

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G576	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/14/2016
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NAME OF PROVIDER OR SUPPLIER  BI-COUNTY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 503 N THIRD ST DECATUR, IN 46733
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W 0000  Bldg. 00	<p>This visit was for an extended annual recertification and state licensure survey.</p> <p>Dates of Survey: January 11, 12, 13 and 14, 2016.</p> <p>Facility number: 001090 Provider number: 15G576 AIM number: 100245540</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/20/16.</p>	W 0000		
W 0122  Bldg. 00	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based upon observation, record review, and interview, the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policy and procedures to protect 1 of 3 sampled clients (client #1) from access to unsafe food.</p>	W 0122	<p><b>Third Street Fundamental Recertification &amp; State Licensure Survey</b></p> <p><b>Noncompliance with Conditions of Participation Plan of Correction Survey Event ID BE4E11 January/February 2016</b></p> <p><b>W122-Condition of</b></p>	02/13/2016

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

TITLE

(X6) DATE

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

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	<p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to prevent abuse, neglect and mistreatment for 1 of 4 sampled clients (client #1). The facility failed to implement effective corrective action to protect client #1 from access to unsafe food. Please see W149.</p> <p>2. The facility failed for 1 of 4 sampled clients to develop and implement effective corrective action to protect client #1 from access to unsafe food after a history of eating unsafe food was identified. Please see W157.</p> <p>9-3-2(a)</p>		<p><b>Participation: Client Protections</b> BCS must ensure the rights of allclients. We understand this obligation exists even when a client is less thanfully competent and requires that the facility is actively engaged inactivities which result in the protection of the client's rights, advocacy forindividual clients who have no family or inactive family, and training programsfor clients and staff on the understanding of protection of client rights.</p> <p>BCS was found to be deficient in not meeting this conditionby failure to implement the Abuse, Neglect, Exploitation &amp; Violation ofIndividual Rights (A/N) policy to protect client #1 from access to unsafefoods. This was demonstrated by:</p> <p>1.Failure to implement policy toprevent abuse, neglect &amp; mistreatment of client #1's access to unsafe foodsand to implement effective corrective action to protect client #1 from accessto unsafe food. (W149)</p> <p>2.Failure to develop &amp;implement effective corrective action to protect him from access to unsafe foodafter a history of eating unsafe food was identified. (W157)</p> <p>To assure protection &amp; advocacy for client #1the following SAFEGUARDS are in place while the Plan of Correction (POC) for</p>	

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			<p>the Condition of Participation related to Client Protections is being developed, written, trained on and implemented.</p> <ul style="list-style-type: none"> <li>·The group home has been assessed and unsafe food/drink/inedible items have been moved to less accessible areas &amp;/or out of sight. His housemates are able to access items &amp;/or ask for assistance in getting things they want/need. They understand the potential risk for client #1's health/safety &amp; are agreeable to these safety prevention steps. Group home environmental assessment(s) will be ongoing for additional prevention/protection options. (January 15th-17th 2016)</li> <li>·Assuring adequate staffing across all settings to provide protection &amp; prevention.</li> <li>·Making changes in his environment during time frames where access to food is more available; such as snack time so as to not be tempted by others snacks, during evening meal prep &amp; clean-up when he is also tempted to grab something to ingest. (Effective the week of Jan. 18th 2016).</li> <li>·All staff working with client #1 across all settings has been re-trained on client #1's need for 1-1 staffing to assure his safety from eating unsafe foods/drinks by remaining in line of sight (LOS) at all times and being within</li> </ul>	

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			<p>arm'sreach to prevent unsafe food intake. A tag team approach can be used by staffshould they tire from the high energy level required when working with client#1. (Week of Jan. 18th 2016)</p> <ul style="list-style-type: none"> <li>Retraining on current pertinent plans, including but not limited to riskplans for dining/dysphagia/GERD/aspiration risk; unawareness of environmental dangers/personal safety; BSP; Providing a Healthy &amp; Safe Environment for client#1 (consumer specific training) and Staff Assignment Protocol with DCS workingwith him. A/N policy retraining with focus on preventing abuse/neglect throughprotection of rights. (Week of Jan. 25th 2016).</li> <li>Visits with family continue to be encouraged at the group home &amp;/orsupervised in the family home, although this continues to be resisted. ATherapeutic Leave form has been developed to use with family for trainingpurposes &amp; reminders prior to visits. This addresses his medications,dining plan, and assuring that they are provided with pureed food and nectarthickened liquids during home visits. (1/13/16).</li> <li>Regular contact with his personal care physician, Dr. Ottenweller, whodesires that he not have unsupervised home visits, but does understand thepotential for the family pulling client #1 from services placing</li> </ul>	

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			<p>him at highrisk. She continues to counsel with the family about the deadly potential for whenhe has access to unsafe food/drink items. (Ongoing).</p> <ul style="list-style-type: none"> <li>·Continued involvement with the Children's Autism Center staff, both ofwhich are certified Applied Behavior Analysis (ABA) Behavior Analyst &amp;Therapist. (1/20/16)</li> <li>·Case analysis by the Indiana Chapter of Developmental DisabilitiesNursing Association on 1/27/16.</li> <li>·Home Observations by administrative team members weekly, as wellResidential Manager (RM) weekly.</li> <li>·Continued efforts to locate behavioral &amp;/or other professionals withexpertise or experience working with autistic individuals with severe/profounddiagnoses who are also non-verbal.</li> </ul> <p>Please reference specific corrective action andfollow-up specific to Client #1 in the W149 &amp; 157 tag responses.</p> <p>Person's responsible: PD; QIDP; RMT's &amp; QAM.</p> <p>Target completion date: 2/13/16.</p>	

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W 0149  Bldg. 00	<p>483.420(d)(1) <b>STAFF TREATMENT OF CLIENTS</b> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based upon observation, record review and interview, the facility neglected to ensure implementation of its policy and procedures which prohibited abuse and neglect by failing to protect 1 of 3 sampled clients (client #1) from access to unsafe food.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 1/11/16 at 4:50 PM and included the following reports involving client #1:</p> <p>1. A report dated 12/27/15 indicated client #1 was admitted to the hospital with aspiration pneumonia. Client #1 had returned to the group home on 12/26/15 after a home visit with family with coughing and vomiting. Client #1's coughing and vomiting dissipated after he returned to the group home, but resumed the following day upon awakening and he was taken to the hospital for evaluation. Corrective action indicated the residential management "will discuss with [client #1's] family</p>	W 0149	<p><b>W149-Staff Treatment of Consumers</b> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the consumer.</p> <p>BCS neglected to implement the A/Npolicy to <b>prevent</b> consumer #1 from access to unsafe food and to implement effective corrective action to <b>protect</b> him from access to unsafe food which is a serious health/safety risk with potential for aspiration.</p> <p>1. Corrective Action and Follow-Up Specific to Consumer #1 (hereafter referred to as C1): 1. Neglect was substantiated for C1 as BCS did not take enough steps to prevent recurrence of access to unsafe foods leading to two ER visits due to concerns about possible aspiration, which were not; two hospitalizations for aspiration, both following family home visits, and family taking him to the ER after ingesting rubbing alcohol while at their home. Preventative measures provided to family to assist with making home visits as safe as possible include, but are not limited to: 1. Encouraging family visits at</p>	02/13/2016	

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	<p>their need for additional supports during the visits to their home, including the offer of providing a staff, which has been refused previously." An undated follow up indicated client #1 remained hospitalized due to the severity of his condition. Client #1's "current risk plans appear to work for him while at [group home], however, historically we find that his family is not compliant with the plans resulting in increased risk for aspiration...." A follow up dated 1/11/16 indicated client #1 was discharged from the hospital on 1/6/16. Corrective action indicated "All staff will be retrained on [client #1's] dining/risk of aspiration risk plan. [Client #1's] family will be educated and provided an updated version of this plan as well. We are currently working in connection with the BDDS and Adult Protective Services to find a better way to better ensure [client #1's] safety across all settings including during visits to his family's home. [Client #1's] primary care physician, [Doctor's name], has written an order that he not have unsupervised visits in his family's home due to recurrent aspiration pneumonia and failure of his parents to follow his dietary restrictions."</p> <p>2. A report dated 11/8/15 indicated client #1 was taken to the hospital due to prolonged coughing and vomiting while</p>		<p>the group home rather than at the family home.</p> <p>2. Providing BCSstaff for support during the family home visits. This has not been acceptable to the family.</p> <p>3. Providing family with current risk plans &amp; offering additional training/review if needed, especially regarding dining plan &amp; aspiration concerns. .</p> <p>4. Providing pureed meals and Thick-It for all visits to the family.</p> <p>5. Primary Care Physician (PCP) provides education/counseling to the family, in particular his mother/co-health care representative (HCR), who attends appointments with the QIDP &amp; C1 on a regular basis. The PCP has been very direct with his mother that this having access to unsafe foods &amp; eating non-pureed food/drinking unthicken liquids can potentially kill him due to aspiration. She always agrees that they will follow the plan &amp; understand the seriousness.</p> <p>6. A therapeutic leave agreement for family home visits was developed/implemented in January 2016 to assist with increased cooperation with medication administration, dining/aspiration risk plan and other items that might be pertinent, such as updates for needing more Thick-It &amp;/or pureed meals.</p> <p>1. Due to the PCP's significant concerns regarding C1's</p>		

