

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G119	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/03/2011
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NAME OF PROVIDER OR SUPPLIER  PEAK COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1234 S 50 E WINAMAC, IN46996
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W0000	<p>This visit was for a full annual recertification and state licensure survey.</p> <p>Dates of Survey: September 26, 27, 28, 29, 30 and October 3, 2011.</p> <p>Facility number: 000656 Provider number: 15G119 AIM number: 100234050</p> <p>Surveyor: Christine Colon, Medical Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/13/11 by Chris Greeney, Medical Surveyor Supervisor and Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0102	<p>The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview for 6 of 6 clients (clients #1, #2, #3, #4, #5 and #6), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to exercise operating direction over the facility to ensure the facility implemented their policy and procedures to complete routine maintenance, to ensure implementation of their "Nursing Services Governance Policy" and to protect clients from physical aggression.</p> <p>Findings include:</p>	W0102	<p>Peak Community Services is committed to ensuring that specific governing body and management requirements are met. 1) The following items in need of maintenance have been addressed: light fixture cover over sink missing; towel rack bar missing; shower faucet leaking; bathroom next to Client #4's room has no toilet paper holder. They were placed on the maintenance log by the Residential Coordinator and all have been completed by the facilities staff. To prevent the</p>	11/02/2011

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>1. Please refer to W104: The governing body failed for 6 of 6 clients (clients #1, #2, #3, #4, #5 and #6) living at the group home, to exercise general operating direction in a manner to ensure routine maintenance was completed and implementation of their "Nursing Services Governance Policy".</p> <p>2. Please refer to W122: The governing body failed to exercise general policy and operating direction over the facility in regards to meeting the Condition of Participation: Client Protections. The facility failed to protect 3 of 6 clients (client #1, #2 and #5) living in the home from physical aggression at the group home and at day programming.</p> <p>9-3-1(a)</p>		<p>reoccurrence of not promptly addressing maintenance issues, the Community Services Manager will re-emphasize with the Residential Coordinator and residential staff on the importance of putting items on the maintenance log in a timely manner and locating items that require maintenance. Monthly inspections will be conducted by the Residential Coordinator. Spot checks will be conducted for three months by the Community Services Manager to assure maintenance is adequately being addressed. 2) Peak Residential staff will be instructed on when to call a nurse. A new form for when to call a nurse will be put into place to document the calls by 11-02-11. A new procedure for getting nursing notes in home and master files will be put into place by 11-02-11. The nurse will complete the form and email to Community Services Manager. The Community Service Manager will scan the document in and send to QMRP for Master files and to Residential Coordinator for Home files. When the nurse's signature is obtained, the original documents will be sent to the QMRP for the Master file; a copy will go to the Residential Coordinator for the Home file. The QMRP is inviting the nurse to all ISP/ Annual meetings where there is a nursing need or involvement. If the nurse is unable to attend the meeting, she</p>		

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			will be asked to provide a report for all items in need of addressing. This procedure has been put into place since September 2011. To prevent the reoccurrence of nurses not providing input for annual meetings, the Director of Support and Quality Assurance will check files on a quarterly basis to assure the nurse was present at the annual meetings and/ or provided input for the meetings. If the ISP Meeting Records' do not show nurse involvement, the QMRP will be retrained in this procedure. If there is no annual nurse's report, the Community Services Manager will be notified and address this with the nurse. The nursing assessment form is being revised to include the current check on health status at the time of the nurse visit and will expand to include a quarterly review of all medical and nursing events of the quarter. This new form will be in place by 11-02-11. The Community Services Manager will monitor that the new nursing assessment forms are being utilized. Peak Community Services is committed to ensuring that specific client protections requirements are met. 1) Effective November 1, for the review of all October incidents, the BDDS Incident Report Review Committee will analyze numbers of aggressive behaviors per person and patterns of whether any person is targeted by any one		

