out."</p> <p>The investigation documentation indicated an interview was conducted with the group home supervisor (GHS) on 10/31/14. The documented interview with the GHS indicated "...they do leave him (client B) in the van longer than an hour, but have not left him overnight before. She said that the Monday through Friday overnight staff person is a male and [client B] will get out of the van and go in the house when the male staff asks him to. She stated she has told staff to leave him in the van until the third shift staff person gets there because it is more dangerous to [client B] and staff to attempt to carry him in the house than to leave him in the van...she stated it (refusals to get off the van) occurs daily."</p> <p>Client B's record was reviewed on 11/13/14 at 1:21 P.M. Client B's Behavior Support Plan (BSP) dated 1/20/14 indicated targeted behaviors of:"</p>		<p>2014</p> <p>The Assistant Director will do a weekly observation of the group home checking for one month and then once a month ongoing checking for adherence to BSPs. The observations will be documented and any issues noted will be corrected.</p> <p>Person Responsible: Assistant Director</p> <p>Completion Date: December 2014</p> <p>Client B, C, D, and E's behavior consultants will conduct a weekly observation of the group home for three months checking for adherence to BSPs. The observations will be documented and any issues noted will be corrected</p> <p>Person Responsible: Supervising Behavior Consultant</p> <p>Completion Date: December 24, 2014</p>	

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	<p>physical aggression (hits, slaps, pushes, shoves and scratches others), resistive behaviors (uncooperativeness), AWOL (absent without leave).</p> <p>Recommendations for resistive behaviors (refusing to exit the van, medications, participate in self-care, climbing on top of the van, laying flat on the ground): "Always check for signs of a possible migraine (dilated pupils, wrinkled forehead, sweating or swatting at staff). Offer PRN (as needed) pain relief medication. If giving a PRN for pain wait 20-30 minutes before making your request for compliance again. Constantly monitor for safety. If no migraine is suspected offer an enticement for [client B] from the what works well list. Do not rush him. [Client B] refuses to leave the van when it is in the garage at the group home and he does not have a migraine, after one hour staff will use a two man lift carry transport."</p> <p>An interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) on 11/13/14 at 2:30 P.M. The QIDP stated, "No, staff did not follow his (client B's) BSP. His BSP says to use a transport carry technique should have been used. Staff thought it would be harmful if they attempted it with him at the back of the van. There was only one staff working, so staff could not do the</p>			

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	<p>transport carry technique.</p> <p>An interview was conducted with the facility Behavior Consultant (BC) on 11/13/14 at 1:53 P.M. The BC stated, "No they should have tried the lift-carry transport. The van has extra room in the center due to where the wheelchairs can be locked down. The staff have all been trained on the plan and the technique. I was very upset when I saw how long he had stayed on the van. I do not understand why staff did not call for assistance earlier. I was completely unaware this was happening daily. He has only had one ABC card (behavior reporting card) in the past year. They should be filling them out each time he refuses to exit the van or does any of his targeted behaviors."</p> <p>An interview was conducted with the facility Quality Director (QD) on 11/13/14 at 1:12 P.M. the QD stated, "The committee found that the BSP for [client B] needs to be revised. It should never have been allowed to happen. The staff should have called on-call sooner and gotten someone over there to help who he responds better to." The QD indicated it was not seen as neglect the way the policy was worded, but it is in no way the intent or mission of the facility. The QD indicated the facility was not</p>				

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W000312	<p>483.450(e)(2)</p> <p>aware client B was staying on the van daily and the manager was having staff leave him on the van until the third shift arrived.</p> <p>This federal tag relates to complaint #IN00158839.</p> <p>This federal tag relates to complaint #IN00159008.</p> <p>9-3-5(a)</p>				

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	<p>DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview, for 1 of 3 sampled clients (client C), the facility failed to ensure her plan included an obtainable plan of reduction for the use of medication to address her behavior.</p> <p>Findings include:</p> <p>Client C's record was reviewed on 11/13/14 at 3:25 P.M. She had a Behavior Support Plan (BSP dated) 5/12/14 which included the targeted behaviors of, "verbal aggression, physical aggression, active resisting, passive resisting and inappropriate touching." Interventions in the BSP indicated "Each staff person should spend a few periods each day interacting with [client C] (total of 10 minutes or so a day) and talk about things that interest her." The plan included the use of Adderall XR, Tenex, and Paxil for ADHD (attention deficit hyperactivity disorder) and oppositional defiant disorder. Client C's Behavior Support Plan indicated "The IDT (interdisciplinary team) will request that the psychiatrist consider a reduction of</p>	W000312	<p>Client C's BSP has been revised to provide obtainable plan of reduction. Staff and supervisor will be retrained on the revised plans.</p> <p>Person Responsible: Behavior Consultant</p> <p>Date Completed: 12/24/14</p> <p>QIDP will be retrained on writing BSPs including setting attainable plans of reduction</p> <p>Person Responsible: Assistant Director</p> <p>Date Completed: 12/24/14</p> <p>The Supervising Behavior Consultant will review all BSPs before they are submitted to the human rights committee to determine if the plans of reduction are obtainable</p>	12/24/2014