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	visiting his family in their home and when arriving back to the [group home]. Upon arrival in the emergency room a chest x-ray and labs (laboratory tests) were completed. [Client #1] was diagnosed with possible aspiration. It is possible [client #1] received unthicken (sic) liquid and food that was not pureed while away from the group home. Due to [client #1] continuing to vomit and cough he was admitted to the hospital. [Client #1] will remain hospitalized until his coughing and vomiting subside and his condition improves...." A follow up report (undated) indicated client #1 had received unthickened liquids from his family which had been aspirated into his lungs. Client #1's family "is neglectful in providing [client #1] a safe space free of non-pureed food and thin liquids while he is in their care. They have self-reported their failure to use the provided Thick-it when giving [client #1] drinks...the plan has been reviewed with the family." The report indicated client #1 had been discharged from the hospital on 11/10/15 and client #1's "family had been encouraged to visit [client #1] at the group home rather than taking him home until the antibiotics prescribed at the hospital were finished and [client #1's] cough subsides." Corrective action indicated "Due to continuing issues regarding staff assistance and supervision		health/safety while in his family's care, she wrote an order that he not have any unsupervised family home visits due to recurrent aspiration pneumonia and failure of family to follow his dietary restrictions. This has become a challenging endeavor for the IST & BCS due to the restrictive nature of individual freedoms for C1 & his family; consideration & input from BDDS, APS & SDOH that the PCP is just one member of the team & as such cannot override a team decision; concerns that the family might "pull him from services" if their visits are restricted/supervised as stated to QIDP & Program Director (PD) and cleared by C1's father & co-HCR. The PCP has requested us to seek legal advice (lawyer, judge) to make the order for no unsupervised family home visits stand". The following steps are being taken to address her concerns, the family's and the potential of C1 being pulled by family from services: 1. 2-3 members of the Human Rights Committee (HRC) will be asked to review C1's status & assist with guidance & direction regarding what seems to be ethical questions. The members of the HRC being asked to review our concerns include the HRC Chairperson who is an attorney with years of experience with vulnerable populations & advocacy for rights, a retired		

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	<p>while visiting his family in their home we will suggest providing staff assistance and supervision if [client #1's] family continues to request visits in their home. Visits at the [group home] will be encouraged."</p> <p>3. A report dated 9/30/15 indicated client #1 was taken to the hospital due to the risk of possible aspiration after he drank a glass of unthicken (sic) glass of water during a home visit with family and upon his return to the group home staff heard a "rattling sound" in his chest. Client #1 was diagnosed with seasonal allergies. Corrective action indicated client #1 would be monitored for worsening symptoms and his dining plan would be followed.</p> <p>Additional BDDS reports involving client #1 from 1/15 were reviewed on 1/12/16 at 10:34 AM and indicated the following:</p> <p>4. A report dated 7/30/15 indicated client #1 was taken to the hospital due to vomiting and the risk of aspiration. A chest x-ray was clear and client #1 was prescribed an anti-nausea medication and discharged to the group home.</p> <p>5. A report dated 3/22/15 indicated client #1 was taken to the emergency room by</p>		<p>physician and a pharmacist. Their input &amp; guidance will assist us in developing plans that focus on C1's protection of rights, as well as prevention of neglect.</p> <p>2. Continued contact &amp; conversations with the PCP, family &amp; other pertinent team members in order to keep communication open and work toward the health, safety &amp; well-being of C1.</p> <p>1. Reference W122 for C1 Safeguards for additional supports in place.</p> <p>2. Appointment with Rick Cain, psychiatric nurse practitioner scheduled for 2/2/16 for psychiatric oversight and psychotropic medication reviews. An observation/assessment at the group home with C1 is requested for additional support &amp; recommendations related to behavioral consultation.</p> <p>3. The QIDP will be reviewing &amp; revising as needed Risk Plans, Consumer Specific Training &amp; other identified assessments, protocols, etc.</p> <p>4. C1's annual BSP is scheduled for review by the HRC on 2/24/16 and the QIDP is currently focusing attention on more restrictive measures in the plan in order to provide increased protection from high risk health/safety concerns through prevention of neglect. Input from the HRC review team will be an important component of the BSP as well.</p> <p>5. Upcoming annual case</p>	

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	<p>his parents after he ingested a bottle of rubbing alcohol while at their home. The physician indicated the rubbing alcohol was non-toxic. Corrective action indicated client #1 had a plan to address eating unsafe foods and all staff had been trained on the plans. An updated follow up report indicated client #1's family had been provided a copy of client #1's risk plan and "staff and management will provide assistance and training as requested or needed to [client #1's family] to aid in preventing future incidents."</p> <p>Observations were completed at the group home on 1/11/16 from 5:19 PM until 6:37 PM. During the evening meal, client #1 periodically walked around the table where clients #3, #4, #5 and #6 ate their meal of chicken strips, mashed potatoes and gravy and cooked carrots and staff followed behind him picking up food items to keep them out of client #1's reach. There was a bowl of chicken strips on the table. Client #1 grabbed a mug and attempted to drink from it before being redirected by staff and periodically opened the refrigerator door to look for food items before staff redirected him to bring out applesauce. Client #1's relatives arrived at the group home at 6:00 PM to visit client #1. Client #1 sat on the floor of the kitchen and picked up bits of food</p>		<p>conference for C1's ISP for implementation 4/1/16 will provide another opportunity for the IST to meet and discuss appropriateness of programming goals/objectives in order to best meet his needs through the assessment, consultation and review process identified in this POC.</p> <p>6. The agency RN's will continue to provide support and hands on involvement in C1's health/safety, plans and monitoring/participation of appointments with his specialists &amp; other health care professionals.</p> <p>7. At the group home, the shift duty lists, C1's Staff Assignment Protocol &amp; other DCS &amp; RM responsibilities will include, but not be limited to:</p> <p>1. Assuring that the floors are swept and kept clean at all times to avoid his picking up &amp; eating items dropped, etc. Trash will be out of his line of sight so as not to be tempting.</p> <p>2. C1 will be kept in LOS by 1-1 staff within arm's reach at all times during waking hours for his protection.</p> <p>3. Changing his environment during time frames when unsafe food is most available to grab (afternoon snack time, dinner prep &amp; clean up, etc.) to decrease his compulsion to eat/drink anything within reach.</p> <p>4. Measuring his food prior to pureeing to monitor portions per</p>		

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	<p>on the floor and then picked up a piece of cat kibble from a bowl placed on a cabinet and placed it in his mouth. Relative #1 placed his finger in client #1's mouth and attempted to remove the cat kibble.</p> <p>Client #1's relatives were interviewed on 1/11/16 at 6:10 PM and indicated client #1 visited the family home twice weekly and spent the night at the family home every other weekend. Relative #1 stated client #1 "aspirates on a dime," and "the biggest problem is overeating. He needs a cup sized or 8 ounces" as his stomach had been surgically reduced to the "size of an egg" and "his esophagus is messed up." Relative #1 indicated he thought client #1 sometimes was given too much food. Relative #2 indicated a concern of food that was left on the floor of the group home kitchen.</p> <p>The House Manager (HM) was interviewed on 1/11/16 at 6:20 PM and indicated the floor of the kitchen was normally swept after the meal, but clients #2, #3, #4 and #5 had left the group home for a basketball game and had not swept the floor before leaving. The HM stated when asked about the cat food "That's the first I've seen him get cat food off the counter. It's a new thing-we put it (cat food) up there (off the floor)." Staff #1</p>		<p>his diet.</p> <ol style="list-style-type: none"> <li>1. Ongoing DS assessment of classroom &amp; agency environmental needs &amp; adequate staffing supports available that setting will be monitored regularly by DS Coordinator, RM, QIDP &amp; Administrative Team to assure C1's health/safety needs are being met.</li> <li>2. An activity assessment by the BCS Activity Coordinator with a degree in Recreation Management will be completed to see if there are any suggestions for activities which might be of interest to him. We will continue to look for activities of interest, as well as ideas for potential relaxation techniques for him such as his "hammock swing". Having more options/activities to try would be to his benefit and for staff.</li> <li>3. We will continue to monitor staff treatment of consumers through the Home Observation (HO) process with weekly, random drop-in times by management and administrative teams at the group home. Follow-up on any concerns will be completed.</li> <li>4. All DCS working with C1 across all settings will receive A/N policy retraining with a focus on preventing abuse/neglect &amp; protection of rights.</li> <li>5. All DCS working with C1 across all settings will be trained on all new &amp;/or revised plans &amp; protocols utilizing competency tests for high risk priority plans.</li> </ol>				

