

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/28/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
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W 0000 Bldg. 00	<p>This visit was for a post certification revisit survey (PCR) to the full recertification and state licensure survey. This visit included the PCR to the investigation of complaint #IN00172392 completed on 5/28/15.</p> <p>Complaint #IN00172392 - Not Corrected.</p> <p>Survey dates: 7/20, 7/21, 7/27 and 7/28/15.</p> <p>Facility Number: 001079 Provider Number: 15G565 AIM Number: 100245500</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0137 Bldg. 00	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (B) and for 1 additional client (G), the facility failed to allow the clients to keep and/or teach the clients to maintain their</p>	W 0137	<p>CORRECTION:</p> <p><i>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients</i></p>	08/27/2015

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

TITLE

(X6) DATE

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

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	<p>own eyeglasses.</p> <p>Findings include:</p> <p>During the 7/20/15 observation period between 3:10 PM and 5:40 PM, at the group home, client G asked for her eyeglasses so she could see at 4:24 PM. Staff #1 retrieved the client's eyeglasses from the office area which was locked. Staff #1 also retrieved client B's eyeglasses and gave them to client B to put on.</p> <p>During the 7/21/15 observation period between 6:10 AM and 7:49 AM, at the group home, clients B and G did not have their eyeglasses until they were getting ready to go to work when facility staff retrieved the eyeglasses from the locked office and handed them to clients B and G to put on.</p> <p>Client B's record was reviewed on 7/21/15 at 12:46 PM. Client B's 11/7/14 Record Of Visit (ROV) indicated client B had an eye examination on 11/7/14 which indicated client B was to "wear full time."</p> <p>Client B's 2/21/15 Individual Support Plan (ISP) and/or 2/22/15 Behavior Support Plan (BSP) did not indicate client B's eyeglasses should be locked.</p>		<p><i>have the right to retain and use appropriate personal possessions and clothing.</i> Specifically, through assessment, the interdisciplinary team has determined that there is not a current need to secure Client B and Client G's eyeglasses and therefore they will no longer be kept in a locked cabinet. The team will develop ongoing supports to support Client B and Client G in caring for their adaptive equipment. Through observation, it has been determined that this deficient practice did not affect any additional clients.</p> <p>PREVENTION:</p> <p>All facility staff will be retrained regarding the need to assure that clients' belongings are available to them at all times unless specifically contraindicated by the Client's plan after appropriate due process has occurred. The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring that individuals have unrestricted access to their belongings including adaptive</p>	

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	<p>Client B's ISP and/or BSP did not indicate client B received training in regard to the care of her eyeglasses.</p> <p>Client G's record was reviewed on 7/21/15 at 1:20 PM. Client G's 2/4/15 ROV indicated client G had lost her eyeglasses and new eyeglasses were ordered.</p> <p>Client G's 7/1/15 ISP and/or 7/31/14 BSP did not indicate client G's eyeglasses should be locked. Client G's ISP and/or BSP did not indicate client G received training in regard to the care of her eyeglasses.</p> <p>Interview with staff #3 on 7/20/15 at 5:25 PM when asked why the clients' eyeglasses were locked, stated "They want them locked." Staff #3 indicated clients B and G received their new eyeglasses in the past 2 weeks. Staff #3 indicated it had taken awhile for the clients to receive their new eyeglasses. Staff #3 indicated the clients' eyeglasses were kept in the medication room so the clients could not lose them. Staff #3 indicated clients B and G had to ask staff to get their eyeglasses.</p> <p>Interview with staff #1 on 7/21/15 at 7:55 AM indicated facility staff was still trying to get client B to wear her eyeglasses.</p>		<p>equipment. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training and to assure that individuals have unrestricted access to their belongings including adaptive equipment. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active treatment sessions no less than weekly for the next 30 days, and no less than twice monthly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning</p>	

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	<p>Staff #1 indicated clients B and G's eyeglasses were kept locked in the medication room, and the clients were given their eyeglasses when they got their morning medications. Staff #1 stated the clients "keep breaking. [Client G] throws eyeglasses when upset and [client B] will destroy them when she is upset." Staff #1 indicated the clients did not know how to maintain/keep their eyeglasses. Staff #1 indicated client G would also lose her eyeglasses.</p> <p>Interview with Clinical Supervisor (CS) #1 and the Qualified Intellectual Disabilities Professional-Designee (QIDP-D) on 7/21/15 at 1:40 PM indicated clients B and G's eyeglasses should not have been locked in the medication room/cabinet. The QIDP-D and CS #1 indicated the clients would break their eyeglasses when having a behavior. The QIDP-D and CS #1 indicated the clients did not have any programs in place to teach the clients to keep their eyeglasses safe.</p> <p>9-3-2(a)</p>		<p>active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i>. Administrative support at the home will include assuring that individuals have unrestricted access to their belongings including adaptive equipment.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support</p>	