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			<p>person. This will be done using sort methods of the behavior data by name and by incident type. Several of the past months have been compiled and will be reviewed for each client at the November meeting. The Director of Support and Quality Assurance is responsible for this as chairperson of the BDDS Incident Report Review Committee beginning with the review of October, 2011 data and will continue for each monthly BDDS Incident Report Review Committee meeting. Additionally, to address the high behavior incidence an increase of staffing for client #5 is being considered. Client #5's team met on 10-20-11 to consider adding a medication to aid in control of her aggressive behaviors and the Primary Care Physician recommended to start the medication. This is approved by the guardian and will be presented to the Human Rights Committee for approval on 10-26-11. Previous interventions that have been tried to address the high client to client aggression at the day service program include: visits to the Primary Care Physician to review medications; make-up of the groups being changed several times; staff-client rearrangements were revised. These actions will continue. The Director of Operations and Community Services Manager have located resources for aging and dementia</p>		

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			<p>training. A training on aging is scheduled for November 3, 2011. A training on Dual Diagnosis: Mental Illness and Developmental Disability is scheduled for November 3, 2011. Two sessions on dementia are being arranged with a behavior consultant. Two Positive Behavior Supports trainings are scheduled for November 2, 2011, which helps accommodate both day services and residential staff attendance. The agency is also investigating sending two staff to CPI specifically for Dementia. It is a 'train the trainer' model, so would benefit the entire agency. On 10-04-11, a Behavior Review Committee began meeting weekly, bringing the team together to discuss incidents that occurred; interventions that were used; how effective Behavior Support Plans were; what changes were recommended. Members of the Committee include: QMRP, Behavior Specialist, Residential Coordinator, and Day Service Coordinator. Minutes are kept on a Behavior Review Committee form on each client who displays aggressive behaviors that week. Behavior Review Committee minutes on client #5 for 10-04-11, 10-10-11 and 10-18-11 are included in supporting documentation. The Day Service team (Day Service Coordinator, QMRP and all Day Service Direct Support Professionals) meets</p>		

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			twice weekly in addition to the Behavior Review Committee meeting on Day Service Programming. One of these meetings is to specifically review effectiveness of Behavior Support Plans, to retrain on each plan, and devise any recommendations for improvement in implementing the plans. 2) A swallow study for Client #4 was previously addressed with the Primary Care Physician, but not documented with the nurse. The nurse will request a Speech evaluation to address the choking issue and obtain further input for a swallow study. During the two to three months gap in the weights noted, Client #4 had gall bladder surgery and has been stable since then. Client #4 has had a CT scan of the abdominal area with results pending. The Primary Care Physician is reviewing client #4's medications to see if they could be causing a problem. To prevent the reoccurrence of regular weight checks being omitted, each home will have an annual calendar to record all weights weekly which will be provided for the nurse to review at her visits. The Residential Coordinator will be responsible for these to be completed weekly and submitted to the nurse. Peak Residential staff will be instructed on when to call a nurse. A new form for when to call a nurse will be put into place to document the calls by 11-02-11. The Community	

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W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview, the governing body failed for 6 of 6 clients (clients #1, #2, #3, #4, #5 and #6) living at the group home, to exercise general operating direction in a manner to ensure 1. routine maintenance was completed, and 2. implementation of their Nursing Services Governance Policy.</p> <p>Findings include:</p> <p>1. A morning observation was conducted at the group home on 9/26/11 from 6:00 A.M. until 8:00 A.M.. Upon entering the bathroom in clients #1, #2, #3, #4, #5 and #6's home, located next to client #2's</p>	W0104	<p>Services Manager will instruct the day service and residential staff on communication log entry, including timeliness of relating information, clarity of all significant medical and behavioral events, and importance of the sharing of information. Person Responsible: Raina Daily, Behavior Specialist Kelly Bendel, Day Service Coordinator Michel Thompson, Residential Coordinator Kris Myers, Community Services Manager Sandra Beckett, QMRP Connie English, Director of Support and Quality Assurance Kathi Thompson, Operations Director</p> <p>Peak Community Services is committed to exercising general policy, budget, and operating direction over the facility.</p> <p>1) The following items in need of maintenance have been addressed: light fixture cover over sink missing; towel rack bar missing; shower faucet leaking; bathroom next to Client #4's room has no toilet paper holder. They were placed on the maintenance log by the Residential Coordinator and all have been completed by the facilities staff. To prevent the reoccurrence of not promptly addressing maintenance issues, the Community Services Manager will re-emphasize with the Residential Coordinator and residential staff on putting items on</p>	11/02/2011