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	<p>then swept the kitchen floor with client #6.</p> <p>Client #1's Health Risk Plan revised July 22, 2015 located in the group home records was reviewed on 1/11/16 at 6:28 PM and indicated client #1 was at risk for choking and aspiration due to being unable to adequately chew and swallow most regularly textured food. The plan indicated client #1 had a surgery to reduce the size of his stomach due to erosion. Client #1 was hospitalized in November, 2013 with aspiration pneumonia resulting from liquid or food aspiration. "It was determined at that time that he is at the highest risk for aspiration when drinking or eating while walking or doing any other activity." The plan indicated he was to receive a pureed diet with nectar thickened liquids and eat 5-6 small meals each day consisting of whole portions of an entree and 1/2 portions of all other menu items. Client #1 "frequently attempts to eat food that is not pureed, posing a choking risk due to unmodified texture...." Client #1 was to be on "1:1 (one to one) supervision during the meal preparation, mealtime, and meal clean-up routine in his home to limit his risk for eating these unsafe foods...Staff is to place themselves between [client #1] and the desired food item(s) at all times...Staff across all</p>		<p>6. At least oncemonthly at home &amp; C1's DS classroom, training for staff &amp; consumers onunderstanding and advocating for consumer's rights &amp; protections willoccur.</p> <p>7. RMT memberswill be trained on the primary components involved with each W tag cited inthis POC so as to have a better understanding of the regulations to assure thatall consumers have quality of care, protection of rights, etc. Competencytesting will be completed on A/N policy related to the condition of participationin assuring prevention, protection of rights, developing &amp; implementingeffective corrective action once a trend/concern is identified so as to preventrecurrence. Training will also encourageRMT members to utilize competency testing to assure that staff are beingtrained thoroughly in order to do their jobs competently &amp; effectively asprevention to A/N. Also training will include the importance of utilizing HO'sas a prevention tool and support for staff. RMT training scheduled for 2/4/16</p> <p>8. All DCS workingwith residential consumers across all settings will be trained on the A/Npolicy and consumer rights &amp; protections.</p> <p>Person's responsible: PD; QAM; QIDP, RM and RA.</p>	

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	<p>settings need to be aware of all food items and drinks in [client #1's] environment and remove them when possible. Strategies for dealing with this behavior are outlined in his Behavior Support Plan (BSP)...."</p> <p>Observations were completed at the group home on 1/12/16 from 7:12 AM until 8:10 AM. Client #1 walked around the table and staff #8 picked up a plate of waffles, and a container of cereal to prevent client #1 from obtaining them. Client #1 reached for discarded cereal in the sink before staff #8 redirected him. Client #1 sat at the table next to staff and across from client #3 as staff #8 assisted him to eat applesauce and a container of yogurt. Staff #8 poured a second helping of applesauce into a bowl without measuring it and client #1 was assisted to eat it with a spoon.</p> <p>Staff #8 was interviewed on 1/12/16 at 7:40 AM and when asked how often client #1 was able to obtain non-pureed food and thin liquids, she stated, "once daily."</p> <p>Client #1's BSP dated 3/1/15 was reviewed at the facility's office on 1/12/16 at 10:05 AM and indicated target behaviors of self injurious behavior, physical aggression and eating unsafe</p>		<p>Target completion date: 2/13/16</p> <p>1. Corrective Action as it relates to BCSpractices agency wide: 1. All SLMT &amp; any other identified supervisory staff will be trained on A.16 above to ensure that all consumers receiving services are free from mistreatment consistently across all settings. They will then be responsible for training SL DCS on A.17 at their next staff/house meetings.</p> <p>Person's Responsible: RA, QAM &amp; SLMT's Target completion date: 2/13/16</p>	

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	<p>food. Client #1 "will sometimes attempt to remove and eat discarded or partially eaten food from the trash and floor. If the opportunity presents itself, [client #1] will steal food and drink from other's plates and hand while they attempt to eat or drink." Interventions for unsafe eating indicated client #1 was to be verbally redirected to inform him of unsafe food as staff "gently guide him away from the food or drink." Staff were to remove food or drink from his hand as gently as possible and if the unsafe food is already in his mouth, staff were not to attempt to remove it as client #1 may bite. Staff were to position themselves between client #1 and unsafe food and beverage and attempt to engage him in other activity.</p> <p>Client #1's undated menu was reviewed on 1/12/16 at 9:50 AM and indicated he was to receive 1/2 cup of cereal, 1/4 cup of egg for breakfast and was to receive 1/2 cup of tuna salad, 1 cup of cereal and 1/2 cup of cabbage for dinner.</p> <p>Client #1's Behavior Tracking Sheet from 2/15-12/15 was reviewed on 1/12/16 at 11:00 AM and indicated client #1 was successful in obtaining unsafe food or drink 61 times in 2/15, 39 times in March, 2015, 23 times in June, 2015, 27 times in July, 2015, 42 times in July,</p>			

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	<p>2015, 16 times in October, 2015, 12 times in November, 2015 and 38 times in December, 2015.</p> <p>The Program Director (PD), group home nurse and QIDP (Qualified Intellectual Disabilities Professional) were interviewed on 1/12/16 at 9:50 AM and indicated client #1's incidents of aspiration pneumonia on 12/27/15 and 11/8/15 were a result of client #1 consuming unsafe food/beverage during home visits. Client #1 consumed corn casserole and chips when a family member who was supposed to be supervising him fell asleep during a home visit prior to his hospitalization for aspiration pneumonia on 12/27/15 and client #1 drank thin liquids at the family home prior to being hospitalized on 11/8/15. The PD indicated the group home was unable to implement client #1's primary care physician's order to restrict visits home with his family to be supervised based upon consultation with Adult Protective Services (APS). The PD indicated client #1's family had been provided pureed food and nectar thickened liquids during home visits and had been counseled upon the importance of following client #1's dining plan. The QIDP indicated the cat food was not usually a target for client #1 and it was moved to the porch or the laundry room</p>			

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	<p>if client #1 showed an interest in obtaining the food. The QIDP stated, "As long as he's awake, he's looking (for food)," and indicated the floor should be swept to ensure no food bits are left. "If there's a little bit, he's (client #1) on it." The QIDP indicated client #1 preferred applesauce and yogurt for his meals. The nurse indicated the amount of applesauce and yogurt client #1 received during the observations was in keeping with the amount of food client #1 was to receive. When asked if eating bits of food or cat kibble placed client #1 at risk the group home nurse stated, "It could be deadly." The QIDP indicated staff are to attempt to engage client #1 in activity to distract him during meal preparation and clean up, but he had little interest in most activities. The QIDP indicated a new swing had been purchased for client #1, but he had not shown interest in using it yet.</p> <p>The facility's Abuse and Neglect, Exploitation and Violation of Individual Rights revised 1/15 was reviewed on 1/11/16 at 4:31 PM and indicated "Employees of Bi-County Services have the responsibility to ensure the protection of all consumers. This means that our consumers are free of mistreatment from abuse, neglect, exploitation or a violation of individual rights...NEGLECT is a</p>			

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W 0157 Bldg. 00	<p>failure to provide necessary supports needed to avoid physical harm and/or mental suffering."</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based upon observation, record review and interview, the facility failed to implement effective corrective action to protect 1 of 3 sampled clients (client #1) from access to unsafe food.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of</p>	W 0157	<p><b>W157-Staff Treatment of Clients</b> Appropriate corrective action must be taken for violations of protection of client rights.</p> <p>BCS failed to develop &amp; implement effective corrective action to protect C1 from access to unsafe food after a history of eating unsafe food was identified.</p>	02/13/2016

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	<p>Developmental Disabilities Services (BDDS) were reviewed on 1/11/16 at 4:50 PM and included the following reports involving client #1:</p> <p>1. A report dated 12/27/15 indicated client #1 was admitted to the hospital with aspiration pneumonia. Client #1 had returned to the group home on 12/26/15 after a home visit with family with coughing and vomiting. Corrective action indicated the residential management "will discuss with [client #1's] family their need for additional supports during the visits to their home, including the offer of providing a staff, which has been refused previously." An undated follow up indicated client #1 remained hospitalized due to the severity of his condition. Client #1's "current risk plans appear to work for him while at [group home], however, historically we find that his family is not compliant with the plans resulting in increased risk for aspiration...." A follow up dated 1/11/16 indicated client #1 was discharged from the hospital on 1/6/16. Corrective action indicated "All staff will be retrained on [client #1's] dining/risk of aspiration risk plan. [Client #1's] family will be educated and provided an updated version of this plan as well. We are currently working in connection with the BDDS and Adult Protective Services to</p>		<p>As it relates to this W157 tagand the Condition of Participation for client protections, we duly note that thesubstantiated neglect in protecting C1 from access to unsafe food did not gofar enough in meeting the criteria for "appropriate" corrective action definedas action which is reasonably likely to prevent neglect from recurring. Knowingthat the potential for neglect for C1 when he has access to unsafe food/drinkposes a serious threat to his health &amp; safety, we are committed toaggressively pursuing effective corrective action that will protect C1 fromfurther occurrence on our watch. As noted in W122 &amp; 149 tags, there are dynamics to C1's situation that can be environmental factors when on familyhome visits that are currently out of our control and also pertain to otherissues/concerns that could be considered restrictions of individual freedom'sfor C1 &amp; his family.</p> <p>That being said, we feel that thecorrective actions addressed in the W149 tag, which along with this W157 tagare the two standards with deficiencies identified as the components of theCondition of Participation for Client Protections, reflect our plan of actionfor the Staff Treatment of Clients corrective action &amp; follow-up.</p>				