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W 0159 Bldg. 00	<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 on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 1 additional client (F), the facility failed to ensure the group home had a Qualified Intellectual Disabilities Professional (QIDP) to monitor the clients' Individual Support Plan (ISP) objectives in regard to implementation. The facility failed to ensure the group home had a QIDP to coordinate the clients' programs in regard to obtaining assessment of a client's adaptive equipment needs. The facility failed to ensure the group home had a QIDP to monitor the clients' programs in regard to data collection for a client. The QIDP failed to coordinate clients' restrictive program plans to ensure the facility's Human Rights Committee reviewed and approved clients' restrictive programs. The facility failed to ensure the group home had a QIDP to ensure a client's interdisciplinary team met to review a client's dental recommendation.</p> <p>Findings include:</p>	W 0159	<p>Staff, Operations Team</p> <p>CORRECTION:</p> <p><i>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. The Clinical Supervisor will assume direct QIDP responsibilities until such time as the governing body can realign staffing resources to assure all agency QIDPs meet regulatory expectations. Specifically,</i></p> <p>Client F is receiving intensive daily physical therapy in a skilled care rehabilitation facility. During a transition meeting on 8/14/15, the interdisciplinary team will meet with facility therapists to review her currently assessed adaptive equipment needs and will assure they are available for Client F, with appropriate staff training in place, prior to her return to the Supervised Group Living facility. A review of support documents and incident documentation indicated this</p>	08/27/2015

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	<p>1. Client C's record was reviewed on 7/21/15 at 12:12 PM. Client C's 10/28/14 Dental Summary Progress Report indicated client C was edentulous as the client's dental note indicated the client's "gingival health WNL (within normal limits)." Client C's dentist recommended the client receive dentures.</p> <p>Client C's 9/11/14 ISP and/or record indicated the client's interdisciplinary team (IDT) had not met to review the client's dental recommendation.</p> <p>Interview with the Qualified Intellectual Disabilities Professional-D (QIDP-D) and the Clinical Supervisor (CS#1) on 7/21/15 at 2:40 PM indicated client C's IDT would still need to meet to address the client's 10/28/14 recommendation to get dentures. CS #1 indicated he served as the QIDP for the group home. CS #1 indicated the facility had not addressed having a QIDP for the group home instead of a QIDP-D.</p> <p>2. The QIDP failed to re-assess client F's need for adaptive equipment in regard to an elevated toilet seat. Please see W210.</p> <p>3. The QIDP failed to address the client's identified training needs in regard to refusing health treatments/exams for client A. Please see W227.</p>		<p>deficient practice did not affect any additional clients.</p> <p>The interdisciplinary team will develop aggressive approaches to support Client A through her pattern of medical appointment refusals.</p> <p>All direct support staff will be retrained and receive ongoing face to face coaching from supervisors regarding the need to provide consistent, aggressive and continuous active treatment for all clients including but not limited to implementing prioritized learning objectives per the implementation schedule and implanting behavior supports as appropriate.</p> <p>Facility direct support staff will be trained toward proper implementation of Client #B's objectives as well proper documentation of document program data. An audit of facility documentation indicated that this deficient practice did not affect any additional clients.</p>		

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	<p>4. The QIDP failed to ensure facility staff implemented the clients' Individual Support Plans (ISPs) when formal and/or informal training opportunities existed for clients A, B and C. Please see W249.</p> <p>5. The QIDP failed to ensure client B's program plan objectives were in the program data book to ensure facility staff collected data as outlined in the client's ISP. Please see W252.</p> <p>6. The QIDP failed to ensure the facility's HRC reviewed and/or approved clients' restrictive plans for clients A, B, C and D. Please see W262.</p> <p>This deficiency was cited on 5/28/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</p>		<p>The QIDP has obtained Human Rights Committee Approval for all restrictive programs for Clients A, B, D and G. Through review of facility documentation, the governing body has determined that this deficient practice did not affect any additional clients.</p> <p>PREVENTION:</p> <p>The QIDP has been retrained regarding the need to assure that all relevant assessments are completed for clients within 30 days of admission and as needed but no less than annually thereafter. . Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will conduct documentation reviews no less than weekly for the next 30 days, twice monthly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. These administrative documentation reviews will include assuring all relevant assessments are current and that support documents correspond to needs identified through ongoing</p>	

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			<p>assessment.</p> <p>The agency will retrain QIDP and facility nurse regarding the need to develop necessary supports and measureable objectives to support clients toward independence. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility weekly for the next 30 days and twice monthly visits for an additional 60 days to assure appropriate supports are included in each client's support plan. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility.</p> <p>The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring the provision of</p>	

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			<p>continuous active treatment. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to meal preparation, family style dining, other domestic skills and meaningful leisure activities. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active treatment sessions no less than weekly for the next 30 days, and no less than twice monthly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to</p>	

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			<p>work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate.</p>	

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			<p>As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i>. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities.</p> <p>The QIDP has been trained regarding the need to assure data collection grids are in place at the facility to give direct support staff the opportunity to collect data on prioritized learning objectives as required, as well as the need to track and monitor progress on all client learning objectives. Along with the QIDP, members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, will conduct documentation reviews to assure data is collected as required at the facility no less than weekly for the next 30 days, and no less than twice monthly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility.</p>	

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			<p>The QIDP will be retrained regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs for all clients. When annual program revisions occur and other restrictive practices are assessed as needed, the Clinical Supervisor will review Human Rights Committee documentation prior to the implementation or renewal of restrictive programs. The QIDP, facility nurse and Human Rights Committee liaison will each maintain copies of Human rights Committee approval forms to assure the ability to reproduce copies of HRC records for surveyors upon request. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility three times weekly for the next 30 days and twice weekly visits for an additional 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of</p>	

