

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G397	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2014
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250
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W000000	<p>This visit was for an extended annual recertification and state licensure survey.</p> <p>Dates of Survey: 2/5/14, 2/6/14, 2/7/14 and 2/10/14.</p> <p>Facility Number: 000911 Provider Number: 15G397 AIMS Number: 100244420</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/17/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (#1) plus one additional client (Former Client #1) . The facility failed to implement its written policies and procedures to</p>	W000122	<p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically:</i> The facility will retrain all staff on</p>	03/12/2014

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>immediately notify the BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an allegation of theft and elopement for client #1, to complete a thorough investigation regarding two incidents of injuries of unknown origin for FC (Former Client) #1, an allegation of theft for client #1 and two incidents of elopement for client #1 and to develop and implement corrective action to address client #1's elopement from the group home.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The facility failed to implement its written policies and procedures to immediately notify the BDDS in accordance with state law regarding an allegation of theft and elopement for client #1, to complete a thorough investigation regarding two incidents of injuries of unknown origin for FC #1, an allegation of theft for client #1 and two incidents of elopement for client #1 and to develop and implement corrective action to address client #1's elopement from the group home. Please see W149. The facility failed to immediately notify the BDDS in accordance with state law regarding an allegation of theft and elopement for client #1. Please see 		<p>the need to report allegations immediately. The facility has submitted BDDS Incident report regarding Client #1's elopement and has submitted an additional initial incident report regarding Client #1's allegations of theft.</p> <p>Addendum: a review of incident documentation indicates no other clients were affected by failure to report incidents to the administrator and the State of Indiana as required.</p> <p>The interdisciplinary team will evaluate current assessment and incident data and meet to develop strategies to prevent Client #1 from gaining access to van and or other automotive keys and to prevent and respond to future attempts of elopement.</p> <p>ADDENDUM: a review of facility incident data and program documents did not uncover additional instances in which the facility failed to develop appropriate protective measures.</p> <p>PREVENTION: Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor responsible for Quality Assurance, who will in turn coordinate and follow-up with the facility QIDP to assure incidents</p>		

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	<p>W153.</p> <p>3. The facility failed to complete a thorough investigation regarding two incidents of injuries of unknown origin for FC #1, an allegation of theft for client #1 and two incidents of elopement for client #1. Please see W154.</p> <p>4. The facility failed to develop and implement corrective action to address client #1's elopement from the group home. Please see W157.</p> <p>9-3-2(a)</p>		<p>are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation, the governing body will administer written corrective action up to and including termination of employment.</p> <p>The Clinical Supervisor will follow-up with the QIDP as needed but no less than weekly to review incident documentation and completed investigations to assure they have been completed thoroughly. Additionally, the governing body will submit a request to the Indiana State Department of Health for an inservice presentation to all agency professional staff regarding the components of a through investigation.</p> <p>The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to elopement to review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require</p>		

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 5 of 14 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to implement its policy and procedures to immediately notify the BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an allegation of theft and elopement for client #1, to complete a thorough investigation regarding two incidents of injuries of unknown origin for FC (Former Client) #1, an allegation of theft for client #1 and two incidents of elopement for client #1 and to develop and implement corrective action to address client #1's elopement from the group home.</p> <p>Findings include:</p> <p>The facility's BDDS reports and investigations were reviewed on 2/5/14 at 1:40 PM. The review indicated the following:</p>			W000149	<p>interdisciplinary team action.</p> <p>RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Operations Team</p> <p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically:</i></p> <p>The facility will retrain all staff on the need to report allegations immediately. The facility has submitted BDDS Incident report regarding Client #1's elopement and has submitted an additional initial incident report regarding Client #1's allegations of theft.</p> <p>Addendum: a review of incident documentation indicates no other clients were affected by failure to report incidents to the administrator and the State of Indiana as required.</p> <p>The interdisciplinary team will evaluate current assessment and incident data and meet to develop strategies to prevent Client #1 from gaining access to van and or other automotive keys and to prevent and respond to future attempts of elopement.</p> <p>ADDENDUM: a review of facility</p>		03/12/2014

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	<p>1. BDDS report dated 1/31/14 indicated on 1/29/14 "[Client #1] was upset with one of his roommates, he said that roommate had taken his rechargeable cigarette and his wallet. Staff asked the roommate if he had taken the items and the roommate said no and [client #1] ran out and staff followed him on foot and when staff could not keep up they came back got van and found [client #1] about 3 miles from the home (sic). [Client #1] was not hurt but was still upset about his items being missing."</p> <p>The review indicated client #1's 1/29/14 allegation of theft and elopement was reported to BDDS on 1/31/14.</p> <p>QIDPD #1 (Qualified Intellectual Disabilities Professional Designee) #1 was interviewed on 2/6/14 at 8:33 AM. QIDPD #1 indicated client #1 had made an allegation of theft on 1/29/14. QIDPD #1 indicated client #1 had walked away from the group home and was out of staff's sight during the incident.</p> <p>2. BDDS report dated 8/3/13 indicated, "[FC #1]... came out of his room down the hallway when staff noticed a red mark above his right eye. After looking at it (sic) staff seen (sic) that it was a scratch." The 8/3/13 BDDS report indicated, "[RM #1 (Residential</p>		<p>incident data and program documents did not uncover additional instances in which the facility failed to develop appropriate protective measures.</p> <p>PREVENTION: Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor responsible for Quality Assurance, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation, the governing body will administer written corrective action up to and including termination of employment.</p> <p>The Clinical Supervisor will follow-up with the QIDP as needed but no less than weekly to review incident documentation and completed investigations to assure they have been completed thoroughly. Additionally, the governing body will submit a request to the Indiana State Department of Health for an inservice presentation to all agency professional staff regarding the components of a</p>				

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	<p>Manager)] will start an investigation to determine where the scratch came from."</p> <p>-Investigation form dated 8/3/13 indicated the facility had conducted an investigation regarding FC #1's red mark/scratches. The 8/3/13 investigation did not indicate documentation of an outcome/conclusion. The 8/3/13 investigation did not indicate documentation of interviews conducted with FC #1's housemates whom were present in the home at the time of the incident.</p> <p>3. BDDS report dated 9/6/13 indicated, "[FC #1] was sitting in the chair and staff noticed a long scratch on the back of neck (sic) on call nurse was notified and advised staff to clean and apply Bacitracin to the scratch...."</p> <p>-Investigation form dated 9/6/13 indicated the facility had conducted an investigation regarding FC #1's scratches. The 9/6/13 investigation did not indicate documentation of an outcome/conclusion. The 9/6/13 investigation did not indicate documentation of interviews conducted with FC #1's housemates.</p> <p>QIDPD #1 was interviewed on 2/6/14 at</p>		<p>through investigation.</p> <p>The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to elopement to review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action.</p> <p>RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Operations Team</p>		