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	<p>find a better way to better ensure [client #1's] safety across all settings including during visits to his family's home. [Client #1's] primary care physician, [Doctor's name], has written an order that he not have unsupervised visits in his family's home due to recurrent aspiration pneumonia and failure of his parents to follow his dietary restrictions."</p> <p>2. A report dated 11/8/15 indicated client #1 was taken to the hospital due to prolonged coughing and vomiting while visiting his family in their home and when arriving back to the [group home]. Upon arrival in the emergency room a chest x-ray and labs (laboratory tests) were completed. [Client #1] was diagnosed with possible aspiration. It is possible [client #1] received unthicken (sic) liquid and food that was not pureed while away from the group home. Due to [client #1] continuing to vomit and cough he was admitted to the hospital. [Client #1] will remain hospitalized until his coughing and vomiting subside and his condition improves...." A follow up report (undated) indicated client #1 had received unthickened liquids from his family which had been aspirated into his lungs. Client #1's family "is neglectful in providing [client #1] a safe space free of non-pureed food and thin liquids while he is in their care. They have</p>		<p><b>Please reference W122 SAFEGUARDS in place for C1 &amp; W149 Corrective Action/ Follow-up &amp; target completion dates in response to this W157 tag.</b></p>	

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	<p>self-reported their failure to use the provided Thick-it when giving [client #1] drinks...the plan has been reviewed with the family." The report indicated client #1 had been discharged from the hospital on 11/10/15 and client #1's "family had been encouraged to visit client #1 at the group home rather than taking him home until the antibiotics prescribed at the hospital were finished and [client #1's] cough subsides." Corrective action indicated "Due to continuing issues regarding staff assistance and supervision while visiting his family in their home we will suggest providing staff assistance and supervision if [client #1's] family continues to request visits in their home. Visits at the [group home] will be encouraged."</p> <p>3. A report dated 9/30/15 indicated client #1 was taken to the hospital due to the risk of possible aspiration after he drank a glass of unthicken (sic) glass of water during a home visit with family and upon his return to the group home staff heard a "rattling sound" in his chest. Client #1 was diagnosed with seasonal allergies. Corrective action indicated client #1 would be monitored for worsening symptoms and his dining plan would be followed.</p> <p>Additional BDDS reports involving</p>			
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	<p>client #1 from 1/15 were reviewed on 1/12/16 at 10:34 AM and indicated the following:</p> <p>4. A report dated 7/30/15 indicated client #1 was taken to the hospital due to vomiting and the risk of aspiration. A chest x-ray was clear and client #1 was prescribed an anti-nausea medication and discharged to the group home.</p> <p>5. A report dated 3/22/15 indicated client #1 was taken to the emergency room by his parents after he ingested a bottle of rubbing alcohol while at their home. The physician indicated the rubbing alcohol was non-toxic. Corrective action indicated client #1 had a plan to address eating unsafe foods and all staff had been trained on the plans. An updated follow up report indicated client #1's family had been provided a copy of client #1's risk plan and "staff and management will provide assistance and training as requested or needed to [client #1's family] to aid in preventing future incidents."</p> <p>Observations were completed at the group home on 1/11/16 from 5:19 PM until 6:37 PM. During the evening meal, client #1 periodically walked around the table where clients #3, #4, #5 and #6 ate their meal of chicken strips, mashed</p>			

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	<p>potatoes and gravy and cooked carrots and staff followed behind him picking up food items to keep them out of client #1's reach. There was a bowl of chicken strips on the table. Client #1 grabbed a mug and attempted to drink from it before being redirected by staff and periodically opened the refrigerator door to look for food items before staff redirected him to bring out applesauce. Client #1's relatives arrived at the group home at 6:00 PM to visit client #1. Client #1 sat on the floor of the kitchen and picked up bits of food on the floor and then picked up a piece of cat kibble from a bowl placed on a cabinet and placed it in his mouth. Relative #1 placed his finger in client #1's mouth and attempted to remove the cat kibble.</p> <p>Client #1's relatives were interviewed on 1/11/16 at 6:10 PM and indicated client #1 visited the family home twice weekly and spent the night at the family home every other weekend. Relative #1 stated client #1 "aspirates on a dime," and "the biggest problem is overeating. He needs a cup sized or 8 ounces" as his stomach had been surgically reduced to the "size of an egg" and "his esophagus is messed up." Relative #1 indicated he thought client #1 sometimes was given too much food. Relative #2 indicated a concern of food that was left on the floor of the</p>			

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	<p>group home kitchen.</p> <p>The House Manager (HM) was interviewed on 1/11/16 at 6:20 PM and indicated the floor of the kitchen was normally swept after the meal, but clients #2, #3, #4 and #5 had left the group home for a basketball game and had not swept the floor before leaving. The HM stated when asked about the cat food "That's the first I've seen him get cat food off the counter. It's a new thing-we put it (cat food) up there (off the floor)." Staff #1 then swept the kitchen floor with client #6.</p> <p>Client #1's Health Risk Plan revised July 22, 2015 located in the group home records was reviewed on 1/11/16 at 6:28 PM and indicated client #1 was at risk for choking and aspiration due to being unable to adequately chew and swallow most regularly textured food. The plan indicated client #1 had a surgery to reduce the size of his stomach due to erosion. Client #1 was hospitalized in November, 2013 with aspiration pneumonia resulting from liquid or food aspiration. "It was determined at that time that he is at the highest risk for aspiration when drinking or eating while walking or doing any other activity." The plan indicated he was to receive a pureed diet with nectar thickened liquids and eat 5-6</p>			
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	<p>small meals each day consisting of whole portions of an entree and 1/2 portions of all other menu items. Client #1 "frequently attempts to eat food that is not pureed, posing a choking risk due to unmodified texture..." Client #1 was to be on "1:1 (one to one) supervision during the meal preparation, mealtime, and meal clean-up routine in his home to limit his risk for eating these unsafe foods...Staff is to place themselves between [client #1] and the desired food item(s) at all times...Staff across all settings need to be aware of all food items and drinks in [client #1's] environment and remove them when possible. Strategies for dealing with this behavior are outlined in his Behavior Support Plan (BSP)...."</p> <p>Observations were completed at the group home on 1/12/16 from 7:12 AM until 8:10 AM. Client #1 walked around the table and staff #8 picked up a plate of waffles, and a container of cereal to prevent client #1 from obtaining them. Client #1 reached for discarded cereal in the sink before staff #8 redirected him. Client #1 sat at the table next to staff and across from client #3 as staff #8 assisted him to eat applesauce and a container of yogurt. Staff #8 poured a second helping of applesauce into a bowl without measuring it and client #1 was assisted to</p>			

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	<p>eat it with a spoon.</p> <p>Staff #8 was interviewed on 1/12/16 at 7:40 AM and when asked how often client #1 was able to obtain non-pureed food and thin liquids, she stated, "once daily."</p> <p>Client #1's BSP dated 3/1/15 was reviewed at the facility's office on 1/12/16 at 10:05 AM and indicated target behaviors of self injurious behavior, physical aggression and eating unsafe food. Client #1 "will sometimes attempt to remove and eat discarded or partially eaten food from the trash and floor. If the opportunity presents itself, [client #1] will steal food and drink from other's plates and hand while they attempt to eat or drink." Interventions for unsafe eating indicated client #1 was to be verbally redirected to inform him of unsafe food as staff "gently guide him away from the food or drink." Staff were to remove food or drink from his hand as gently as possible and if the unsafe food is already in his mouth, staff were not to attempt to remove it as client #1 may bite. Staff were to position themselves between client #1 and unsafe food and beverage and attempt to engage him in other activity.</p> <p>Client #1's Behavior Tracking Sheet from</p>			

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	<p>2/15-12/15 was reviewed on 1/12/16 at 11:00 AM and indicated client #1 was successful in obtaining unsafe food or drink 61 times in 2/15, 39 times in March, 2015, 23 times in June, 2015, 27 times in July, 2015, 42 times in July, 2015, 16 times in October, 2015, 12 times in November, 2015 and 38 times in December, 2015.</p> <p>The Program Director (PD), group home nurse and QIDP (Qualified Intellectual Disabilities Professional) were interviewed on 1/12/16 at 9:50 AM and indicated client #1's incidents of aspiration pneumonia on 12/27/15 and 11/8/15 were a result of client #1 consuming unsafe food/beverage during home visits. Client #1 consumed corn casserole and chips when a family member who was supposed to be supervising him fell asleep during a home visit prior to his hospitalization for aspiration pneumonia on 12/27/15 and client #1 drank thin liquids at the family home prior to being hospitalized on 11/8/15. The PD indicated the group home was unable to implement client #1's primary care physician's order to restrict visits home with his family to be supervised based upon consultation with Adult Protective Services (APS). The PD indicated client #1's family had been provided pureed food and nectar</p>			

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	<p>thickened liquids during home visits and had been counseled upon the importance of following client #1's dining plan. The QIDP indicated the cat food was not usually a target for client #1 and it was moved to the porch or the laundry room if client #1 showed an interest in obtaining the food. The QIDP stated, "As long as he's awake, he's looking (for food)," and indicated the floor should be swept to ensure no food bits are left. "If there's a little bit, he's (client #1) on it." When asked if eating bits of food or cat kibble placed client #1 at risk the group home nurse stated, "It could be deadly." The QIDP indicated staff are to attempt to engage client #1 in activity to distract him during meal preparation and clean up, but he had little interest in most activities. The QIDP indicated a new swing had been purchased for client #1, but he had not shown interest in using it yet.</p> <p>9-3-2(a)</p>			