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W 0210 Bldg. 00	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, interview and record review for 1 additional client (F), the client's interdisciplinary team failed to obtain an assessment and/or an accurate assessment in regard to the client's adaptive equipment needs.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 7/21/15 at 11:40 AM and on 7/27/15 at</p>	W 0210	<p>Operations/General Manager will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include review of Human Rights Committee records to assure appropriate approvals have been obtained.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p><i>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Specifically, Client F is receiving intensive daily physical therapy in a skilled care rehabilitation facility. During a transition meeting on 8/14/15, the interdisciplinary team will</i></p>	08/27/2015

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	<p>9:19 AM. The facility's 7/18/15 investigation report indicated "[Client F] (individual supported by ResCare) was receiving stand-by assistance with her morning shower from Direct Support Professional [staff #4]. After she finished in the shower, she asked for assistance using the toilet. While staff was assisting her with transferring to her wheelchair the toilet seat appeared to break off and [client F] fell to the floor on her left side. She complained of severe pain in her left leg and hip. Staff called 911 and EMS (Emergency Medical Services) transported [client F] via ambulance to the [name of hospital] Emergency Department for evaluation and treatment. ER (emergency room) personnel took X-rays which revealed [client F] had a sustained closed fracture of the left hip. She was admitted to the hospital and is scheduled for surgery to repair with pins on 7/19/15...."</p> <p>Review of the facility's 7/18/15 to 7/24/15 Investigation Summary indicated client F was using the west bathroom when client F fell off and/or on the toilet seat. The facility's 7/24/15 investigation indicated staff #4 slipped on the wet floor, which had towels down and pulled client F down with her as she had a hold of the client's gait belt assisting the client to transfer to the toilet to pull up the</p>		<p>meet with facility therapists to review her currently assessed adaptive equipment needs and will assure they are available for Client F, with appropriate staff training in place, prior to her return to the Supervised Group Living facility. A review of support documents and incident documentation indicated this deficient practice did not affect any additional clients.</p> <p>PERVENTION:</p> <p>The QIDP has been retrained regarding the need to assure that all relevant assessments are completed for clients within 30 days of admission and as needed but no less than annually thereafter. . Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will conduct documentation reviews no less than weekly for the next 30 days, twice monthly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. These administrative documentation reviews will</p>	

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	<p>client's adult diaper. The facility's investigation indicated client F hit the toilet seat on the way down and broke the toilet seat.</p> <p>During the 7/20/15 observation period between 3:10 PM and 5:40 PM, at the group home, the group home had 2 bathrooms in the back hallway of the group home. The east bathroom had an elevated toilet seat with rails. The toilet seat was secure on the toilet and in good repair. The east bathroom shower was not handicap accessible as it had a tub shower in it. The west bathroom had a regular toilet seat. The toilet seat was secure on the toilet and in good repair. The west bathroom was handicap accessible as it had a shower which was wheelchair/shower chair accessible.</p> <p>Client F's record was reviewed on 7/21/15 at 2:08 PM. Client F's 3/27/15 ISP (Individual Support Plan) indicated client F's diagnoses included, but were not limited to, Drop Seizures, Scoliosis and Cerebral Palsy. Client F's ISP indicated client F utilized a wheelchair for mobility. Client F's ISP indicated the client wore a gait belt and required staff physical assistance when transferring. Client F's ISP also indicated client F wore a helmet due to her seizures, wore eyeglasses, utilized bed rails</p>		<p>include assuring all relevant assessments are current and that support documents correspond to needs identified through ongoing assessment.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>				

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	<p>(seizures/safety) and had a baby monitor in her bedroom at night to allow staff to hear when/if the client had a seizure. Client F's ISP and/or record did not indicate client F utilized and/or needed an elevated toilet seat.</p> <p>Interview with Clinical Supervisor (CS) #1 and the Qualified Intellectual Disabilities Professional-Designee (QIDP-D) on 7/21/15 at 2:40 PM indicated client F required staff physical assistance when being transferred. CS #1 indicated the elevated toilet seat in the east bathroom was used by client F. CS #1 indicated no other client required the use of the elevated toilet seat. CS #1 and the QIDP-D indicated the elevated toilet seat was not part of the client's 3/27/15 ISP. CS #1 indicated the elevated toilet seat was put in place by the maintenance staff as client F was breaking the toilet seat when the client sat down. CS #1 and the QIDP-D indicated client F had not been assessed for the need of the elevated toilet seat. CS #1 indicated the west bathroom, where client F fell, did not have an elevated/adaptive toilet seat.</p> <p>This deficiency was cited on 5/28/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>			

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W 0227 Bldg. 00	<p>9-3-4(a)</p> <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. Based on interview and record review for 1 of 4 sampled clients (A), the client's Individual Support Plan (ISP) failed to address the client's identified need in regard to refusals to participate in medical appointments/examinations.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 7/21/15 at 10:29 AM. Client A's Record of Visits (ROV) indicated the following:</p> <p>-10/9/14 Client A went to have her mammogram done. The form indicated "Attempted to do exam pt (patient) refused after multiple attempts."</p> <p>-6/1/15 Client A went to have a mammogram screening done. The ROV indicated "Unable to do screening mammogram due to pt (patient) condition."</p> <p>A fax dated 11/12/13 indicated client A would not attend "...any appts</p>	W 0227	<p>CORRECTION:</p> <p><i>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment. Specifically, the interdisciplinary team will develop aggressive approaches to support Client A through her pattern of medical appointment refusals.</i></p> <p>PERVENTION:</p> <p>The agency will retrain QIDP and facility nurse regarding the need to develop necessary supports and measureable objectives to support clients toward independence. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility weekly for the next 30</p>	08/27/2015	