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	<p>8:33 AM. QIDPD #1 indicated FC #1's housemates had not been interviewed to determine the origin of FC #1's injuries. QIDPD #1 indicated FC #1's injury of unknown origin investigation dated 8/3/13 and 9/6/13 did not include documentation of conclusions/summaries of the investigations.</p> <p>4. BDDS report dated 1/20/14 indicated, "[Client #1] obtained a spare set of van keys of which staff on duty were not aware. [Client #1] exited the house and [staff #1] followed him to the van and attempted to redirect him verbally to return to the house without success. [Client #1] got into the van locked the doors, backed out of the driveway and pulled away. A police report was filed and the supervisory and senior management teams were notified immediately." The 1/20/14 BDDS report indicated, "[Client #1], who does not have a driver's license, was located by the police at 9:30 PM, at another [facility service site]... 8 miles from his home." The 1/20/14 BDDS report indicated, "[Client #1] was away from staff supervision in the van for two hours and was considered a danger to himself and others since he is not a licensed driver. An investigation into the circumstances of the incident is</p>						

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	<p>underway and the IDT (Interdisciplinary Team) will meet to evaluate [client #1's] current supports and make adjustments as needed."</p> <p>IDT meeting note dated 1/22/14 indicated, "Subject: Elopement. Meeting Agenda: Staff will keep [client #1] in line of sight at all time (sic) when he is awake."</p> <p>-EMPI (Elopement/Missing Person Investigation) form dated 1/19/14 indicated staff #1 and staff #2 were interviewed regarding client #1's 1/19/14 elopement incident. The 1/19/14 EMPI did not indicate documentation of interviews with supervisory and management team members. The 1/19/14 EMPI did not indicate documentation of interviews with clients #2, #3, #4, #5, #6, #7 or #8. The 1/19/14 EMPI did not indicate documentation of review of staff #1 and #2's actions prior to or during client #1's elopement to determine if they had appropriately implemented client #1's BSP (Behavior Support Plan). The EMPI did not indicate documentation of review of how client #1 obtained keys to the facility van.</p> <p>QIDPD #1 was interviewed on 2/6/14 at 8:33 AM. QIDPD #1 indicated he had</p>						

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	<p>completed the 1/19/14 EMPI regarding client #1's elopement. QIDPD #1 stated, "[Client #1] had gone out to the van. [Staff #1] went with him and was able to redirect him back into the house. [Client #1] wanted to come back into the house to get his cigarettes. [Staff #1] thought that meant he was calming down. [Client #1] smokes to calm himself. [Client #1] went back out to the van and left. After the incident, he, [client #1], told us he had been agitated because [client #3] was making too much noise." QIDPD #1 indicated the investigation did not clarify the circumstances that precipitated client #1's elopement. QIDPD #1 indicated staff #1 and #2 were interviewed regarding the incident. QIDPD #1 indicated additional staff and management had arrived at the group home after client #1's elopement and had assisted with searching for client #1 and coordinated efforts with local law enforcement. QIDPD #1 indicated clients #2, #3, #4, #5, #6, #7 or #8 were not interviewed regarding client #1's elopement. When asked if the 1/19/14 EMPI was thorough, QIDPD #1 stated, "No, I should have included more information. I guess I should have talked with the other people that came and helped."</p> <p>4. BDDS report dated 1/31/14 indicated</p>						

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	<p>on 1/29/14 "[Client #1] was upset with one of his roommates, he said that roommate had taken his rechargeable cigarette and his wallet. Staff asked the roommate if he had taken the items and the roommate said no and [client #1] ran out and staff followed him on foot and when staff could not keep up they came back got van and found [client #1] about 3 miles from the home (sic). [Client #1] was not hurt but was still upset about his items being missing." The 1/31/14 BDDS report indicated, "Plan to resolve: Staff will be retrained on [client #1's] BSP and resident manager will start 15 minute checks to be performed daily and documented by all staff for hours [client #1] is awake. [QIDPD #1] will update [client #1's] BSP."</p> <p>-EMPI form dated 1/29/14 did not indicate documentation regarding client #1's allegation of theft. EMPI dated 1/29/14 did not indicate documentation of interviews with RM #1 and/or other clients present in the home at the time of the allegation/incident.</p> <p>IDT meeting note dated 2/2/14 indicated, "[Client #1] will be placed on 15 minute checks to ensure staff knows (sic) where he is at all times to ensure his safety."</p>						

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	<p>Client #1's record was reviewed on 2/6/14 at 9:43 AM. Client #1's BSP dated 9/20/13 did not indicate documentation of revision since 9/20/13. Client #1's BSP did not indicate documentation of revision to reflect the 2/2/14 and/or 1/22/14 IDT recommendations for client #1 to be on line of sight supervision or 15 minute status checks.</p> <p>QIDPD #1 was interviewed on 2/6/14 at 8:33 AM. QIDPD #1 indicated the facility had conducted IDTs on 1/22/14 and 2/2/14 to determine ways to address client #1's elopement and prevent future occurrences. QIDPD #1 indicated the 1/22/14 IDT recommended client #1 be in line of sight at all times. When asked if the IDT had discussed alternate methods to redirect client #1 from elopement attempts, QIDPD #1 stated, "No." When asked how maintaining client #1 in line of sight would prevent future elopement attempts, QIDPD #1 stated, "[Client #1] gets frustrated easily with noises. [Client #1] doesn't like it when [client #3] gets too loud. [Client #1] will get frustrated and then just take off. He really didn't tell anyone he was leaving, he just walked out. I think staff need to watch him, [client #1], and direct him to things that calm him down. He likes to go to his room and listen to</p>						

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	<p>music or play video games." When asked if the IDT had included recommendations regarding how to monitor or redirect client #1 while on line of sight, QIDPD #1 stated, "No." QIDPD #1 indicated the 2/2/14 IDT had recommended client #1 be placed on 15 minute checks. QIDPD #1 indicated the IDT had not reviewed how staff should ensure client #1 did not obtain keys to vehicles. QIDPD #1 indicated the IDT should make recommendations to address client #1's elopement and prevent future occurrences.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 2/6/14 at 10:50 AM. CS #1 indicated all allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be reported to BDDS within 24 hours. CS #1 indicated all allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be thoroughly investigated and include documentation of a summary/conclusion of the investigation findings. CS #1 indicated the facility should develop and implement actions to prevent reoccurrence of client #1's elopements. CS #1 indicated the facility's abuse and neglect policy should be implemented.</p> <p>The facility's policy and procedures were</p>						