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W 0159 Bldg. 00	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based upon record review and interview, the QIDP (Qualified Intellectual Disabilities Professional) failed to complete routine visits to the group home to ensure ISP (Individual Support Plan) implementation for 3 of 3 sampled clients (clients #1, #2 and #3) and 3 additional clients (clients #4, #5 and #6). The QIDP failed to obtain consent for 1 of 3 sampled client's (client #1's) plan.</p> <p>Findings include:</p> <p>1. Observations and visits to the group home to assess for active treatment for clients #1, #2, #3, #4, #5 and #6 by the QIDP were reviewed on 1/13/15 at 3:30 PM and indicated visits to the home on 5/8/15 from 10:00 PM until 10:02 PM and again on 5/14/15 from 12:20 AM until 12:50 AM.</p> <p>The Program Director and QIDP were interviewed on 1/14/16 at 12:55 PM and indicated there were gaps in evidence of QIDP observation reviews.</p>	W 0159	<p><b>W159-QIDP</b> Each client's active treatment program must be integrated, coordinated and monitored by a QIDP.</p> <p>BCS failed to have documentation of the time spent by the QIDP completing routine visits to the group home to ensure ISP implementation and failure to have written informed consent for C1's BSP &amp; from the HCR &amp; consumer.</p> <p>1. Corrective Action and Follow-Up Specific to Third Street Consumers and C#1: 1. The QIDP makes regular visits to the home at a minimum of twice weekly, however, there is no documentation of those visits other than the few home observations indicated in the findings section of the citation. There is documentation available of time spent at the group home through the AccelTrax payroll and billing system. In the future the QIDP will document those visits to the home through the AccelTrax note/documentation section. Also Home Observations</p>	02/13/2016

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	<p>2. The QIDP failed to ensure written informed consent was obtained for 1 of 3 sampled clients (client #1), for the use of restrictive interventions in behavior support plans (psychotropic medications and physical guidance from unsafe food). Please see W263.</p> <p>9-3-3(a)</p>		<p>will be completed at least monthly with a focus on monitoring active treatment, identifying staff training needs &amp; competency in implementing plans and behavior management. I would be remiss in not acknowledging that although the QIDP standard was not met during this survey process, she is a top notch QIDP. She performs other professional staff duties at the agency and as such it would be ideal to have someone available to provide additional support as a QIDP-Designee. Her ISP's are definitely individualized and she demonstrates great skills in addressing the complexity of needs manifested by the six men living in the group home.</p> <p>2. Written/signed informed consents for C1's BSP components including use of restrictive interventions and medication side effects/risks &amp; benefits have been in the past the responsibility of the Residential Secretary once the BSP has been forwarded by the QIDP for signatures. That position was eliminated and during the time frame before the Administrative Assistant position was developed &amp; started we obviously missed some consent signature(s) follow-up. Since August of 2015, this problem has resolved itself moving forward. We will continue with the Administrative Assistant monitoring &amp; assuring signatures</p>		

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			<p>indicating informed consent has been given by guardians,HCR's and consumers. The QIDP is responsible for forwarding all plans for HRCreview/approval in a timely manner to the Administrative Assistant in order forguardians/HCR's to have time to review the plans and provide consent prior tothe HRC meetings.</p> <p>3.Training on QIDP standardcomponents, including regulatory guidance &amp; facility practices will beprovided to all RMT members at a POC meeting scheduled for 2/4/16. This training will also include the specific items cited in A.1 &amp; A.2 above of routine visits to the home to ensure ISP implementation and the agency processfor QIDP's to forward BSP's for HRC review to the Administrative Assistant in atimely manner for guardian/HRC informed consent signatures. Person's responsible: PD, QIDP's, RM's &amp; AdministrativeAssistant Target completion date: 2/13/16</p> <p>1. Corrective Action as it relates to BCSpractices agency wide: 1.All QIDP's working in the SL programwill receive training on the QIDP role as indicated in A.1 above by 2/13/16. SLQIDP's are not responsible for the BSP components as this is done by theBehavior Specialists/Consultants for waiver</p>	

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W 0164 Bldg. 00	<p>483.430(b)(1) PROFESSIONAL PROGRAM SERVICES Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (clients #1), the facility failed to assure the professional program services clinician (behavioral consultant) was available in the group home to develop and ensure implementation of their behavior plans.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 1/11/16 at 4:50 PM and included the following reports involving client #1:</p> <p>1. A report dated 12/27/15 indicated client #1 was admitted to the hospital with aspiration pneumonia. Client #1 had returned to the group home on 12/26/15</p>	W 0164	<p>consumers who have that service in their waiver budgets.</p> <p>Persons responsible: PD, RA, &amp; QAM.</p> <p><b>Target Completion date:</b> <b>2/13/16</b></p> <p><b>W164-Professional Program Services</b> Each client must receive the professional program services needed to implement the active treatment program defined by each client's ISP.</p> <p>BCS failed to assure that a professional program services clinician (behavioral consultant) was available in the group home to develop and ensure implementation of their behavior plans.</p> <p>We couldn't agree more that the effectiveness of the active treatment effort is dependent on assembling competent teams with multidisciplinary approaches as part of consumers IST's. And we would be grateful for and have sought out guidance &amp; referral recommendations for Behavior Consultant from a variety of sources including</p>	02/13/2016

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	<p>after a home visit with family with coughing and vomiting. Corrective action indicated the residential management "will discuss with [client #1's] family their need for additional supports during the visits to their home, including the offer of providing a staff, which has been refused previously."</p> <p>2. A report dated 11/8/15 indicated client #1 was taken to the hospital "due to prolonged coughing and vomiting while visiting his family in their home and when arriving back to the [group home]. Upon arrival in the emergency room a chest x-ray and labs (laboratory tests) were completed. [Client #1] was diagnosed with possible aspiration. It is possible [client #1] received unthicken (sic) liquid and food that was not pureed while away from the group home."</p> <p>3. A report dated 9/30/15 indicated client #1 was taken to the hospital due to the risk of possible aspiration after he drank a glass of unthicken (sic) glass of water during a home visit with family and upon his return to the group home staff heard a "rattling sound" in his chest. Client #1 was diagnosed with seasonal allergies. Corrective action indicated client #1 would be monitored for worsening symptoms and his dining plan would be followed.</p>		<p>butnot limited to: Indiana Resource Center for Autism, Children's Autism Center, psychiatristswho provide our consumers with psychotropic medication reviews &amp;psychiatric oversight, mental health social workers providing counseling, twoBehavior Consulting firms (Opportunities for Positive Growth &amp; Linked In)&amp; the DDNA. No one we spoke with/contacted had knowledge of a referralrecommendation for any behavioral consultant with experience with individualswith diagnoses of severe/profound intellectual disability and autism who arealso non-verbal. We will continue to reach out to seek behavioral supports. Wedo need to be honest about our unwillingness to contact a few behaviorconsulting groups that we would not utilize by choice due to past &amp; currentexperiences with Behavior Management (BMAN) providers for some of our Medicaid Waiverconsumers. Our unwillingness is because of inadequate developing and monitoringof plans, lack of assessing effectiveness and certainly no timely modifications.In addition "punishment" type interventions are implemented.</p> <p>Until we can locate a behavioralconsultant with experience &amp; expertise, we do have some professionalprogram</p>				

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	<p>Additional BDDS reports involving client #1 from 1/15 were reviewed on 1/12/16 at 10:34 AM and indicated the following:</p> <p>4. A report dated 7/30/15 indicated client #1 was taken to the hospital due to vomiting and the risk of aspiration. A chest x-ray was clear and client #1 was prescribed an anti-nausea medication and discharged to the group home.</p> <p>5. A report dated 3/22/15 indicated client #1 was taken to the emergency room by his parents after he ingested a bottle of rubbing alcohol while at their home. The physician indicated the rubbing alcohol was non-toxic. Corrective action indicated client #1 had a plan to address eating unsafe foods and all staff had been trained on the plans. An updated follow up report indicated client #1's family had been provided a copy of client #1's risk plan and "staff and management will provide assistance and training as requested or needed to [client #1's family] to aid in preventing future incidents."</p> <p>Observations were completed at the group home on 1/11/16 from 5:19 PM until 6:37 PM. During the evening meal, client #1 periodically walked around the</p>		<p>services in place identified in the correction action below,</p> <p>1. Corrective Action as it relates to Consumer #1: 1. On 1/20/16 Jill Forte, Certified Behavior Analyst, &amp; Emily Cozad, ABA Therapist with The Children's Autism Center returned to Third to re-evaluate C1. Following the observation, they stated to the QIDP that C1 seems very content &amp; at home at Third Street. They had no recommendations at this time for C1, but said that they plan on focusing more on working with his parents and their home. We consider that a win-win situation. We will continue to be involved with them as they have demonstrated a pattern in the past year of checking in every four months or so. Although they are certified behavioral analyst &amp; therapist in Applied Behavior Analysis, they have provided C1 with functional ISP goals/programming. 2. C1 sees Rick Cain, psychiatric nurse practitioner who provides C1's psychotropic medication reviews &amp; mental health oversight at least quarterly. Scheduled appointment for 2/2/16 at which time he will discuss further with the QIDP the possibility of providing consultation/assessment with C1 at his group home. We are optimistic about this. 3. An activity assessment by</p>		