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	<p>(appointments) or is very combative once @ (at) appt. Can we get an order for a pre med (medication) for all appts? Valium 10 mg (milligrams po (by mouth) 1 hour prior to scheduled appointments."</p> <p>Client A's 6/1/15 physician's order indicated client A was administered Diazepam (pre-sedation) 10 milligrams 1 hour prior to the examination on 6/1/15.</p> <p>Client A's 7/29/15 Behavior Support Plan (BSP) indicated client A had a targeted behavior of "Non-cooperation: This usually occurs when [client A] is asked to participate in a functional activity. [Client A] will frequently refuse to participate...." Client A's 7/29/15 BSP and/or 7/29/15 ISP indicated the client's identified need in regard to refusals to participate in examinations and/or medical appointments was not addressed.</p> <p>Interview with Clinical Supervisor (CS) #1, the Qualified Intellectual Disabilities Professional-Designee (QIDP-D) and LPN #1 on 7/21/15 at 2:40 PM indicated client A went to get a mammogram on 6/1/15. LPN #1 and the QIDP-D indicated client A was not cooperative in getting the mammogram completed. LPN #1 indicated client A had received a medication for sedation prior to going to the examination. The QIDP-D indicated</p>		<p>days and twice monthly visits for an additional 60 days to assure appropriate supports are included in each client's support plan. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>		

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W 0249 Bldg. 00	<p>the client's refusal to be examined and/or to go to medical appointments had not been addressed.</p> <p>This deficiency was cited on 5/28/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) 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, interview and record review for 3 of 4 sampled clients (A, B and C), the facility failed to implement the clients' objectives as written/outlined in the clients' Individual Support Plans (ISPs) when formal and/or informal training opportunities existed.</p> <p>Findings include:</p> <p>1. During the 7/21/15 observation period between 6:10 AM and 7:49 AM, at the group home, client A was sitting on her bed yelling and screaming at 6:10 AM.</p>	W 0249	<p>CORRECTION:</p> <p><i>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Specifically, all direct support staff will be retrained and receive ongoing face to face coaching</i></p>	08/27/2015

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	<p>Client A was wanting to take her morning shower but other clients were in both bathrooms at the time. Staff #5 told client A she would need to wait to use the bathroom. Client A continued to sit on her bed yelling and screaming with no further redirection. Once client A finished her shower/dressing, client A sat in the living room on the couch without an activity and/or training from 6:36 AM until the client went to eat breakfast at 7:08 AM. During that time client A sat on the couch yelling and screaming while client D was trying to watch TV. At 6:45 AM, staff #5 stated to client A "Do you need to scream?" Staff #5 did not offer the client an alternate activity to participate in. The Qualified Intellectual Disabilities Professional-Designee (QIDP-D) came over to client A and started talking to the client. Client A continued to yell and stated "Shut up." At 7:00 AM, client A was yelling and screaming and client D stated to client A "I can't hear the TV." Client D got up and turned the TV up to try and cover up client A's yelling. During the 7/21/15 observation of the breakfast meal, facility staff did not encourage client A to wash her hands prior to eating breakfast.</p> <p>Client A's record was reviewed on 7/21/15 at 10:29 AM. Client A's 7/29/15 ISP indicated client A had objectives to</p>		<p>from supervisors regarding the need to provide consistent, aggressive and continuous active treatment for all clients including but not limited to implementing prioritized learning objectives per the implementation schedule and implanting behavior supports as appropriate.</p> <p>PREVENTION:</p> <p>The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring the provision of continuous active treatment. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to meal preparation, family style dining, other domestic skills and meaningful leisure activities. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP</p>	

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	<p>participate in an activity of her choice, to identify/state values of coins and to wash her hands after toileting which facility staff did not implement when formal and/or informal opportunities existed.</p> <p>Client A's 7/29/15 Behavior Support Plan (BSP) indicated client A demonstrated verbal aggression defined as "yelling, using profanity, screaming, and name calling." Client A's 7/29/15 BSP indicated when the client demonstrated verbal aggression, staff was to "Verbally redirect [client A] by encouraging her to become involved in an activity in another room away from the person she is targeting,...."</p> <p>Interview with the Clinical Supervisor (CS) #1 and the Qualified Intellectual Disabilities Professional-Designee (QIDP-D) on 7/21/15 at 2:40 PM indicated clients' ISP objectives should be implemented throughout the day when training presented itself. The QIDP-D indicated client A should be redirected when client A started to yell and/or scream.</p> <p>2. During the 7/21/15 observation period between 6:10 AM and 7:49 AM, at the group home, client B sat on the couch without an activity, sat with her finger in her mouth and/or stood in the</p>		<p>will conduct observations during active treatment sessions no less than weekly for the next 30 days, and no less than twice monthly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening</p>	