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	<p>reviewed on 2/10/14 at 8:00 AM. The facility's 9/14/07 policy and procedure entitled, "Abuse, Neglect, Exploitation" indicated, "(5.) Following Adept protocol for the exact process to report incidents, once the suspicion has been reported to the supervisor and/or PD (Program Director), the PD will report, within 24 hours, the suspected abuse, neglect or exploitation as follows: ... (g.)To the BDDS...."</p> <p>The facility's 9/14/07 policy and procedure entitled, "Investigations" indicated, "Practices: 3. (b) Ensure alleged incident of abuse, neglect, mistreatment, exploitation or injuries of unknown origin are fully investigated within 5 calendar days from the date the allegations were made and investigation was initiated." The 9/14/07 policy indicated, "A thorough investigation final report will be written at the completion of the investigation. The report shall include, but is not limited to, the following:... concerns and recommendations... (and) methods to prevent future incidents."</p> <p>9-3-2(a)</p>						

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 of 14 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to immediately notify the BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an allegation of theft and elopement for client #1.</p> <p>Findings include:</p> <p>The facility's BDDS reports and investigations were reviewed on 2/5/14 at 1:40 PM. The review indicated the following:</p> <p>-BDDS report dated 1/31/14 indicated on 1/29/14 "[Client #1] was upset with one of his roommates, he said that roommate had taken his rechargeable cigarette and his wallet. Staff asked the roommate if he had taken the items and the roommate said no and [client #1] ran out and staff followed him on foot and when staff could not keep up they came back got van and found [client #1] about</p>	W000153	<p>CORRECTION:</p> <p><i>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Specifically, the facility will retrain all staff on the need to report allegations immediately. The facility has submitted BDDS Incident report regarding Client #1's elopement and has submitted an additional initial incident report regarding Client #1's allegations of theft.</i></p> <p>Addendum: a review of incident documentation indicates no other clients were affected by failure to report incidents to the administrator and the State of Indiana as required.</p> <p>The QIDP has been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed and all relevant documents reviewed.</p> <p>PREVENTION:</p>	03/12/2014			

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W000154	<p>3 miles from the home (sic). [Client #1] was not hurt but was still upset about his items being missing."</p> <p>The review indicated client #1's 1/29/14 allegation of theft and elopement was reported to BDSS on 1/31/14.</p> <p>QIDPD #1 (Qualified Intellectual Disabilities Professional Designee) #1 was interviewed on 2/6/14 at 8:33 AM. QIDPD #1 indicated client #1 had made an allegation of theft on 1/29/14. QIDPD #1 indicated client #1 had walked away from the group home and was out of staff's sight during the incident.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 2/6/14 at 10:50 AM. CS #1 indicated all allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be reported to BDSS within 24 hours.</p> <p>9-3-1(b)(5) 9-3-2(a) 483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 5 of 14 allegations of abuse, neglect, mistreatment, exploitation and injuries</p>	W000154	<p>Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor responsible for Quality Assurance, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation, the governing body will administer written corrective action up to and including termination of employment.</p> <p>RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Operations Team</p> <p>CORRECTION: The facility must have evidence that all alleged violations are thoroughly investigated. Specifically, the</p>	03/12/2014			

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	<p>of unknown origin reviewed, the facility failed to complete a thorough investigation regarding two incidents of injuries of unknown origin for FC (Former Client) #1, an allegation of theft for client #1 and two incidents of elopement for client #1.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/5/14 at 1:40 PM. The review indicated the following:</p> <p>1. BDDS report dated 8/3/13 indicated, "[FC #1]... came out of his room down the hallway when staff noticed a red mark above his right eye. After looking at it (sic) staff seen (sic) that it was a scratch." The 8/3/13 BDDS report indicated, "[RM #1 (Residential Manager)] will start an investigation to determine where the scratch came from."</p> <p>-Investigation form dated 8/3/13 indicated the facility had conducted an investigation regarding FC #1's red mark/scratches. The 8/3/13 investigation did not indicate documentation of an outcome/conclusion. The 8/3/13 investigation did not indicate</p>		<p>QIDP has been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed and all relevant documents reviewed. PREVENTION: The QIDP will turn in copies of completed investigations to the Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will follow-up with the QIDP as needed but no less than weekly to review incident documentation and completed investigations to assure they have been completed thoroughly. Additionally, the governing body will submit a request to the Indiana State Department of Health for an inservice presentation to all agency professional staff regarding the components of a through investigation. RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Operations Team</p>		

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	<p>documentation of interviews conducted with FC #1's housemates whom were present in the home at the time of the incident.</p> <p>2. BDDS report dated 9/6/13 indicated, "[FC #1] was sitting in the chair and staff noticed a long scratch on the back of neck (sic) on call nurse was notified and advised staff to clean and apply Bacitracin to the scratch...."</p> <p>-Investigation form dated 9/6/13 indicated the facility had conducted an investigation regarding FC #1's scratches. The 9/6/13 investigation did not indicate documentation of an outcome/conclusion. The 9/6/13 investigation did not indicate documentation of interviews conducted with FC #1's housemates.</p> <p>3. BDDS report dated 1/20/14 indicated, "[Client #1] obtained a spare set of van keys of which staff on duty were not aware. [Client #1] exited the house and [staff #1] followed him to the van and attempted to redirect him verbally to return to the house without success. [Client #1] got into the van locked the doors, backed out of the driveway and pulled away. A police report was filed and the supervisory and senior management teams were notified</p>						

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	<p>immediately." The 1/20/14 BDDS report indicated, "[Client #1], who does not have a driver's license, was located by the police at 9:30 PM, at another [facility service site]... 8 miles from his home." The 1/20/14 BDDS report indicated, "[Client #1] was away from staff supervision in the van for two hours and was considered a danger to himself and others since he is not a licensed driver. An investigation into the circumstances of the incident is underway and the IDT (Interdisciplinary Team) will meet to evaluate [client #1's] current supports and make adjustments as needed."</p> <p>-EMPI (Elopement/Missing Person Investigation) form dated 1/19/14 indicated staff #1 and staff #2 were interviewed regarding client #1's 1/19/14 elopement incident. The 1/19/14 EMPI did not indicate documentation interviews with supervisory and management team members. The 1/19/14 EMPI did not indicate documentation of interviews with clients #2, #3, #4, #5, #6, #7 or #8. The 1/19/14 EMPI did not indicate documentation of review of staff #1 and #2's actions prior to or during client #1's elopement to determine if they had appropriately implemented client #1's BSP (Behavior Support Plan). The EMPI did not</p>						