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	<p>table where clients #3, #4, #5 and #6 ate their meal of chicken strips, mashed potatoes and gravy and cooked carrots and staff followed behind him picking up food items to keep them out of client #1's reach. There was a bowl of chicken strips on the table. Client #1 grabbed a mug and attempted to drink from it before being redirected by staff and periodically opened the refrigerator door to look for food items before staff redirected him to bring out applesauce. Client #1's relatives arrived at the group home at 6:00 PM to visit client #1. Client #1 sat on the floor of the kitchen and picked up bits of food on the floor and then picked up a piece of cat kibble from a bowl placed on a cabinet and placed it in his mouth. Relative #1 placed his finger in client #1's mouth and attempted to remove the cat kibble. Client #1 did not engage in activity other than walking around the table looking for food, opening the refrigerator door and cabinets and sitting on the floor looking for bits of food.</p> <p>Client #1's relatives were interviewed on 1/11/16 at 6:10 PM and indicated client #1 visited the family home twice weekly and spent the night at the family home every other weekend. Client #1's relative #2 indicated client #1 had previously received services of autism specialists in his home and indicated he may not need</p>		<p>theagency Activity Coordinator with degree in Recreation Management to provideinput into options we can try with C1 for potential activities of interest, aswell as possible relaxation techniques.</p> <p>4. Quarterly monitoring byRegistered Dietician consultant who has known C1 since his admission to BCS.</p> <p>5. On 1/27/16 at the Indiana Chapterof the Developmental Disabilities Nursing Association quarterly meetingprovided a case study for C1, totally anonymous of course. There were nosuggestions/recommendations as they all agreed that he is a challengingindividual &amp; that we need to "let the State know". Unfortunately no one wasable to provide any referral possibilities for a Behavior Consultant withexperience.</p> <p>6. The HRC "quorum" of professionalsto hopefully provide us with guidance and direction as it relates to family,PCP orders for no unsupervised visits to the family home and concerns aboutrestrictive nature of individual's freedoms for C1 and his family. ReferenceW149 A.2 (a &amp; b).</p> <p>7. Again, we will continue to seekout behavioral consultation.</p> <p>8. Any revisions to plans oradditional protocols developed as a result of professional program services recommendationswill be</p>				

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	<p>as much medication if the services were used again.</p> <p>The House Manager (HM) was interviewed on 1/11/16 at 6:20 PM and indicated the floor of the kitchen was normally swept after the meal, but clients #2, #3, #4 and #5 had left the group home for a basketball game and had not swept the floor before leaving. The HM stated when asked about the cat food "That's the first I've seen him get cat food off the counter. It's a new thing-we put it (cat food) up there (off the floor)." Staff #1 then swept the kitchen floor with client #6.</p> <p>Client #1's Health Risk Plan revised July 22, 2015 located in the group home records was reviewed on 1/11/16 at 6:28 PM and indicated client #1 was at risk for choking and aspiration due to being unable to adequately chew and swallow most regularly textured food. The plan indicated client #1 had a surgery to reduce the size of his stomach due to erosion. Client #1 was hospitalized in November, 2013 with aspiration pneumonia resulting from liquid or food aspiration. "It was determined at that time that he is at the highest risk for aspiration when drinking or eating while walking or doing any other activity." The plan indicated he was to receive a pureed diet</p>		<p>incorporated and all staff working with C1 across all settings will be trained on any changes.</p> <p>Persons Responsible: C1's IST, QIDP, Medical Department &amp; PD</p> <p>Target completion date: 2/13/16</p> <p>1. Corrective Action as it relates to BCSpractices agency wide: 1. All RMT's, SLMT's, DS Coordinator and other identified supervisory staff will receive training on the importance of utilizing professional program services with W164 standard &amp; guidance.</p> <p>Persons Responsible: PD, QAM &amp; QIDP.</p> <p>Target Completion date: 2/13/16</p>		

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	<p>with nectar thickened liquids and eat 5-6 small meals each day consisting of whole portions of an entree and 1/2 portions of all other menu items. Client #1 "frequently attempts to eat food that is not pureed, posing a choking risk due to unmodified texture...." Client #1 was to be on "1:1 (one to one) supervision during the meal preparation, mealtime, and meal clean-up routine in his home to limit his risk for eating these unsafe foods...Staff is to place themselves between [client #1] and the desired food item(s) at all times...Staff across all settings need to be aware of all food items and drinks in [client #1's] environment and remove them when possible. Strategies for dealing with this behavior are outlined in his Behavior Support Plan (BSP)...."</p> <p>Observations were completed at the group home on 1/12/16 from 7:12 AM until 8:10 AM. Client #1 walked around the table and staff #8 picked up a plate of waffles, and a container of cereal to prevent client #1 from obtaining them. Client #1 reached for discarded cereal in the sink before staff #8 redirected him. Client #1 sat at the table next to staff and across from client #3 as staff #8 assisted him to eat applesauce and a container of yogurt. Staff #8 poured a second helping of applesauce into a bowl without</p>			

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	<p>measuring it and client #1 was assisted to eat it with a spoon. Client #1 did not engage in activity other than walking around the table looking for food, opening the refrigerator door and cabinets and sitting on the floor looking for bits of food.</p> <p>Staff #8 was interviewed on 1/12/16 at 7:40 AM and when asked how often client #1 was able to obtain non-pureed food and thin liquids, she stated, "once daily."</p> <p>Client #1's BSP dated 3/1/15 was reviewed at the facility's office on 1/12/16 at 10:05 AM and indicated target behaviors of self injurious behavior, physical aggression and eating unsafe food. Client #1 "will sometimes attempt to remove and eat discarded or partially eaten food from the trash and floor. If the opportunity presents itself, [client #1] will steal food and drink from other's plates and hand while they attempt to eat or drink." Interventions for unsafe eating indicated client #1 was to be verbally redirected to inform him of unsafe food as staff "gently guide him away from the food or drink." Staff were to remove food or drink from his hand as gently as possible and if the unsafe food is already in his mouth, staff were not to attempt to remove it as client #1 may bite. Staff</p>			

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	<p>were to position themselves between client #1 and unsafe food and beverage and attempt to engage him in other activity. The plan was signed by the QIDP on 2/25/15, the group home nurse on 2/20/15 and approved by the facility's Human Rights Committee on 2/25/15.</p> <p>Client #1's Behavior Tracking Sheet from 2/15-12/15 was reviewed on 1/12/16 at 11:00 AM and indicated client #1 was successful in obtaining unsafe food or drink 61 times in 2/15, 39 times in March, 2015, 23 times in June, 2015, 27 times in July, 2015, 42 times in July, 2015, 16 times in October, 2015, 12 times in November, 2015 and 38 times in December, 2015. Client #1 engaged in self injurious behavior 26 times in 2/15, 24 times in March, 2015, 3 times in June, 2015, 2 times in July, 2015, 4 times in August, 2015, 10 times in October, 2015, 11 times in October, 2015, 45 times in November, 2015, 2 times in December, 2015.</p> <p>Client #1's Providing a Healthy and Safe Environment for [client #1] Consumer Specific Training updated March, 2015 was reviewed on 1/13/15 at 3:30 PM and indicated in the area of Behavior Management, client #1 "has a behavior support plan due to his use of psychotropic medications prescribed by</p>			

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	<p>[psychiatric nurse practitioner], to manage behavioral concerns (self injurious behavior, physical aggression, anxiety and hyperactivity). Staff were to employ blocking techniques to address self injurious behavior.</p> <p>The Program Director (PD), group home nurse and QIDP (Qualified Intellectual Disabilities Professional) were interviewed on 1/12/16 at 9:50 AM and indicated client #1's incidents of aspiration pneumonia on 12/27/15 and 11/8/15 were a result of client #1 consuming unsafe food/beverage during home visits. The QIDP indicated staff are to attempt to engage client #1 in activity to distract him during meal preparation and clean up, but he had little interest in most activities. The QIDP indicated a new swing had been purchased for client #1, but he had not shown interest in using it yet. The QIDP indicated she had written the plan and a behavior specialist had not been involved in assessing client #1's behavior, developing a plan or assisting in training staff to competently implement the plan. The QIDP indicated the services of the autism specialists previously used by client #1 had been contacted and provided suggestions for interventions for client #1.</p> <p>The suggested interventions by the</p>			

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W 0249  Bldg. 00	<p>autism specialists were included in Employee In-Service training records dated 3/12/15 for client #1 and were reviewed on 1/12/16 at 3:30 PM. The interventions indicated client #1 was to be encouraged to use signs for shoes, all done, bathroom, choosing a picture of food and to be encouraged to sit on the toilet daily. There was no additional evidence provided of a behavior specialist's involvement to address client #1's behaviors.</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the</p>			