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	<p>kitchen with her finger in her mouth from 6:28 AM to 7:08 AM without redirection to participate in a more meaningful activity. Client B was limited in her communication in that the client did not speak/was nonverbal.</p> <p>Client B's record was reviewed on 7/21/15 at 12:46 PM. Client B's 2/21/15 ISP indicated client B had objectives to prepare a side dish item, to repeat 2 words and/or phrase, and when given 2 choices of a leisure activity, choose an activity to participate in. Staff #1, #2 and #5 did not implement the client's above mentioned objectives when opportunities for training existed.</p> <p>Interview with the Clinical Supervisor (CS) #1 and the QIDP-D on 7/21/15 at 2:40 PM indicated clients' ISP objectives should be implemented throughout the day when training presented itself.</p> <p>3. During the 7/20/15 observation period between 3:10 PM and 5:40 PM and the 7/21/15 observation period between 6:10 AM and 7:49 AM, at the group home, client C was difficult to understand when she spoke. Client C was not redirected to slow down and/or speak in a clear manner.</p> <p>Client C's record was reviewed on</p>		<p>toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i>. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>		

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W 0252 Bldg. 00	<p>7/21/15 at 12:12 PM. Client C's 9/11/14 ISP indicated client C had an objective to slow down and take her time speaking in a clear manner which facility staff did not implement when formal and/or informal training opportunities existed.</p> <p>Interview with the Clinical Supervisor (CS) #1 and the QIDP-D on 7/21/15 at 2:40 PM indicated clients' ISP objectives should be implemented throughout the day when training presented itself.</p> <p>This deficiency was cited on 5/28/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <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.</p> <p>Based on interview and record review for 1 of 4 sampled clients (B), the facility failed to collect data in regard to the client's Individual Support Plan (ISP) objectives.</p> <p>Findings include:</p>	W 0252	<p>CORRECTION:</p> <p><i>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Specifically, facility direct support staff will be trained toward proper</i></p>	08/27/2015

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	<p>Client B's record was reviewed on 7/21/15 at 12:46 PM. Client B's July 2015 Data Book indicated client B did not have any ISP training objectives/sheets in the July Data Sheet book.</p> <p>Client B's 2/21/15 ISP indicated client B had the following ISP objectives:</p> <ul style="list-style-type: none"> -To prepare a side dish at dinner. -To repeat 2 words and/or a phrase. -When given a choice of 2 leisure activities, client B was to choose an activity to participate in. -To retrieve her hygiene supplies. -To brush her teeth twice daily. -To identify a quarter. <p>Interview with the Qualified Intellectual Disabilities Professional-Designee (QIDP-D) on 7/21/15 at 2:40 PM indicated client B worked on the above ISP objectives. The QIDP-D indicated client B should have data sheets for the above mentioned objectives. The QIDP-D indicated client B did not have any objectives in the July 2015 data book.</p> <p>This deficiency was cited on 5/28/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>		<p>implementation of Client #B's objectives as well proper documentation of document program data. An audit of facility documentation indicated that this deficient practice did not affect any additional clients.</p> <p>PREVENTION:</p> <p>The QIDP has been trained regarding the need to assure data collection grids are in place at the facility to give direct support staff the opportunity to collect data on prioritized learning objectives as required, as well as the need to track and monitor progress on all client learning objectives. Along with the QIDP, members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, will conduct documentation reviews to assure data is collected as required at the facility no less than weekly for the next 30 days, and no less than twice monthly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility.</p>	

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W 0262 Bldg. 00	<p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on interview and record review for 3 of 4 sampled clients (A, B and D) and 1 additional client G, with restrictive programs, the facility failed to have its Human Rights Committee (HRC) review and/or approve the clients' restrictive programs.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 7/21/15 at 10:29 AM. Client A's 7/29/15 Behavior Support Plan (BSP) indicated client A demonstrated physical aggression and "Aggression on Van/Attempts to Vacate the Van." Client A's BSP indicated facility staff could utilize "Gentle block" when the client demonstrated physical aggression and/or utilize physical redirection to move the client when client A was "targeting"</p>	W 0262	<p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION: <i>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Specifically, the QIDP has obtained Human Rights Committee Approval for all restrictive programs for Clients A, B, D and G. Through review of facility documentation, the governing body has determined that this deficient practice did not affect any additional clients.</i></p> <p>PREVENTION: The QIDP will be retrained</p>	08/27/2015

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	<p>others. Client A's BSP indicated facility staff was not to use physical redirection after all other "...less restrictive supports have been attempted." Client A's BSP also indicated facility staff could utilize physical redirection if client A became aggressive while on the van. Client A's 7/29/15 BSP did not indicate client A's restrictive program had been reviewed and/or approved by the facility's HRC.</p> <p>Interview with Clinical Supervisor (CS) #1 and the QIDP-D (QIDP-Designee) on 7/21/15 at 2:40 PM indicated the facility's HRC had not reviewed and/or approved the client's restrictive program. The QIDP-D indicated she had only obtained approval for client A's behavioral/psychotropic medication.</p> <p>2. Client B's record was reviewed on 7/21/15 at 12:46 PM. Client B's 2/22/15 Behavior Action Plan (BAP) indicated client B demonstrated physical aggression. Client B's BAP indicated facility staff could utilize "gentle blocks" when client B demonstrated physical aggression and/or use "physical redirection" of moving the client when she "targeted" another client. Client B's 2/22/15 BAP indicated "Physical Redirect" was to be utilized as a last resort after other "less restrictive supports have been used." Client B's record and/or</p>		<p>regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs for all clients. When annual program revisions occur and other restrictive practices are assessed as needed, the Clinical Supervisor will review Human Rights Committee documentation prior to the implementation or renewal of restrictive programs. The QIDP, facility nurse and Human Rights Committee liaison will each maintain copies of Human rights Committee approval forms to assure the ability to reproduce copies of HRC records for surveyors upon request. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility three times weekly for the next 30 days and twice weekly visits for an additional 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing</p>	