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W000323	<p>Paxil (antidepressant) if [client C] displays less than 3 instances of verbal aggression towards others, less than 2 physical aggression towards others, less than 3 active resistance, less than 3 passive resistance, less than 2 incidents of inappropriate touching for 12 consecutive months."</p> <p>An interview was conducted with the Assistant Residential Director (ARD) on 11/18/14 at 8:26 A.M. The ARD indicated that client C most likely would not be able to meet the behavior objectives in her BSP.</p> <p>9-3-5(a)</p> <p>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,</p>	W000323	<p>Person Responsible: Assistant Director</p> <p>Date Completed: 12/24/14</p> <p>BSPs for all clients will be reviewed to ensure that they include obtainable plans for reduction of medications to address behavior. Any plans found to not be obtainable will be revised</p> <p>Person Responsible: Behavior Consultant</p> <p>Date Completed: 12/24/14</p>	12/24/2014	

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	<p>the facility failed to obtain an annual hearing evaluation for 1 of 3 sampled clients (client B).</p> <p>Findings include:</p> <p>Client B's record review was completed on 11/13/14 at 1:21 P.M. Client B's record indicated he had a hearing evaluation on 4/24/2009 and was to return in three years. There was no other hearing evaluation available for review.</p> <p>The RN was interviewed on 11/18/14 at 10:24 A.M. The RN indicated this was the current hearing evaluation for client B.</p> <p>9-3-6(a)</p>		<p>Client B has an audiology exam dated 5/7/12. He is due for another hearing exam in May 2015. Please see attachment</p> <p>The nurses will be retrained to have all audiology exams submitted to central files on the correct form to prevent them from being incorrectly filed</p> <p>Person Responsible: Nurse Practitioner</p> <p>Date Completed: 12/24/14</p>				
W000460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview, the facility failed to provide meals for well balanced and specially prescribed diets for 3 of 3 sampled clients (clients A, B and C) and for 2 of 2 additional clients (clients D and E).</p>	W000460	<p>Menus formulated by a dietician have been posted in the group home. Additional menus indicating appropriate substitutions for different nutritional needs will be available</p>	12/24/2014			

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	<p>Findings include:</p> <p>Observations were conducted at the group home where clients A, B, C, D and E lived on 11/12/14 from 3:40 P.M. through 6:17 P.M. Client A was in the kitchen assisting the group home supervisor (GHS) with preparing dinner. The food items prepared that evening were chicken Alfredo, broccoli, dinner rolls, peach slices, milk, rice milk, water, fruit punch; ketchup and barbeque sauce were used by clients C and D. There was a handwritten menu posted for the week. It did not indicate portion sizes for each item. There was no menu available indicating how staff should assist the clients with their different dietary needs. There were no food portion sizes listed for clients A, C and E who are on calorie controlled diets. There was no low fat/low cholesterol options for clients A and D. There was no increased fiber diet for client B. Clients A, C and D served themselves from serving bowls. No prompting regarding size of portions taken. Client B was assisted serving himself via hand-over-hand. He was served a large portion of fettuccine chicken Alfredo, broccoli and peach slices. The HS cut the food up for client B with a fork. DSP #2 then tried to cut client B's food into smaller pieces, but</p>		<p>in a binder in the kitchen</p> <p>Person Responsible: House supervisor</p> <p>Date Completed: 12/15/14</p> <p>Staff and the supervisor will be trained on using the dietician menus including specialized diets and portion sizes</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>The supervisor will be trained on how to appropriately grocery shop for the group home according to the menus formulated by a dietician and providing an appropriate food supply</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>The group home staff and supervisor will be retrained on the client's dining plans</p>	