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	<p>bedroom, the light fixture cover over the sink was observed to be missing, the towel rack bar was observed to be missing and the shower faucet was observed to be leaking. The bathroom next to client #4's room was observed to not have a toilet paper holder.</p> <p>An interview with the Qualified Mental Retardation Professional/Group Home Manager (QMRP/GHM) was conducted on 9/29/11 at 1:40 P.M.. The QMRP/GHM indicated there were no maintenance request forms submitted for the needed maintenance repairs. No additional information was submitted to indicate when the maintenance concerns would be repaired/replaced.</p> <p>2. A morning observation was conducted at the group home on 9/26/11 from 6:00 A.M. until 8:00 A.M.. During the entire observation period client #4 cried and screamed she did not feel well.</p> <p>An evening observation was conducted at the group home on 9/26/11 from 3:05 P.M. until 5:30 P.M.. During the entire observation period client #4 cried and screamed she did not feel well.</p> <p>A review of the facility's records was conducted on 9/26/11 at 10:01 A.M..</p>		<p>the maintenance log in a timely manner and locating items that require maintenance. Monthly inspections will be conducted by the Residential Coordinator. Spot checks will be conducted for three months by the Community Services Manager to assure maintenance is adequately being addressed.</p> <p>2) Peak Residential staff will be instructed on when to call a nurse. A new form for when to call a nurse will be put into place to document the calls by 11-02-11.</p> <p>A new procedure for getting nursing notes in home and master files will be put into place by 11-02-11. The nurse will complete the form and email to Community Services Manager. The Community Service Manager will scan the document in and send to QMRP for Master files and to Residential Coordinator for Home files. When the nurse's signature is obtained, the original documents will be sent to the QMRP for the Master file; a copy will go to the Residential Coordinator for the Home file.</p> <p>The QMRP is inviting the nurse to all ISP/ Annual meetings where there is a nursing need or involvement. If the nurse is unable to attend the meeting, she will be asked to provide a report for all items in need of addressing. This procedure has been put into place since September 2011.</p> <p>To prevent the reoccurrence of</p>				

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	<p>Review of the facility's Bureau Of Developmental Disabilities Services (BDDS) reports indicated:</p> <p>Incident dated 4/5/11: "On April 5, 2011 while eating lunch [client #4] choked 3 separate times. Staff intervened on the first 2 episodes and administered 3 back blows each time; on the 3rd episode no intervention was needed." Further review of the report failed to indicate client #4 had been assessed by nursing staff.</p> <p>Incident dated 5/2/11: "On May 2, 2011 [client #4] was lethargic; having difficulty swallowing her medications and fluids; her skin appeared to be discolored." Further review of the report failed to indicate client #4 had been assessed by nursing staff.</p> <p>Incident dated 8/17/11: "While eating lunch, [client #4] was trying to talk to others around her and subsequently began choking on her food. She signaled to those around her that she was choking and a Direct Support Professional, providing supervision at the time, immediately intervened. The Direct Support Professional administered 5 back blows, dislodging the obstruction and allowing [client #4] to resume breathing. Further review of the report failed to indicate client #4 had been assessed by nursing</p>		<p>nurses not providing input for annual meetings, the Director of Support and Quality Assurance will check files on a quarterly basis to assure the nurse was present at the annual meetings and/ or provided input for the meetings. If the ISP Meeting Records' do not show nurse involvement, the QMRP will be retrained in this procedure by the Director of Support and Quality Assurance. If there is no annual nurse's report, the Community Services Manager will be notified and address this with the nurse. The nursing assessment form is being revised to include the current check on health status at the time of the nurse visit and will expand to include a quarterly review of all medical and nursing events of the quarter. This new form will be in place by 11-02-11. The Community Services Manager will monitor that the new nursing assessment forms are being utilized.</p> <p>Person Responsible: Michel Thompson, Residential Coordinator Kris Myers, Community Services Manager Sandra Beckett, QMRP Connie English, Director of Support and Quality Assurance Kathi Thompson, Operations Director</p>	