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	<p>2/22/15 BAP indicated the facility's HRC had not reviewed and/or approved the client's restrictive program.</p> <p>Interview with CS #1 and the QIDP-D on 7/21/15 at 2:40 PM indicated the facility's HRC had not reviewed and/or approved the client's restrictive program. The QIDP-D indicated she had only obtained approval for client B's behavioral/psychotropic medication.</p> <p>3. Client G's record was reviewed on 7/21/15 at 1:20 PM. Client G's 7/31/14 Behavior Action Plan (BAP) indicated client G wore a helmet due to the client's self-injurious behavior of head banging. Client G's BAP indicated a 1 person and/or 2 person standing and/or sitting restraint could be utilized when client G became self-injurious, physically aggressive, disrobed and/or demonstrated behaviors of "sexual boundaries." Client G's 7/31/14 BAP also indicated "Calling for emergency Police assistance should be the absolute last resort when helping [client G] learns (sic) to control her behavior. This option is only used with the approval of the QIDP (Qualified Intellectual Disabilities Professional)...." Client G's 7/31/14 BAP indicated the facility's HRC had not reviewed and/or approved the restrictive behavior plan.</p>		<p>support needed at the facility. These administrative documentation reviews will include review of Human Rights Committee records to assure appropriate approvals have been obtained.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>Interview with Clinical Supervisor (CS) #1 and the QIDP-D on 7/21/15 at 2:40 PM indicated the facility's HRC had not reviewed and/or approved the client's restrictive program. The QIDP-D indicated she had only obtained approval for client G's behavioral/psychotropic medication.</p> <p>4. Client D's record was reviewed on 7/21/15 at 1:40 PM. Client D's 6/2/15 BSP indicated the client demonstrated physical aggression and self-injurious behavior. Client D's BSP indicated facility staff could utilize restraints with 1 or 2 person holds if the client demonstrated self injurious behavior and/or physical aggression. Client D's 6/2/15 restrictive program and/or record indicated the facility's HRC had not reviewed and/or approved the client's restrictive program.</p> <p>Interview with CS #1 and the QIDP-D on 7/21/15 at 2:40 PM indicated the facility's HRC had not reviewed and/or approved the client's restrictive program. The QIDP-D indicated she had only obtained approval for client D's behavioral/psychotropic medication.</p> <p>This deficiency was cited on 5/28/15. The facility failed to implement a systemic plan of correction to prevent</p>			

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W 0268 Bldg. 00	<p>recurrence.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, interview and record review for 1 of 4 sampled clients (A), the facility failed to ensure the client's dignity in regards to hair combing.</p> <p>Findings include:</p> <p>During the 7/21/15 observation period between 6:10 AM and 7:49 AM, at the group home at 6:36 AM, client A came out of her bedroom after getting showered and dressed for the day. Client A's hair was wet and uncombed. Staff #5 told staff #1 she was not able to find client A's comb and/or brush. Staff #1 told staff #5 it was in the client's room. At 7:49 AM, client A was assisted to get on the group home's van to go to work. Client A's hair remained uncombed as the client left for the day program.</p> <p>Interview with staff #1 on 7/21/15 at 7:55 AM indicated client A had a comb and brush. Staff #1 stated "It is normally in</p>	W 0268	<p>CORRECTION:</p> <p><i>These policies and procedures must promote the growth, development and independence of the client. Specifically, direct support staff will be retrained regarding the need to assure all clients are dressed neatly in clothing appropriate for the weather and occasion. Through observation, the team has determined that this deficient practice may have affected all clients.</i></p> <p>PERVENTION:</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer</p>	08/27/2015

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	<p>drawer. It could be in her purse."</p> <p>Interview with the Qualified Intellectual Disabilities Professional-Designee (QIDP-D) and Clinical Supervisor (CS #1) on 7/21/15 at 2:40 PM indicated facility staff should have combed client A's hair before letting the client go to work with her hair uncombed. The QIDP-D indicated she was aware client A went to work with her hair uncombed.</p> <p>9-3-5(a)</p>		<p>medication as prescribed and that all prescribed medications are available. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to assessing direct support staff interaction with clients and to provide hands on coaching and training including but not limited to staff train clients to groom themselves appropriately.</p> <p>Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than weekly for the next 30 days, and no less than twice monthly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p>	

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			<p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p>	