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	<p>there were still fettuccine noodles several inches in length and the chicken and broccoli were not mechanical soft (1/4 inch) pieces.</p> <p>Observations were conducted at the group home where clients A, B, C, D and E lived on 11/16/14 from 2:17 P.M. through 4:11 P.M. There was another hand written menu posted for the current week. None of the items on the menu was located in the home. The menu did not include Monday's meals. Tuesday's dinner meal consisted of breaded pork chops, rice pilaf, broccoli, fruited jello, bread with butter, milk, juice and pudding and juice for snack in the evening. Observations of the refrigerator, freezer, and freezer in the garage, revealed no pork chops, milk, juice or pudding. The freezer in the garage had frozen vegetables, one roll of sausage, 5 loaves of high fiber bread, frozen potato patties and a few other small items. The freezer in the kitchen had a package of liver, frozen potato patties, and a stack of frozen pot pies. There was no milk, eggs or fresh vegetables, fruit observed to be in the refrigerator. There was a basket of oranges on the counter.</p> <p>Client A's record was reviewed on 11/13/14 at 12:57 P.M. Client A's nutrition assessment dated 5/22/14</p>		<p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>The QIDP will complete an observation of the group home during a meal time once a week for 3 months and then once a month ongoing checking for use of dietician formulated menus and adequate food available in the home for the menus. The observations will be documented and any issues noted will be corrected.</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>The Assistant Director will do a weekly observation of the group home checking for one month and then once a month ongoing checking for use of dietician formulated menus and adequate food available in the home for the menus. The observations will be documented and any issues noted will be corrected.</p>	

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	<p>indicated she was on a low cholesterol diet. Client A had a risk plan dated 5/6/14 indicating she was obese. Her current weight was 180 pounds and her height was 64 inches. Her ideal body weight range was 108-120 pounds.</p> <p>Client B's record was reviewed on 11/13/14 at 1:21 P.M. Client B's nutrition assessment dated 5/22/14 indicated he was to have a mechanical soft diet, additional portions, high fiber, avoid breaded products, no hot dogs, no milk, liberal snacks. His weight was 112 pounds and his height was 64.5 inches. His ideal body weight range was to be 120-146 pounds. The Registered Dietician (RD) indicated "...Staff report when menued meal item has food allergens, they will often provide a [Name] rice meal...It is recommended to continue to reintroduce the avoid food list slowly, a least restrictive diet would like be beneficial for overall nutritional health and may promote desired weight gain. Recommendations: 1) Continue current diet. 2) Encourage second portions at meals. 3) A nutritional supplement to be considered if weight drops below current weight of 112 or if client is leaving > 25% (more then 25%) uneaten at meals. 4) Continue to progress with reintroduction of foods with family's guidance and comfort. 5) Refer to RD</p>		<p>Person Responsible: Assistant Director</p> <p>Date Completed: 12/24/14</p>	

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	<p>when significant weight changes occur or as needed."</p> <p>Client C's record was reviewed on 11/13/14 at 3:25 P.M. Client C's nutrition assessment dated 5/22/14 indicated she was on a 1200 calorie diet with limit juice intake to 6oz per day. Her weight was 236 pounds and her height was 64 inches. Her ideal body weight range was 108-132 pounds. The RD indicated "Weight has shown a 21 pound or 10% weight gain over the past year. BMI (body mass index) now indicates morbid obesity. 1200 Calorie meal plan handout provided to staff."</p> <p>Client D's record was reviewed on 11/19/14 at 10:32 A.M. Client D's nutrition assessment dated 5/22/14 indicated she was on a low fat and low cholesterol diet. Her weight was 110 pounds and her height was 62 inches. Her ideal body weight range was 99-121 pounds. The RD indicated "Weight has decreased 3.6 pounds over past year. Dining plan indicates 'maintain weight at least 115 pounds.'...Client presents at nutritional risk due to leaving food behind, weight loss with history of being self conscious in regards to her weight."</p> <p>Client E's record was reviewed on 11/19/14 at 10:31 A.M. Client E's</p>			

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	<p>nutrition assessment dated 5/22/14 indicated she was on a mechanical soft diet, reduced salt intake, portion control, limit one non-fruit dessert to 1 time weekly. Her weight was 230 pounds and her height was 64 inches. Her ideal body weight range was 108-132 pounds.</p> <p>The facility RN was interviewed on 11/20/14 at 10:37 A.M. The RN stated, "I am most concerned about [client C's] and [client D's] diets being followed. We like [client B] to eat so he can gain weight. I would be interested to know if he was sick after eating two servings of Alfredo sauce (due to his intolerance to dairy products). His parents are willing for him to try small amounts of new and different foods."</p> <p>The assistant residential director (ARD) was interviewed on 11/18/14 at 8:26 A.M. The ARD stated "The house supervisor was unaware there were dietician menus that she should be using. I have given her the menus and talked about making substitutions for... diet restrictions."</p> <p>This federal tag relates to complaint #IN00159008.</p> <p>9-3-8(a)</p>			