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	<p>indicate documentation of review of how client #1 obtained keys to the facility van.</p> <p>4. BDDS report dated 1/31/14 indicated on 1/29/14 "[Client #1] was upset with one of his roommates, he said that roommate had taken his rechargeable cigarette and his wallet. Staff asked the roommate if he had taken the items and the roommate said no and [client #1] ran out and staff followed him on foot and when staff could not keep up they came back got van and found [client #1] about 3 miles from the home (sic). [Client #1] was not hurt but was still upset about his items being missing."</p> <p>-EMPI form dated 1/29/14 did not indicate documentation regarding client #1's allegation of theft. EMPI dated 1/29/14 did not indicate documentation of interviews with RM #1 (Residential Manager) and/or other clients present in the home at the time of the allegation/incident. The EMPI dated 1/29/14 did not indicated client #1 was "... always in the line of sight."</p> <p>QIDPD #1 (Qualified Intellectual Disabilities Professional Designee) #1 was interviewed on 2/6/14 at 8:33 AM.</p> <p>QIDPD #1 indicated FC #1's housemates</p>			

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	<p>had not been interviewed to determine the origin of FC #1's injuries. QIDPD #1 indicated FC #1's injury of unknown origin investigation's dated 8/3/13 and 9/6/13 did not include documentation of conclusions/summaries of the investigations.</p> <p>QIDPD #1 indicated he had completed the 1/19/14 EMPI regarding client #1's elopement. QIDPD #1 stated, "[Client #1] had gone out to the van. [Staff #1] went with him and was able to redirect him back into the house. [Client #1] wanted to come back into the house to get his cigarettes. [Staff #1] thought that meant he was calming down. [Client #1] smokes to calm himself. [Client #1] went back out to the van and left. After the incident, he, [client #1], told us he had been agitated because [client #3] was making too much noise." QIDPD #1 indicated the investigation did not clarify the circumstances that precipitated client #1's elopement. QIDPD #1 indicated staffs #1 and #2 were interviewed regarding the incident. QIDPD #1 indicated additional staff and management had arrived at the group home after client #1's elopement and had assisted with searching for client #1 and coordinated efforts with local law enforcement. QIDPD #1 indicated clients #2, #3, #4, #5, #6, #7 or #8 were</p>						

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W000157	<p>not interviewed regarding client #1's elopement. When asked if the 1/19/14 EMPI was thorough, QIDPD #1 stated, "No, I should have included more information. I guess I should have talked with the other people that came and helped."</p> <p>QIDPD #1 indicated staff were not able to maintain line of sight of client #1 during the 1/29/14 elopement. QIDPD #1 indicated RM #1 and client #1's housemates were not interviewed during the EMPI dated 1/29/14. QIDPD #1 indicated client #1's allegation of theft was not reviewed/addressed during the EMPI dated 1/29/14.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 2/6/14 at 10:50 AM. CS #1 indicated all allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be thoroughly investigated and include documentation of a summary/conclusion of the investigation findings.</p> <p>9-3-2(a) 483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 2 of 14 allegations of abuse, neglect,</p>	W000157	CORRECTION:If the alleged violation is verified, appropriate	03/18/2014			

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	<p>mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to develop and implement corrective action to address client #1's elopement from the group home.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/5/14 at 1:40 PM. The review indicated the following:</p> <p>1. BDDS report dated 1/20/14 indicated, "[Client #1] obtained a spare set of van keys of which staff on duty were not aware. [Client #1] exited the house and [staff #1] followed him to the van and attempted to redirect him verbally to return to the house without success. [Client #1] got into the van, locked the doors, backed out of the driveway and pulled away. A police report was filed and the supervisory and senior management teams were notified immediately." The 1/20/14 BDDS report indicated, "[Client #1], who does not have a driver's license, was located by the police at 9:30 PM, at another [facility service site]... 8 miles from his home." The 1/20/14 BDDS report indicated, "[Client #1] was away from staff supervision in the van for two</p>		<p>corrective action must be taken. Specifically, the interdisciplinary team will evaluate current assessment and incident data and meet to develop strategies to prevent Client #1 from gaining access to van and or other automotive keys and to prevent and respond to future attempts of elopement. PREVENTION: The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to elopement to review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team</p>		

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	<p>hours and was considered a danger to himself and others since he is not a licensed driver. An investigation into the circumstances of the incident is underway and the IDT (Interdisciplinary Team) will meet to evaluate [client #1's] current supports and make adjustments as needed."</p> <p>IDT meeting note dated 1/22/14 indicated, "Subject: Elopement. Meeting Agenda: Staff will keep [client #1] in line of sight at all time (sic) when he is awake."</p> <p>2. BDDS report dated 1/31/14 indicated on 1/29/14 "[Client #1] was upset with one of his roommates, he said that roommate had taken his rechargeable cigarette and his wallet. Staff asked the roommate if he had taken the items and the roommate said no and [client #1] ran out and staff followed him on foot and when staff could not keep up they came back got van and found [client #1] about 3 miles from the home (sic). [Client #1] was not hurt but was still upset about his items being missing." The 1/31/14 BDDS report indicated, "Plan to resolve: Staff will be retrained on [client #1's] BSP (Behavior Support Plan) and resident manager will start 15 minute checks to be performed daily and documented by all staff for hours [client</p>			

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	<p>#1] is awake. [QIDPD #1] will update [client #1's] BSP."</p> <p>IDT meeting note dated 2/2/14 indicated, "[Client #1] will be placed on 15 minute checks to ensure staff knows (sic) where he is at all time to ensure his safety."</p> <p>Client #1's record was reviewed on 2/6/14 at 9:43 AM. Client #1's BSP dated 9/20/13 did not indicate documentation of revision since 9/20/13. Client #1's BSP did not indicate documentation of revision to reflect the 2/2/14 and/or 1/22/14 IDT recommendations for client #1 to be on line of sight supervision or 15 minute status checks.</p> <p>QIDPD #1 (Qualified Intellectual Disabilities Professional Designee) #1 was interviewed on 2/6/14 at 8:33 AM. QIDPD #1 indicated the facility had conducted IDTs on 1/22/14 and 2/2/14 to determine ways to address client #1's elopement and prevent future occurrences. QIDPD #1 indicated the 1/22/14 IDT recommended client #1 be in line of sight at all times. When asked if the IDT had discussed alternate methods to redirect client #1 from elopement attempts, QIDPD #1 stated, "No." When asked how maintaining</p>						