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W 0312	483.450(e)(2) DRUG USAGE		<p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assessing direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff assist clients with appropriate grooming.</p> <p>RESPONSIBLE PARTIES:</p> <p>Health Services Team, QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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Bldg. 00	<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 interview and record review for 2 of 4 sampled clients (B and C) on behavior controlling medications and for 1 additional client (G), the facility failed to ensure each client had an active treatment program for each medication which were prescribed, and to ensure each behavior controlling medication was included/part of the client's behavior plan.</p> <p>Findings include:</p> <p>1. Client B's record was reviewed on 7/21/15 at 12:46 PM. Client B's 6/1/15 physicians orders indicated client B received Sertraline 150 milligrams daily for Depression.</p> <p>Client B's 2/22/15 Behavior Support Plan (BSP) indicated client B's Sertraline listed as one of the client's psychotropic medications in the client's BSP. Client B's 2/22/15 BSP did not indicate client B had an active treatment program for the use of the Sertraline for Depression, and/or define how client B demonstrated the Depression.</p>	W 0312	<p>CORRECTION:</p> <p><i>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. Specifically the QIDP will modify Client B, C and G's Behavior support plan to include active treatment programs for each prescribed behavior controlling medication.</i></p> <p>PERVENTION:</p> <p>The QIDP has been retrained regarding the need to assure that active treatment programs are in place to support the reduction and eventual elimination of all currently prescribed psychotropic medications. Additionally, members of the Operations Team (including Clinical Supervisor, the Program Manager, Nurse Manager and Executive Director) will review facility Behavior Support Plans no less than</p>	08/27/2015			

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	<p>Interview with Clinical Supervisor (CS) #1 and the Qualified Intellectual Disabilities Professional-Designee (QIDP-D) on 7/21/15 at 2:40 PM indicated client B received Sertraline for Depression. The QIDP-D and CS #1 indicated client B did not have an active treatment program for Depression. The QIDP-D and CS #1 also did not know how client B's Depression was defined.</p> <p>2. Client C's record was reviewed on 7/21/15 at 12:12 PM. Client C's 6/1/15 physician's orders indicated client C received Desyrel 50 milligrams at bedtime for "sleep aid."</p> <p>Client C's 9/11/14 BSP indicated client C's restrictive behavior plan did not include the use of Desyrel for a sleep aid. Client C's BSP did not include an active treatment program for client C's sleeplessness.</p> <p>Interview with CS #1 and the QIDP-D on 7/21/15 at 2:40 PM indicated client C's Desyrel was not part of the client's BSP and the client did not have an active treatment program for the client's sleep.</p> <p>3. Client G's record was reviewed on 7/21/15 at 1:20 PM. Client G's 6/1/15 physician's order indicated client G received Melatonin 5 milligrams at</p>		<p>monthly and to assure the plans include active treatment programs designed to reduce and eventually eliminate the use of each prescribed behavior controlling medication.</p> <p>RESPONSIBLE PARTIES:</p> <p>Health Services Team, QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>		

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W 0331 Bldg. 00	<p>bedtime for sleep and Concerta 36 milligrams 2 tablets in the morning for Attention Deficit Hyperactivity Disorder (ADHD).</p> <p>Client G's 7/31/14 Behavior Action Plan (BAP) indicated G's Concerta for ADHD was not part of the client's Behavior Support Plan (BSP). Client G's 7/31/14 BSP indicated the client's ADHD was not clearly defined. Also, client G's 7/31/14 BSP did not include the use of Melatonin for sleep and/or indicate client G had an active treatment program for sleep.</p> <p>Interview with CS #1 and the QIDP-D designee on 7/21/15 at 2:40 PM indicated the use of the Melatonin was not part of the BAP, and the BAP did not include an active treatment program which monitored/tracked client G's sleep.</p> <p>This deficiency was cited on 5/28/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-5(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and</p>	W 0331		08/27/2015			

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	<p>record review for 1 of 4 sampled clients (A), the facility's nursing services failed to ensure facility staff obtained accurate and consistent weights with client A. The facility's nursing services failed to ensure client A's low body weight was addressed/reviewed by the client's doctor and/or failed to obtain a recommended lab ordered by the client's physician.</p> <p>Findings include:</p> <p>1. During the 7/20/15 observation period between 3:10 PM and 5:40 PM and the 7/21/15 observation period between 6:10 AM and 7:49 AM indicated client A was small in size with a bony prominence seen in the client's upper arms/shoulder and chest areas. During the above observation periods, client A ate one serving of food at the breakfast and dinner meals.</p> <p>Client A's record was reviewed on 7/21/15 at 10:29 AM. Client A's 6/1/15 physician's order indicated "Check weight weekly on Wednesday. Call nurse for 5 pound gain or loss in one month. Fax results on Wednesday at 8 PM...."</p> <p>Client A's 12/29/14 Group Home Quarterly Nutrition Assessment indicated client A had a "history of low weights."</p>		<p>CORRECTION:</p> <p><i>The facility must provide clients with nursing services in accordance with their needs. Specifically: The facility nurse will be retrained regarding the need to develop risk plans for all relevant medical conditions. Specifically the nurse has arranged for Client A's primary care physician to evaluate her for conditions contributing to her weight loss. All currently ordered labs have been collected. Additionally, the nurse will work with direct support and supervisory staff to develop a therapeutic approach that assists staff with obtaining consistently accurate readings when weighing Client A.</i></p> <p>A review of current diagnostic information and risk plans indicated this deficient practice did not affect additional clients.</p> <p>PERVENTION:</p> <p>The QIDP will assure that the nursing team is included in all discussions/decisions relevant to clients' health and safety and modifications will be made to Comprehensive High Risk Plans</p>	
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	<p>Client A's nutritional assessment indicated client A's ideal body weight was between 122 to 149 pounds.</p> <p>Client A's nursing Monthly Summaries indicated the following weights: 1/15 125 pounds 2/15 121 pounds 3/15 126 pounds</p> <p>Client A's April 2015 MAR (Medication Administration Record) indicated the following weights: 4/1/15 112 pounds 4/8/15 110.2 pounds 4/15/15 Refused 4/22/15 116.5 pounds 4/29/15 119.8 pounds</p> <p>Client A's May 2015 Nursing Monthly Summary indicated client A's "current weight" was 118 pounds. The May 2015 summary indicated client A weighed 114 pounds a month ago and 128.4 pounds 6 months ago. Client A's May 2015 monthly summary indicated the facility's nurse did not make any additional comments and/or recommendations in regard to client A's weights.</p> <p>Client A's June 2015 MAR indicated the following weekly weights:</p>		<p>accordingly. The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans. The nurse manager will review all facility risk plan modifications for the next 90 days to assure they contain appropriate detail, and will conduct periodic audits of facility risk plans on an ongoing basis.</p> <p>Members of the Operations Team (including Clinical Supervisors, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility weekly for the next 30 days and twice monthly visits for an additional 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include review of healthcare records and incident documentation to assure appropriate risk plans and</p>	