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W000480	<p>483.480(c)(1)(iv) MENUS Menus must include the average portion sizes for menu items. Based on observation, record review and interview, the facility failed to have menus which included the average portion sizes for menu items for 3 of 3 sampled clients (clients A, B and C) and for 2 of 2 additional clients (clients D and E).</p> <p>Findings include:</p> <p>Observations were conducted at the group home where clients A, B, C, D and E lived on 11/12/14 from 3:40 P.M. through 6:17 P.M. Client A was in the kitchen assisting the group home supervisor (GHS) with preparing dinner. The food items prepared that evening were chicken Alfredo, broccoli, dinner</p>	W000480	<p>Menus formulated by a dietician including average portion sizes for menu items have been posted in the group home. Additional menus indicating appropriate substitutions for different nutritional needs will be available in a binder in the kitchen</p> <p>Person Responsible: House supervisor</p> <p>Date Completed: 12/15/14</p> <p>Staff and the supervisor will be trained on using the dietician menus and portion sizes</p>	12/24/2014

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	<p>rolls, peach slices, milk, rice milk, water, fruit punch; ketchup and barbeque sauce were used by clients C and D. There was a handwritten menu posted for the week. It did not indicate portion sizes for each item. There was no menu available indicating how staff should assist the clients with their different dietary needs.</p> <p>Observations were conducted at the group home where clients A, B, C, D and E lived on 11/16/14 from 2:17 P.M. through 4:11 P.M. There was another hand written menu posted for the current week. None of the items on the menu was located in the home. The menu did not include Monday's meals. Tuesday's dinner meal consisted of breaded pork chops, rice pilaf, broccoli, fruited jello, bread with butter, milk, juice and pudding and juice for snack in the evening. The posted menu did not include portion sizes or dietary substitutions for clients' dietary needs.</p> <p>The assistant residential director (ARD) was interviewed on 11/18/14 at 8:26 A.M. The ARD stated "The house supervisor was unaware there were dietician menus that she should be using. I have given her the menus and talked about making substitutions for... diet restrictions and portion sizes."</p>		<p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>The supervisor will be trained on how to appropriately grocery shop for the group home according to the menus formulated by a dietician and providing an appropriate food supply</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>The group home staff and supervisor will be trained on the client's dining plans</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>The QIDP will complete an observation of the group home during a meal time once a week for 3 months and then once a month ongoing checking for use of dietician formulated menus and</p>	

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W000488	<p>This federal tag relates to complaint #IN00159008.</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview, the</p>	W000488	<p>that adequate food is available in the home for menus. The observations will be documented and any issues noted will be corrected.</p> <p>Person Responsible: QIDP Date Completed: 12/24/14</p> <p>The Assistant Director will do a weekly observation of the group home checking for one month and then once a month ongoing checking for use of dietician formulated menus and that adequate food is available in the home for menus. The observations will be documented and any issues noted will be corrected.</p> <p>Person Responsible: Assistant Director Date Completed: 12/24/14</p>	12/24/2014	

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	<p>facility failed to ensure 3 of 3 sampled clients (clients A, B and C) and 1 of 2 additional clients (client D) participated in all formal and informal opportunities for training in grocery shopping. The facility failed to ensure clients C and D ate in a family-style manner, including eating with other clients and training on manners.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/12/14 from 3:40 P.M. through 6:18 P.M. At 3:40 P.M. the group home supervisor (GHS) had just returned from grocery shopping for items for the evening meal and other food items. The GHS had not had any of the clients go to the grocery store with her to participate in grocery shopping. Client A arrived home first on the city bus. She began to prepare the evening meal with the group home supervisor. At 4:43 P.M. clients C and D entered the group home and selected a movie to watch and watched the movie throughout the entire observation period. Client B had arrived home at the same time as clients C and D but remained on the van.</p> <p>Client A's ABAS (adaptive behavior assessment system) dated 5/2014 was reviewed on 11/13/14 at 12:57 P.M. and</p>		<p>The staff and supervisor will be trained on family style dining including eating with other clients and training on manners</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>Menus formulated by a dietician have been posted in the group home. Additional menus indicating appropriate substitutions for different nutritional needs will be available in a binder in the kitchen</p> <p>Person Responsible: House supervisor</p> <p>Date Completed: 12/15/14</p> <p>Staff and the supervisor will be trained on using the dietician menus and portion sizes</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p>	