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	<p>client #1 in line of sight would prevent future elopement attempts, QIDPD #1 stated, "[Client #1] gets frustrated easily with noises. [Client #1] doesn't like it when [client #3] gets too loud. [Client #1] will get frustrated and then just take off. He really didn't tell anyone he was leaving, he just walked out. I think staff need to watch him, [client #1], and direct him to things that calm him down. He likes to go to his room and listen to music or play video games." When asked if the IDT had included recommendations regarding how to monitor or redirect client #1 while on line of sight, QIDPD #1 stated, "No." QIDPD #1 indicated the 2/2/14 IDT had recommended client #1 be placed on 15 minute checks. QIDPD #1 indicated the IDT had not reviewed how staff should ensure client #1 did not obtain keys to vehicles. QIDPD #1 indicated the IDT should make recommendations to address client #1's elopement and prevent future occurrences.</p> <p>9-3-2(a)</p>						

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview, the QIDP (Qualified Intellectual Disabilities Professional) failed to monitor, coordinate and integrate each client's active treatment program by failing to ensure the facility's HRC (Human Rights Committee) obtained the written informed consent of client #1's guardian before the use of psychotropic medications and restrictive program for the management of client #1's behavior, to ensure client #1's ISP (Individual Support Plan)/BSP (Behavior Support Plan) included the use of 15 minute checks and/or unsupervised alone time and to ensure client #1 used his prescription eyeglasses.</p> <p>Findings include:</p> <p>1. The QIDP failed to monitor, coordinate and integrate each client's active treatment program by failing to ensure the facility's HRC obtained the written informed consent of client #1's guardian before the use of psychotropic medications and restrictive program for the management of client #1's behavior.</p>	W000159	<p>CORRECTION:</p> <p><i>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Specifically, the QIDP will receive additional training to improve integration, coordination, and monitoring of Client #1's active treatment program. The training will focus on:</i></p> <p>The need to obtain prior written informed consent from the Human Rights Committee and guardians for the use of psychotropic medications and rights restrictions.</p> <p>ADDENDUM: a review of client records indicated that Client #7's guardian had not provided written informed consent for Client #7's restrictive programs and therefore the team will contact the guardian to obtain the appropriate consents.</p> <p>The need to incorporate enhanced supervision including but not limited to 15 minute checks into Behavior Support Plans. ADENDUM: A review of facility support documents indicated that no other clients had rights restrictions that were not addressed in the individual support plan.</p> <p>The need to develop programs to</p>	03/12/2014	

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W000263	<p>Please see W263.</p> <p>2. The QIDP failed to monitor, coordinate and integrate each client's active treatment program by failing to ensure client #1's ISP/BSP included the use of 15 minute checks. Please see W289.</p> <p>3. The QIDP failed to monitor, coordinate and integrate each client's active treatment program by failing to ensure client #1 used his prescription eyeglasses. Please see W436.</p> <p>9-3-3(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & 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 record review and interview</p>	W000263	<p>teach clients to make informed decisions about the use of adaptive equipment. ADDENDUM: a review of documentation and current support documents indicated that the team has provided programmatic support to other clients who have demonstrated the need to learn to make informed decisions about the use of adaptive equipment.</p> <p>PREVENTION: Members of the Operations Team will conduct twice monthly audits of facility support documents and for the next 90 days. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly audits designed to assure that the QIDP integrates, coordinates and monitors, the active treatment program effectively. Administrative staff will provide guidance, mentorship and corrective measures as needed.</p> <p>RESPONSIBLE PARTIES: QIDP, Operations Team</p> <p>CORRECTION:</p>	03/12/2014	

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	<p>for 1 of 4 sampled clients with restrictive programs (client #1), the facility's HRC (Human Rights Committee) failed to obtain the written informed consent of client #1's guardian before the use of psychotropic medications and restrictive program for the management of client #1's behavior.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 2/6/14 at 9:43 AM. Client #1's ISP (Individual Support Plan) dated 9/20/13 indicated client #1 had a legal guardian. Client #1's BSP (Behavior Support Plan) dated 9/20/13 indicated client #1's targeted behaviors included verbal aggression, physical aggression and leaving his assigned area. Client #1's BSP dated 9/20/13 indicated facility staff were to utilize YSIS (You're Safe, I'm Safe) physical management/personal safety techniques as reactive strategies/specific interventions regarding physical aggression and leaving his assigned area. Client #1's BSP did not indicate documentation of written informed consent from client #1's guardian regarding the use of restrictive practices of physical management of client #1's behaviors. Client #1's POF (Physician's Orders Form) dated 12/27/13 indicated client #1</p>		<p><i>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. Specifically, the team will obtain written consent from Client #1's guardian for the use of behavior controlling medications and restrictive programs.</i></p> <p>ADDENDUM: a review of client records indicated that Client #7's guardian had not provided written informed consent for Client #7's restrictive programs and therefore the team will contact the guardian to obtain the appropriate consents.</p> <p>PREVENTION: Professional staff will be retrained regarding the need to obtain prior written informed consent from guardians, advocates and healthcare representatives for all restrictive programs prior to implementation. Retraining will focus on assuring that the QIDP has a clear understanding of what specifically constitutes a restrictive program and proper preparation for presenting program modifications guardians and other legal representatives. Prior to granting approval to restrictive programs, the Human Rights Committee will obtain confirmation that the facility has received prior written informed consent from Guardian or other legal representatives. The agency has established a quarterly</p>				

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W000289	<p>had a physician's order for Methylphenidate tablet 18 milligrams (Attention Deficit/Hyperactivity Disorder) dated 11/1/13. Client #1's record did not indicate written informed consent from client #1's guardian regarding the use of psychotropic medication for behavior management.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 2/6/14 at 10:51 AM. CS #1 indicated client #1's BSP and psychotropic medication used for behavior management should have written informed consent from client #1's guardian prior to implementation or use.</p> <p>9-3-4(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1's ISP (Individual Support Plan)/BSP (Behavior Support Plan) included the use of 15 minute checks.</p> <p>Findings include:</p>	W000289	<p>system of internal audits that review all facility systems including, but not limited to due process and prior written informed consent. Administrative staff will conduct visits to the facility as needed but no less than monthly.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p> <p>CORRECTION: <i>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan. Specifically, the use of 15 minute checks will be incorporated into Client #1's Behavior Support</i></p>	03/12/2014			