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	<p>achievement of the objectives identified in the individual program plan.</p> <p>Based upon observations, record review and interview, the facility failed for 1 of 3 sampled clients (client #1) to ensure his risk plan and BSP (Behavior Support Plan) were implemented.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 1/11/16 from 5:19 PM until 6:37 PM. During the evening meal, client #1 periodically walked around the table where clients #3, #4, #5 and #6 ate their meal of chicken strips, mashed potatoes and gravy and cooked carrots and staff followed behind him picking up food items to keep them out of client #1's reach. There was a bowl of chicken strips on the table. Client #1 grabbed a mug and attempted to drink from it before being redirected by staff and periodically opened the refrigerator door to look for food items before staff redirected him to bring out applesauce. Client #1's relatives arrived at the group home at 6:00 PM to visit client #1. Client #1 sat on the floor of the kitchen and picked up bits of food on the floor and then picked up a piece of cat kibble from a bowl placed on a cabinet and placed it in his mouth. Relative #1 placed his finger in client #1's mouth and attempted to remove the</p>	W 0249	<p><b>W249-Program Implementation</b></p> <p>Once the IST has formulated aclient's ISP, each individual must receive a continuous active treatmentprogram consisting of needed interventions and services in sufficient numberand frequency to support the achievement of the objectives identified in theISP.</p> <p>BCS failed to ensure thatconsumer #1's risk plan(s) and BSP were implemented.</p> <p><b>As it relates tothe to this W249 citation most of the corrective action is addressed in theW122 condition of participation-client protections reference SAFEGUARDS inplace for C1 and W149 Corrective Action/Follow-up &amp; target completion datesfor this tag as well.</b></p> <p>1. Corrective action and follow-up as itrelates to C1; 1. For C1's health and safety morerestrictive interventions will be needed to keep him safe from accessing unsafe food. For example BSP interventions will most likely include escort, changingenvironment(s) especially during identified high risk time frames such asaafternoon snack &amp; evening meal &amp; cleanup, Changes to risk plans willhave similar things as</p>	02/13/2016
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	<p>cat kibble. Client #1 did not engage in activity other than walking around the table looking for food, opening the refrigerator door and cabinets and sitting on the floor looking for bits of food.</p> <p>Client #1's relatives were interviewed on 1/11/16 at 6:10 PM and indicated client #1 visited the family home twice weekly and spent the night at the family home every other weekend. Client #1's relative #2 indicated client #1 had previously received services of autism specialists in his home and indicated he may not need as much medication if the services were used again.</p> <p>The House Manager (HM) was interviewed on 1/11/16 at 6:20 PM and indicated the floor of the kitchen was normally swept after the meal, but clients #2, #3, #4 and #5 had left the group home for a basketball game and had not swept the floor before leaving. The HM stated when asked about the cat food "That's the first I've seen him get cat food off the counter. It's a new thing-we put it (cat food) up there (off the floor)." Staff #1 then swept the kitchen floor with client #6.</p> <p>Client #1's Health Risk Plan revised July 22, 2015 located in the group home records was reviewed on 1/11/16 at 6:28</p>		<p>well as updates on health crisis in past year.</p> <p>2.All staff working with C1 acrossall settings will be trained on the new &amp;/or revised plans with competencytesting afterward.</p> <p>3.All RMT members will be trainedon the W249 standard and guidance on program implementation.</p> <p>Persons responsible: C1's IST, QIDP, PD, RN's and QAM.</p> <p>Target completion date: 2/13/16</p> <p>1.Corrective action as it relates to BCSpractices agency wide: 1.Reference W149 corrective action</p> <p>Person's responsible: QIDP's, RMT's, SLMT's, DSCoordinator, PD, RA &amp; QAM</p> <p>Target completion date: 2/13/16</p>		

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	<p>PM and indicated client #1 was at risk for choking and aspiration due to being unable to adequately chew and swallow most regularly textured food. The plan indicated client #1 had a surgery to reduce the size of his stomach due to erosion. Client #1 was hospitalized in November, 2013 with aspiration pneumonia resulting from liquid or food aspiration "It was determined at that time that he is at the highest risk for aspiration when drinking or eating while walking or doing any other activity." The plan indicated he was to receive a pureed diet with nectar thickened liquids and eat 5-6 small meals each day consisting of whole portions of an entree and 1/2 portions of all other menu items. Client #1 "frequently attempts to eat food that is not pureed, posing a choking risk due to unmodified texture..." Client #1 was to be on "1:1 (one to one) supervision during the meal preparation, mealtime, and meal clean-up routine in his home to limit his risk for eating these unsafe foods...Staff is to place themselves between [client #1] and the desired food item(s) at all times...Staff across all settings need to be aware of all food items and drinks in [client #1's] environment and remove them when possible. Strategies for dealing with this behavior are outlined in his Behavior Support Plan (BSP)...."</p>			

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	<p>Observations were completed at the group home on 1/12/16 from 7:12 AM until 8:10 AM. Client #1 walked around the table and staff #8 picked up a plate of waffles, and a container of cereal to prevent client #1 from obtaining them. Client #1 reached for discarded cereal in the sink before staff #8 redirected him. Client #1 sat at the table next to staff and across from client #3 as staff #8 assisted him to eat applesauce and a container of yogurt. Staff #8 poured a second helping of applesauce into a bowl without measuring it and client #1 was assisted to eat it with a spoon. Client #1 did not engage in activity other than walking around the table looking for food, opening the refrigerator door and cabinets and sitting on the floor looking for bits of food.</p> <p>Staff #8 was interviewed on 1/12/16 at 7:40 AM and when asked how often client #1 was able to obtain non-pureed food and thin liquids, she stated, "once daily."</p> <p>Client #1's BSP dated 3/1/15 was reviewed at the facility's office on 1/12/16 at 10:05 AM and indicated target behaviors of self injurious behavior, physical aggression and eating unsafe food. Client #1 "will sometimes attempt</p>			

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	<p>to remove and eat discarded or partially eaten food from the trash and floor. If the opportunity presents itself, [client #1] will steal food and drink from other's plates and hand while they attempt to eat or drink." Interventions for unsafe eating indicated client #1 was to be verbally redirected to inform him of unsafe food as staff "gently guide him away from the food or drink." Staff were to remove food or drink from his hand as gently as possible and if the unsafe food is already in his mouth, staff were not to attempt to remove it as client #1 may bite. Staff were to position themselves between client #1 and unsafe food and beverage and attempt to engage him in other activity.</p> <p>The Program Director (PD), group home nurse and QIDP (Qualified Intellectual Disabilities Professional) were interviewed on 1/12/16 at 9:50 AM and indicated client #1's aspiration pneumonia on 12/27/15 and 11/8/15 were a result of client #1 consuming unsafe food/beverage during home visits. The QIDP and PD indicated there should not be food on the floor for client #1 to consume.</p> <p>9-3-4(a)</p>			

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W 0263 Bldg. 00	<p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on observation, record review and interview, the facility failed to ensure written informed consent was obtained for 1 of 3 sampled clients (client #1), for the use of restrictive interventions in behavior support plan (psychotropic medications and physical guidance from unsafe food).</p> <p>Findings include:</p> <p>Client #1's Behavior Support Plan (BSP) dated 3/1/15 was reviewed at the facility's office on 1/12/16 at 10:05 AM and indicated target behaviors of self injurious behavior, physical aggression and eating unsafe food. Client #1 "will sometimes attempt to remove and eat discarded or partially eaten food from the trash and floor. If the opportunity presents itself, [client #1] will steal food and drink from other's plates and hand while they attempt to eat or drink." Interventions for unsafe eating indicated client #1 was to be verbally redirected to</p>	W 0263	<p><b>W263 Program Monitoring and Change</b> Ensure that BSP &amp; other restrictive plans are conducted only with written consent of the client, guardians and HCR's.</p> <p>BCS failed to ensure written informed consent for C1's BSP. This will be signed belatedly by his HCR on 2/3/16 as she is aware of the plan and its restrictions &amp; was willing to provide written informed consent. The Medication Side Effects/Risks &amp; Benefits written informed consent signed on 3/18/15 by HCR, C1 and QIDP.</p> <p><b>Please reference W159 A.2 for corrective action/follow-up and target completion dates as it is our corrective action for this W263 citation as well.</b></p>	02/13/2016

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	<p>inform him of unsafe food as staff "gently guide him away from the food or drink." Staff were to remove food or drink from his hand as gently as possible and if the unsafe food is already in his mouth, staff were not to attempt to remove it as client #1 may bite. Staff were to position themselves between client #1 and unsafe food and beverage and attempt to engage him in other activity. The plan included the use of Klonopin 25 mg (milligrams) TID (three times daily) for anxiety, Melatonin 3 mg daily for sleep disorder, Citalopram 20 mg daily for anxiety/depression, Zyprexa 15 mg daily for hyperactivity, trileptal 300 mg for aggression/hyperactivity and trazodone 50 mg as need for sleep. The plan was signed by the QIDP on 2/25/15, the group home nurse on 2/20/15 and approved by the facility's Human Rights Committee on 2/25/15. Additional records for client #1 were reviewed on 1/12/16 at 12:20 PM and indicated client #1 had health care representatives (HCRs)/relatives to assist him in making decisions. There was no evidence of the HCRs' signature or consent for the plan.</p> <p>The (Qualified Intellectual Disabilities Professional) was interviewed on 1/12/16 at 9:50 AM and indicated she would look for evidence of signatures for the consent of client #1's plan by his HCRs.</p>			