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	<p>indicated Client A needed to work on home living skills and community use.</p> <p>Client B's ABAS dated 10/2014 was reviewed on 11/13/14 at 1:21 P.M. and indicated Client B needed to work on home living skills and community use.</p> <p>Client C's ABAS dated 5/2014 was reviewed on 11/13/14 at 3:25 P.M. and indicated Client C needed to work on home living skills and community use.</p> <p>Client D's ABAS dated 7/2014 was reviewed on 11/13/14 at 3:48 P.M. and indicated Client D needed to work on home living skills and community use.</p> <p>Confidential interviews (CI) were conducted between the dates of 11/12/14 and 11/20/14.</p> <p>CI #9 "The house supervisor (HS) shops a lot and is gone for hours. She will come back with just a couple of bags of food. I've never seen her take clients with her."</p> <p>CI #11 "The HS goes to the grocery store by herself all the time. She never takes clients with her. Some of the clients love to go. She goes almost daily and there is never the right food in the house to make what is on the menu of to follow the clients' diets."</p>		<p>The supervisor will be trained on how to appropriately grocery shop for the group home according to the menus formulated by a dietician and providing an appropriate food supply</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>The group home staff and supervisor will be trained on the client's dining plans</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 12/24/14</p> <p>The QIDP will complete an observation of the group home during a meal time once a week for 3 months and then once a month ongoing checking for family style dining and staff training on manners. The observations will be documented and any issues noted will be corrected.</p> <p>Person Responsible: QIDP</p>	

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	<p>Client B's guardian was interviewed on 11/17/14 at 8:20 A.M. "He (client B) would love to go to the store. He loves to help. He used to carry in the groceries, load the dishwasher, sweep. I just took him to the [name] of store with me on Saturday, and he had no problems at all. He needs to feel like he is doing a meaningful activity."</p> <p>An interview was conducted with the Assistant Residential Director (ARD) on 11/18/14 at 8:26 A.M. The ARD stated, "The HS usually takes [client C], [client A] and [client D] grocery shopping with her after dinner. On Wednesday (11/12/14) our scheduler called the HS and asked her to work at another house that was short staffed so she went grocery shopping early, before the clients got home. This is not the norm. I was at the house yesterday and looked in the cabinets and refrigerator. There is almost no food in the freezer in the kitchen but the deep freezer in the garage had plenty of food. There is a three day supply of food. Because three of the clients are overweight, they do not keep a lot of snack food on hand. The HS goes grocery shopping twice a week."</p> <p>2. Observations were conducted at the group home on 11/12/14 from 3:40 P.M.</p>		<p>Date Completed: 12/24/14</p> <p>The Assistant Director will complete an observation of the group home during a meal time once a week for 3 months and then once a month ongoing checking for family style dining and staff training on manners. The observations will be documented and any issues noted will be corrected.</p> <p>Person Responsible: Assistant Director</p> <p>Date Completed: 12/24/14</p>	

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	<p>through 6:18 P.M. At 4:43 P.M. clients C and D entered the group home and selected a movie to watch and watched the movie throughout the entire observation period even during the evening meal which they ate in the living room. Client C put barbeque sauce on her chicken fettuccini Alfredo. Client D put ketchup on her chicken fettuccine Alfredo. Client C was observed with barbeque sauce on her chin through out most of her meal. Staff did give a verbal prompt for her to wipe her chin. There was no other reinforcement of manners and social behaviors.</p> <p>Client C's ABAS dated 5/2014 was reviewed on 11/13/14 at 3:25 P.M. and indicated Client C needed to work on home living skills, socialization skills and communication skills.</p> <p>Client D's ABAS dated 7/2014 was reviewed on 11/13/14 at 3:48 P.M. and indicated Client D needed to work on home living skills, socialization skills and communication skills.</p> <p>The assistant residential director (ARD) was interviewed on 11/18/14 at 8:26 A.M. The ARD stated "[Client C] sometimes wants to watch her DVD player while eating dinner. When she does this, the other clients complain</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G415	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/24/2014
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NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 8626 STANDRIDGE RUN FORT WAYNE, IN 46825
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(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
	<p>because the DVD player is disruptive and loud. Staff should be encouraging her to pause her movie and eat in the kitchen with the rest of the clients, but if she refuses she is allowed to eat at the table in the living room. We have talked about adding this to her new behavior plan.</p> <p>There is no reason that I am aware of, for [client D] to be eating in the living room. I have created a training on active treatment and am addressing this issue with the house supervisor and staff."</p> <p>This federal tag relates to complaint #IN00159008.</p> <p>9-3-8(a)</p>			