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	<p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/5/14 at 1:40 PM. The review indicated the following:</p> <p>-BDDS report dated 1/31/14 indicated on 1/29/14 "[Client #1] was upset with one of his roommates, he said that roommate had taken his rechargeable cigarette and his wallet. Staff asked the roommate if he had taken the items and the roommate said no and [client #1] ran out and staff followed him on foot and when staff could not keep up they came back got van and found [client #1] about 3 miles from the home (sic). [Client #1 was not hurt but was still upset about his items being missing." The 1/31/14 BDDS report indicated, "Plan to resolve: Staff will be retrained on [client #1's] BSP (Behavior Support Plan) and resident manager will start 15 minute checks to be performed daily and documented by all staff for hours [client #1] is awake. [QIDPD #1] will update [client #1's] BSP."</p> <p>IDT meeting note dated 2/2/14 indicated, "[Client #1] will be placed on 15 minute checks to ensure staff knows (sic) where he is at all time to ensure his safety."</p>		<p>Plan. ADENDUM: A review of facility support documents indicated that no other clients had rights restrictions that were not addressed in the individual support plan</p> <p>PREVENTION: Members of the Operations Team will conduct twice monthly audits of facility support documents and for the next 90 days to assure that all programs are addressed in the plans. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly audits designed to assure that the QIDP integrates, coordinates and monitors, the active treatment program effectively. Administrative staff will provide guidance, mentorship and corrective measures as needed.</p> <p>RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Health Services Team, Operations Team</p>		

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W000312	<p>Client #1's record was reviewed on 2/6/14 at 9:43 AM. Client #1's BSP dated 9/20/13 did not indicate documentation of revision since 9/20/13. Client #1's BSP did not indicate documentation of the use 15 minute checks. Client #1's ISP dated 9/20/13 did not include documentation of the use of 15 minute checks.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 2/6/14 at 10:51 AM. CS #1 indicated facility staff had been implementing 15 minute status checks/monitoring of client #1.</p> <p>9-3-5(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 4 sampled clients (#1) who were on medications related to behaviors, the facility failed to ensure the client's BSP (Behavior Support Plan) included specific/clear criteria for how psychotropic drug usage would change in relation to progress or regression of behavior management objectives.</p>	W000312	CORRECTION: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, Client #1's Behavior Support Plan will be updated to include short term and	03/12/2014			

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	<p>Findings include:</p> <p>Client #1's record was reviewed on 2/6/14 at 9:43 AM. Client #1's BSP dated 9/20/13 indicated, "Medication Reduction Plan: [Client #1] is currently not on any psychotropic medications and his diabetes will be monitored by an edironologist (sic)." Client #1's ISP dated 9/20/13 did not indicate the use of psychotropic medications.</p> <p>Client #1's POF (Physician's Orders Form) dated 12/27/13 indicated client #1 had a physician's order for Methylphenidate tablet 18 milligrams (Attention Deficit/Hyperactivity Disorder) dated 11/1/13.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 2/6/14 at 10:51 AM. CS #1 indicated psychotropic medication should be included in client #1's BSP and include a plan of titration.</p> <p>9-3-5(a)</p>		<p>long term plans for the reduction of psychotropic medications. PREVENTION:The QIDP will be retrained on the development of Medication Reduction Plans. The retraining will focus on the need to target a specific medication for reduction, prioritize the order in which attempts will be made to reduce behavior controlling medications as well as the need to maintain current behavior data with which to determine the criteria for reduction attempts. Members of the Operations Team will review Behavior Support Plans as part of an ongoing internal audit process that will include assuring that behavior support programs include specific plans to reduce the use of behavior controlling drugs. Operations Team members will conduct site visits that incorporate BSP reviews twice monthly for the next 90 days to assure that all programs are addressed in the plans. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONS PARTIES:QIDP, Direct Support Staff, Health Services Team, Operations Team</p>				

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W000327	<p>483.460(a)(3)(iv) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure an initial/annual TB (Tuberculosis) testing, x-ray or symptom checklist screening was completed for client #1.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 2/6/14 at 9:43 AM. Client #1's record did not indicate documentation of a TB test, x-ray or screening checklist.</p> <p>LPN #1 (Licensed Practical Nurse) was interviewed on 2/6/14 at 10:13 AM. LPN #1 stated, "[Client #1] should have had an initial TB or screening done when he was admitted (10/1/13)."</p> <p>9-3-6(a)</p>	W000327	<p>CORRECTION: The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Specifically, the team will assist Client @1 with obtaining a tuberculosis screening test. PREVENTION: The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine appointments and lab tests to assure they occur as recommended. Additionally, Operations Team members will review medical documentation while auditing active treatment sessions, no less than monthly, and make recommendations to the Health Services Team as appropriate. RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Health Services Team, Operations Team</p>	03/12/2014

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 3 of 4 sampled clients (#1, #3 and #4), the facility nursing services failed to ensure client #1's laboratory physicians orders were reconciled with the MAR (Medication Administration Record) and completed as ordered, ensure facility staff notified the nurse of blood sugar readings greater than 200, ensure client #4 had recommended follow up dental services and ensure client #4's labs were completed as ordered.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 2/6/14 at 9:43 AM. Client #1's Diabetes Comprehensive High Risk Health Plan (CHRHP) undated indicated, "Nurse will assure that HBA1C is obtained quarterly." Client #1's POF (Physician's Orders Form) dated 12/27/13 did not indicate a physician's order for quarterly HBA1C testing. Client #1's record did not indicate documentation of HBA1C testing since his 10/1/13 admission date.</p> <p>Client #1's Diabetes CHRHP undated indicated, "Check blood sugars as ordered on the MAR (Medication</p>	W000331	<p>CORRECTION:</p> <p><i>The facility must provide clients with nursing services in accordance with their needs. Specifically:</i></p> <p>The nurse will assure that an HBA1C test is completed for Client #1 and that the test occurs quarterly as ordered.</p> <p>ADDENDUM: A review of client records indicated lab tests have been completed as scheduled for Clients #2 - #8.</p> <p>The nurse will retrain all staff on the parameters for notifying the nurse regarding Client #1's blood glucose levels. ADDENDUM: A review of client records indicated no other clients were affected by this deficiency.</p> <p>The team will schedule Client #4 for recommended dental follow-up. ADDENDUM: A review of client records indicated dental follow-up has occurred as recommended for Clients #1 - #3 and #5 - #8.</p> <p>PREVENTION:</p> <p>The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine appointments and lab tests to assure they occur as</p>	03/12/2014			