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W 0268	<p>An informed consent assessment dated 8/3/15 was reviewed on 1/13/16 at 2:53 PM and indicated client #1 required assistance to make decisions in regards to medication usage and program planning.</p> <p>A verbal consent form from client #1's HCR dated 2/24/15 was reviewed on 1/13/16 at 2:54 PM and indicated client #1's HCRs had consented to client #1's BSP and was provided a copy of the plan and a signature page to return. The form indicated a tracking sheet would be implemented on 3/2/15 to ensure the form was returned with signatures. No further evidence was provided of consent for client #1's plan.</p> <p>The Program Director and QIDP were interviewed on 1/14/16 at 12:55 PM and indicated the administrative assistant was to ensure consent was obtained for BSPs.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT</p>						

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Bldg. 00	<p>These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based upon observation and interview, the facility failed for 1 of 3 sampled clients (client #1) to promote his dignity by ensuring he wore clothing that fit.</p> <p>Findings included:</p> <p>Observations were completed at the group home on 1/11/16 from 5:19 PM until 6:37 PM. During the observation, client #1 wore pants that extended past his feet and client #1 walked on the ends of his pant legs throughout the observation.</p> <p>Staff #1 was interviewed on 1/11/16 at 6:15 PM and indicated client #1 usually wore a belt to keep his pants up.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 1/12/16 at 4:00 PM and indicated client #1 should be wearing clothing that fit.</p> <p>9-3-5(a)</p>	W 0268	<p><b>W268-Conduct Toward Client(s)</b></p> <p>Promote the growth, development and independence of the consumers</p> <p>BCS failed to promote the dignity of C1 by ensuring that he wore clothing that fit.</p> <p>1. Corrective Action and Follow-Up Specific to Consumer #1:</p> <p>1. C1's clothing will fit properly for his dignity and also safety. Clothing will be altered (hem pants, adjust waist band) if clothing is in good condition. Purchase clothing that fits and if alternations need to be made do so. Encourage him to wear a belt,</p> <p>2. Third Street staff will be trained on item #1 above, importance of dignity for all human beings, as well as promoting growth, development and independence for all consumers.</p> <p>3. All RMT's, DS Coordinator, administrative team &amp; other identified supervisory staff will be trained on the W268 standard and guidance.</p> <p>4. All DCS working with residential consumers across all settings will be trained on item #2 above.</p> <p>Persons responsible: QIDP,</p>	02/13/2016

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W 0440 Bldg. 00	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based upon record review and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2 and #3), and for 3 additional clients (clients #4, #5 and #6) to conduct quarterly evacuation drills for the day shift.</p> <p>Findings include:</p> <p>The facility's evacuation drills from</p>	W 0440	<p>RMT's, PD &amp; QAM.</p> <p>Target completion date: 2/13/16</p> <p>1. Corrective Action for BCS Practices agency wide: 1. All SLMT members &amp; other identified supervisory will be trained on items A, 2 &amp; A.3 above, They will be responsible for training their staff at next upcoming house &amp;/or staff meetings</p> <p>Persons responsible: QIDP's, SLMT's, PD &amp; Res/SL Administrator</p> <p>Target completion date: 2/13/16 for SLMT's</p> <p><b>W440-Evacuation Drills</b> BCS will hold evacuation drills at least quarterly for each shift of personnel. Each Supervised Group Living (SGL) home has a drill rotation schedule posted &amp; a reminder from the Quality Assurance Manager (QAM) during the week that the drill is scheduled. The following Residential Evacuation Drill(s) Procedure has been reviewed and revised by the Program Director (PD) &amp; QAM to address any</p>	02/13/2016

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	<p>1/15-1/16 were reviewed on 1/11/16 at 6:30 PM. The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, #4, #5 and #6 on the overnight shift since 9/4/15.</p> <p>The House Manager was interviewed on 1/11/16 at 6:35 PM and indicated she would look for additional evacuation drills. No other evidence of evacuation drills was provided.</p> <p>The Program Director was interviewed on 1/14/16 at 12:55 PM and indicated there were no additional drills for the overnight shift for the missing time period.</p> <p>9-3-7(a)</p>		<p>changes to the emergency drill rotation schedule, which was the problem that led to the lack of a 3rd shift drill being available the 4th quarter of 2015.</p> <p><b>Residential Evacuation Drill(s) Procedure</b></p> <p><b>Bi-County Services, Inc. will assure that the residential group homes are in compliance with the regulations regarding evacuation drills as evidenced by the following procedures.</b></p> <p>1. BCS residences' hold evacuation drills at least quarterly</p>		

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			<p>for each shift of personnel and under varied conditions:</p> <p>1. Each group home has a regular rotation of drills by shift, per quarter for the current year with the Quality Assurance Manager (QAM) in conjunction with the Residential Manager (RM) assuming the responsibility of monitoring and documenting that this occurs. The RM will also assure that drills utilize all group home egresses so that staff and consumers are knowledgeable of safety and protection safeguards under varied conditions. The rotation drill schedule is updated annually each November to assure that evacuation drills are conducted quarterly on each shift at all group homes during a calendar year. The QAM and RM's are responsible for developing this emergency drill rotation schedule annually as a team.</p> <p>The drill rotation schedule &amp; any designated assignments will be posted in the EAP book. Any updates or changes will be the responsibility of the RM to communicate to Direct Care Staff (DCS)/Residential Trainers. <b>Under NO circumstances can DCS change drill times without prior approval of a Residential Management Team (RMT) &amp;/or QAM. The Residential On-Call system can be used to contact the RMT if there are legitimate needs for the time to be changed.</b></p>	

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			<p>·TheRM or designee will check off that the drills have been completed by the 25th of each month. This is documented on the RM Monthly Check Off list.</p> <p>·RM does a fire alarm check weekly and the maintenance department completes the check on a monthly basis.</p> <p>·Evacuation training, including each group homes EAP &amp; Emergency Drill(s) Procedure, for DCS staff occurs at least bi-monthly (every other month). This is to assure that all personnel on all shifts are familiar with the use of alarms, emergency and disaster plans, special needs and assistance for residents, as well as impaired fire alarm and/or sprinkler system procedure ("fire watch" monitoring).</p> <p>·RM's (or designee) provide group home orientation for new staff and/or relief employees that address specific "Emergency Issues". The Emergency Issues include, but are not limited to emergency telephone numbers, how to operate the fire alarm system, where consumers should go, explanation of drills and how to do them, location of fuse box and training on the EAP for that house.</p> <p>1. All evacuation drills will be recorded on the Residential Drill Reports and left for the RM to review and complete all management documentation requirements prior to copying &amp; forwarding to the QAM and then</p>	

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			<p>filing with other Life Safety Code (LSC) paperwork for the group home. The QAM will log completed drills into a spreadsheet and monitor perregulation(s) throughout the year.</p> <p>2. The Residential Drill Reports will also indicate when and who were evacuated during any actual evacuation drills.</p> <p>3. In addition, BCS has an Emergency Action Plan (EAP) for each site location. Site locations include all group homes, Day Services settings and sheltered workshops. The EAP notes purpose, evacuation procedure, staffing needs and alternative refuge locations. Provisions are in place for evacuation drills and EAP's for individuals with physical disabilities. Pertinent telephone numbers for contact is also part of this EAP.</p> <p>4. Actual Evacuation Drills (with residents evacuated from the homes) will occur at least once a year on each shift. During actual evacuation(s) consumers may be evacuated to a safe area in another agency or community facilities certified under the Health Care Occupancies Chapter of the LSC</p> <p>5. In order to assure that all staff on all shifts is trained to perform assigned tasks as they relate to evacuation drills, new employees will be checked off during group home orientation/training and</p>	

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			<p>documented on a training list that RM maintains files on. A designee may complete training of staff, but documentation still requires RM review and sign-off.</p> <p>1. All Residential Management Teams (RMT's) will be retrained annually at the regularly scheduled November RMT meeting on the mandatory requirement of assuring that fire drills are conducted quarterly on each shift for all four calendar quarters. This re-training will also stress our commitment to being "Red Cross Ready" which involves consumer and staff training involvement in increasing awareness for safety, readiness for emergency action, and EAP follow through. The drill process is a priority for the safety of consumers.</p> <p>2. Every November the RM's and QAM will develop the annual drill rotation schedule for the upcoming year for each group home assuring that they meet the requirements of conducting drills quarterly per shift for all four calendar quarters. This team will be in agreement regarding the annual drill rotation schedule prior to posting and training direct care staff (DCS) to ALERT them of the new drill rotation for the upcoming year at each group home(s) by December 15th of each year.</p> <p>3. QAM will provide RMT's with "ALERT" notice one week prior to the next drills scheduled in the</p>	

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			<p>rotation, thus providing an additional safeguard to assure compliance with LSC &amp; SDOH regulations regarding evacuation drills.</p> <p>(Revised: 1/2016)</p> <p><b>1. Corrective Action and follow-up for Third Street:</b></p> <p>1. Residential Management Team members will be trained on the revised Residential Evacuation Drill(s) Procedure on 2/4/16.</p> <p>2. All Third Street staff will be trained on the revised Drill Procedure as well as a review of the EAP &amp; 2016 Emergency Drill Rotation schedule by 2/13/16.</p> <p><b>1. Corrective Action as it relates to BCS practices agency wide:</b></p> <p>1. All SGL DCS will be trained on item #2 above by 2/13/16</p> <p>Person's Responsible: PD, QAM, RA &amp; RM's.</p> <p>Target Completion Date: 2/13/16</p>	