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	<p>6/3/15 113 pounds 6/10/15 119 pounds 6/17/15 115.5 pounds 6/2015 115 pounds</p> <p>Client A's June 2015 Nursing Monthly Summary indicated client A's "current weight" was 115 pounds. The nurse note indicated client A weighed 118 pounds "1 mo (month) ago Wt (weight) 6 mo ago" was 125 pounds. Client A's June 2015 monthly summary indicated the facility's nurse did not make any additional comments and/or recommendations in regard to client A's weights.</p> <p>Client A's July MAR indicated the following weekly weights:</p> <p>7/1/15 126 pounds 7/8/15 104 pounds 7/15/15 101 pounds</p> <p>Client A's 7/1/15 risk plan in regard to weight loss indicated client A received a mechanical soft diet, and the client's food could be pureed as needed. The 7/1/15 risk plan indicated staff should offer client A seconds as desired. Client A's risk plan also indicated "...Check weight weekly as indicated on MAR and record result/OBTAIN WEIGHT IN THE CHAIR SCALE. 7. Notify nurse if</p>		<p>nursing supports are in place.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team</p>	

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	<p>weight is below 122 lbs (pounds)...."</p> <p>Client A's record and/or monthly nurse notes did not indicate client A's doctor had been informed/contacted in regard to client A's low weights, and/or indicate if the client had been evaluated/re-evaluated.</p> <p>Interview with staff #3 on 7/20/15 at 5:25 PM indicated client A received a regular pureed diet. Staff #3 indicated client A did not receive doubles and/or a second helping. When asked how client A's weight was doing, staff #3 stated "Up and down."</p> <p>Interview with staff #2 on 7/21/15 at 7:50 AM stated client A "Ate good." Staff #2 stated client A had difficulty eating due to the client's "shaking."</p> <p>Interview with staff #1 on 7/21/15 at 7:55 AM indicated staff #1 thought client A weighed around 118 pounds. Staff #1 stated client A's weight "was up and down but stable in the past 3 weeks." Staff #1 indicated client A had not seen her primary care physician (PCP) in regard to her low weight and/or weight loss. Staff #1 indicated client A was not to see her PCP until October 16, 2015. Staff #1 indicated that was as soon as they could get client A in to see her</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/28/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
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	<p>doctor.</p> <p>Interview with Clinical Supervisor (CS) #1, LPN #1 and the QIDP-D (Qualified Intellectual Disabilities Professional-Designee) on 7/21/15 at 2:40 PM indicated client A was to be weighed weekly. LPN #1 indicated she was aware of client A's weights. LPN #1 and the QIDP-D indicated client A was to use the chair scale when staff weighed client A. LPN #1 stated "Not sure what is happening with weights. They are all over the place. Not accurate." LPN #1 and the QIDP-D indicated they were not sure how facility staff were weighing client A. LPN #1 indicated she had been considering obtaining an order for a nutritional supplement for client A. LPN #1 and the QIDP-D indicated client A could have seconds at meals. LPN #1 indicated client A's weight had not been evaluated by the client's PCP. LPN #1 indicated client A would not see her doctor until October 2015. LPN #1 indicated she was waiting on the dietician to come in and make some recommendations in regard to client A's weights/weight loss. LPN #1 indicated the dietician should be in some time this month (July 2015).</p> <p>2. Client A's record was reviewed on 7/21/15 at 10:29 AM. Client A's 8/5/14</p>			

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	<p>Record Of Visits indicated "...Please do a hemocult (checking for blood in stool) & (and) send me a copy of results...."</p> <p>Client A's 5/28/15 Record Of Visit (ROV) form indicated client A had lab work done on 5/28/15. Client A's 5/28/15 ROV form and/or record did not indicate the facility obtained the recommended hemocult lab.</p> <p>Interview with LPN #1 and the QIDP-D on 7/21/15 at 2:40 PM indicated they did not see where the hemocult lab had been completed/obtained.</p> <p>This federal tag relates to complaint #IN00172392.</p> <p>This deficiency was cited on 5/28/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>			