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	<p>Administration Record). Call nurse if blood sugar is less than 70 or more than 200." Client #1's Recurrent Diabetic Ketoacidosis CHRHP undated indicated, "Call nurse if blood sugar is less than 70 or more than 200."</p> <p>Client #1's DBSR (Daily Blood Sugar Recording) form for the month of November 2013 indicated the following readings:</p> <p>-11/1/13, morning result 335; bedtime result 312 -11/2/13, morning result 273; noon result 230; evening result 265; bedtime result 233 -11/3/13, morning result 295; evening result 201 -11/4/13, morning result 349; evening result 385; bedtime result 257 -11/5/13, morning result 312; evening result 247; bedtime result 375 -11/6/13, morning result 214; bedtime result 234 -11/7/13, morning result 265; evening result 297 -11/8/13, evening result 247; bedtime result 258 -11/9/13, morning result 262; bedtime result 248 -11/10/13, evening result 366 -11/11/13, evening result 347; bedtime result 257</p>		<p>recommended.</p> <p>ADDENDUM: The facility nurse will provide onsite monitoring, teaching, training and modeling as needed but no less than weekly to ensure that Clients' blood sugar is maintained at a manageable level. Additionally, Operations Team members will review medical documentation while auditing active treatment sessions, twice monthly for the next 90 days to assure labs and appointments occur as recommended and that the nurse is notified of health status as directed by the physician and as written in the clients' high risk plans. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly.</p> <p>RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Health Services Team, Operations Team</p>		

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	<p>-11/12/13, morning result 250; noon result 64</p> <p>-11/14/13, morning result 287; evening result 309; bedtime result 297</p> <p>-11/15/13, morning result 325</p> <p>-11/16/13, morning result 226, noon result 57; bedtime result 217</p> <p>-11/17/13, morning result 244; noon result 208</p> <p>-11/18/13, morning result 269; evening result 351</p> <p>-11/19/13, morning result 229; evening result 264; bedtime result 204</p> <p>-11/20/13, morning result 290; evening result 210; bedtime result 266</p> <p>-11/23/13, morning result 233; evening result 234</p> <p>-11/24/13, evening result 249; bedtime result 263</p> <p>-11/25/13, morning result 279; evening result 291</p> <p>-11/26/13, morning result 407; noon result 306</p> <p>Client #1's DBSR form for the month of December 2013 indicated the following readings:</p> <p>-12/2/13, evening result 432; bedtime result 343</p> <p>-12/3/13, morning result 335; bedtime result 332</p> <p>-12/4/13, morning result 339</p> <p>-12/7/13, morning result 315; evening</p>						

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	<p>result 257</p> <p>-12/8/13, bedtime result 271</p> <p>-12/9/13, morning result 265</p> <p>-12/10/13, morning result 294; evening result 233</p> <p>-12/11/13, morning result 218; evening result 225</p> <p>-12/12/13, morning result 203; bedtime result 280</p> <p>-12/13/13, noon result 206</p> <p>-12/14/13, evening result 235; bedtime result 249</p> <p>-12/15/13, bedtime result 441</p> <p>-12/16/13, morning result 352; noon result 288; evening result 271</p> <p>-12/17/13, morning result 376</p> <p>-12/18/13, morning result 234; bedtime result 212</p> <p>-12/19/13, bedtime result 284</p> <p>-12/20/13, morning result 255; noon result 262; bedtime result 246</p> <p>-12/21/13, morning result 309; bedtime result 246</p> <p>Client #1's DBSR form for the month of January 2014 indicated the following readings:</p> <p>-1/3/14, bedtime results 301</p> <p>-1/6/14, morning results 211</p> <p>-1/7/14, morning results 334</p> <p>-1/8/14, morning results 328; bedtime results 248</p> <p>-1/9/14, morning results 306; noon</p>						

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	<p>results 211; bedtime results 248 -1/10/14, noon result 307; evening result 301 -1/11/14, morning result 400; evening result 264; bedtime result 311 -1/13/14, morning result 252 -1/14/14, morning result 297; evening result 337; bedtime result 361 -1/15/14, noon result 211; evening result 320; bedtime result 490 -1/16/14, noon result 296; evening result 436 -1/17/14, morning result 374; noon result 208; evening result 275; bedtime result 257 -1/18/14, evening result 382; bedtime result 259 -1/19/14, noon result 212 -1/20/14, evening result 258 -1/21/14, noon result 295; evening result 450; bedtime result 251 -1/22/14, morning result 288; noon result 216; evening result 400 -1/23/13, morning result 219; evening result 236; bedtime result 425 -1/24/14, morning result 295; evening result 294; bedtime result 318 -1/25/14, evening result 233; bedtime result 325 -1/26/14, morning result 354; evening result 227 -1/27/14, morning result 462; evening result 358 -1/28/14, morning result 317; evening</p>						

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	<p>result 221; bedtime result 309 -1/29/14, morning result 250; bedtime result 261 -1/30/14, morning result 320, noon result 331, evening result 258; bedtime result 265 -1/31/14, morning result 298; bedtime result 455</p> <p>Client #1's record did not indicate documentation of the facility nurse being notified or nursing instructions following client #1's blood sugar readings greater than 200.</p> <p>Observations were conducted at the group home on 2/6/14 from 6:30 AM through 7:45 AM. At 6:55 AM, client #1 completed his blood glucose testing with a result of 352.</p> <p>4. Client #4's record was reviewed on 2/6/14 at 12:33 PM. Client #4's dental progress note dated 11/8/12 indicated the recommendation to return to complete his cleaning pre-sedated. Client #4's record did not indicate documentation of follow up or address the 11/8/12 dental recommendations. Client #4's record did not indicate additional documentation of dental services. Client #4's POF dated 12/27/13 indicated client #4 should have his</p>						

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	<p>Hepatic profile checked every 6 months. Client #4's record indicated client #4's Hepatic labs were completed on 9/15/13 and 6/19/13. Client #4's record did not indicate additional Hepatic profile testing.</p> <p>LPN #1 (Licensed Practical Nurse) was interviewed on 2/6/14 at 10:13 AM. LPN #1 indicated the facility had changed nurses over the previous 3 month period. When asked if she had been notified of any blood glucose readings above 200 for client #1, LPN #1 stated, "I've only been the nurse for this house a few weeks. I haven't been personally notified of any readings but I can check to see if [Nurse Manager (NM) #1] or the on call nurse may have something." LPN #1 stated, "I'm not sure why [client #1's] risk plan says to call if it's 200. Usually, the doctor will recommend 300." LPN #1 stated, "If staff call and report [client #1's] glucose is over 200 we would encourage him to drink water, monitor and retest. He may need to drink more fluids but we would need to monitor him."</p> <p>LPN #1 indicated client #4 did not have additional documentation of dental services. LPN #1 indicated client #4's laboratory orders should be followed as written.</p>						

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W000336	<p>NM #1 was interviewed on 2/6/14 at 10:44 AM. NM #1 did not provide documentation of nursing staff being notified regarding client #1's glucose readings greater than 200. NM #1 indicated she had not been notified regarding client #1's glucose readings.</p> <p>9-3-6(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility's nursing services failed to conduct quarterly nursing assessments of clients' health status and medical needs for clients #1, #2, #3 and #4.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 2/6/14 at 9:43 AM. Client #1's POF (Physician's Order Form) dated 12/27/13 indicated client #1's diagnoses included but were not limited to mild intellectual disability, diabetes, anxiety and depression. Client #1's QNA (Quarterly Nursing Assessment) form for the year</p>	W000336	<p>CORRECTION: <i>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Specifically, the facility has a new nurse that has been trained on expectations for quarterly nursing physicals and nursing physicals for the current quarter. ADDENDUMM: A record review indicated the deficient practice also affected Clients #5, #6, #7 and #8 and nursing physicals have been completed for the current quarter for these individuals.</i></p> <p>PREVENTION:</p>	03/12/2014			

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	<p>2013 did not indicate documentation of a quarterly or 3 month nursing physical assessment of client #1's health status and medical needs from his date of admission of 10/1/13 through the date of review of 2/6/14.</p> <p>2. Client #2's record was reviewed on 2/6/14 at 10:56 AM. Client #2's POF dated 12/27/13 indicated client #2's diagnoses included but were not limited to mental retardation, autism, intermittent explosive disorder, depression, xxy syndrome and constipation. Client #2's QNA form for the year 2013 did not indicate documentation of a quarterly nursing physical assessment of client #2's health status and medical needs from 1/1/13 through 8/26/13 and from 8/26/13 through 12/31/13.</p> <p>3. Client #3's record was reviewed on 2/6/14 at 12:03 PM. Client #3's POF dated 12/27/13 indicated client #3's diagnoses included but were not limited to mental retardation, attention deficit/hyperactivity disorder, asthma, tourettes, sinusitis and dysphonia. Client #3's QNA form for the year 2013 did not indicate documentation of a quarterly nursing physical assessment of client #2's health status and medical needs from 1/1/13 through 8/26/13 and from</p>		<p>Copies of quarterly nursing physical examinations will be placed in the each individual's medical chart upon completion. The Nurse Manager will maintain a tracking system to assure quarterly nursing physical examinations are completed as required. Additionally, Administrative Team members will review nursing documentation while conducting routine audits in the home, no less than monthly, to assure records of quarterly nursing evaluations are completed and filed appropriately. Copies of audits of medical charts will be provided to the facility nurse and nurse manager to facilitate appropriate follow-up.</p> <p>RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Health Services Team, Operations Team</p>				

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	<p>8/26/13 through 12/31/13.</p> <p>4. Client #4's record was reviewed on 2/6/14 at 12:33 PM. Client #4's POF dated 12/27/13 indicated client #4's diagnoses included but were not limited to mental retardation, hypertension, scoliosis, obsessive compulsive disorder, urinary incontinence, insomnia, constipation, hyperlipidemia, atrial fibrillation and seizures. Client #4's QNA form for the year 2013 did not indicate documentation of a quarterly nursing physical assessment of client #2's health status and medical needs from 1/1/13 through 8/26/13 and from 8/26/13 through 12/31/13.</p> <p>LPN #1 (Licensed Practical Nurse) was interviewed on 2/6/14 at 10:13 AM. LPN #1 indicated nursing physical assessments of clients' health status and medical needs should be conducted on a quarterly basis. LPN #1 indicated there were no additional nursing physical assessments available for review regarding clients #1, #2, #3 and #4.</p> <p>9-3-6(a)</p>				

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#1) with adaptive equipment, the facility failed to ensure client #1 used his prescription eyeglasses.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/5/14 from 3:45 PM through 5:15 PM. Client #1 was observed in the home throughout the observation period. Client #1 did not wear eyeglasses throughout the observation period. Client #1 was not encouraged by staff #1, staff #2, staff #3, RM (Residential Manager) #1, QIDPD #1 (Qualified Intellectual Disabilities Professional Designee) or CS (Clinical Supervisor) #1 to use/wear his eyeglasses.</p> <p>Observations were conducted at the group home on 2/6/14 from 6:30 AM through 7:45 AM. Client #1 was observed throughout the observation period. Client #1 did not wear</p>	W000436	<p>CORRECTION:</p> <p><i>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Specifically, the interdisciplinary team will develop a learning objective to support Client #1 with learning to make informed decisions regarding the use of his eyeglasses. ADDENDUM: a review of documentation and current support documents indicated that the team has provided programmatic support to other clients who have demonstrated the need to learn to make informed decisions about the use of adaptive equipment.</i></p> <p>PREVENTION:</p> <p>Facility professional staff will be expected to observe no less than two morning and two evening active treatment sessions per week to assure all clients possess and are using prescribed</p>	03/12/2014	

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	<p>eyeglasses throughout the observation period. Client #1 was not encouraged by staff #4, staff #5, RM #1 or QIDPD #1 to use/wear his eyeglasses.</p> <p>Observations were conducted at client #1's day services location on 2/7/14 from 10:35 AM through 11:20 AM. Client #1 did not wear eyeglasses throughout the observation period. Client #1 was not encouraged by day service staff to use/wear his eyeglasses.</p> <p>Client #1's record was reviewed on 2/6/14 at 9:43 AM. Client #1's Vision Exam form dated 11/22/13 indicated the recommendation for full time prescription eyeglass use.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 2/6/14 at 10:51 AM. CS #1 indicated client #1's vision recommendations should be followed. CS #1 indicated client #1 should be encouraged to use his eyeglasses.</p> <p>9-3-7(a)</p>		<p>adaptive equipment. Additionally, members of the Operations Team will conduct active treatment observations on a weekly basis for the next 60 days and after two months, no less than monthly to assure that clients receive training toward appropriate use of adaptive equipment as recommended.</p> <p>RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Operations Team</p>		