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	<p>staff.</p> <p>A review of client #4's record was conducted at the facility's administrative office on 9/27/11 at 12:45 P.M.. Review of the record indicated:</p> <p>First Aid Report dated 7/5/11: "[Client #4] bit herself on the right wrist." Further review of the record failed to indicate client #4 had been assessed by nursing staff.</p> <p>Health Concern Case Note dated 7/6/11: "[Client #4] stated her stomach hurts, she was crying and after three verbal prompts stated that her stomach hurts." Further review of the record failed to indicate client #4 had been assessed by nursing staff.</p> <p>Health Concern Case Note dated 7/14/11: "[Client #4]'s color is so pale-also very tired today-she has a puffy area on right eyelid which seems to be larger than before." Further review of the record failed to indicate client #4 had been assessed by nursing staff.</p> <p>First Aid Report dated 7/18/11: "Has a small sore on top of her right foot." Further review of the record failed to indicate client #4 had been assessed by nursing staff.</p>			

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	<p>Health Concern Case Note dated 7/25/11: "[Client #4] talking about a stomach ache all morning." Further review of the record failed to indicate client #4 had been assessed by nursing staff.</p> <p>Health Concern Case Note dated 7/27/11: "[Client #4] stated that her stomach hurt-pointing to her lower stomach." Further review of the record failed to indicate client #4 had been assessed by nursing staff.</p> <p>Health Concern Case Note dated 7/28/11: "8:40 A.M.-[Client #4] stated several times her lower right side of her stomach hurt real bad...9:40 A.M.-[Client #4] complained again-lower right side of stomach hurt...12:40 P.M.-[Client #4] saying again lower right side of her stomach hurts...1:45 P.M.-[Client #4] saying again-lower right side of her stomach hurts." Further review of the record failed to indicate client #4 had been assessed by nursing staff.</p> <p>Health Concern Case Note dated 8/1/11: "[Client #4] complained of her stomach hurting this A.M.." Further review of the record failed to indicate client #4 had been assessed by nursing staff.</p> <p>First Aid Report dated 8/2/11: "[Client</p>				

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	<p>#4]...Open infected wound." Further review of the record failed to indicate client #4 had been assessed by nursing staff.</p> <p>First Aid Report dated 8/3/11: "[Client #4]...Wound." Further review of the record failed to indicate client #4 had been assessed by nursing staff.</p> <p>Health Concern Case Note dated 8/4/11: "At lunch time @ (at) 11:04 [client #4] started crying and slapping staff on the arm saying her stomach hurt. Further review of the record failed to indicate client #4 had been assessed by nursing staff.</p> <p>First Aid Report dated 8/17/11: "[Client #4] was at lunch and was talking with food in her mouth. [Client #4] started choking, staff started the back throws and the pizza came out." Further review of the record failed to indicate client #4 had been assessed by nursing staff.</p> <p>First Aid Report dated 8/23/11: "Staff was changing [client #4]'s bandage on her right wrist." Further review of the record failed to indicate client #4 had been assessed by nursing staff.</p> <p>First Aid Report dated 8/31/11: "[Client #4] was finishing her lunch when staff,</p>						

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	<p>who was sitting next to [client #4], noticed her lips were a lilac/blue color. [Client #4] didn't choke, cough or anything while she was eating lunch. Staff called for other staff to take a look and agreed about color of lips. [Client #4] was breathing and eating fine." Further review of the record failed to indicate client #4 had been assessed by nursing staff.</p> <p>3. A morning observation was conducted at the group home on 9/26/11 from 6:00 A.M. until 8:00 A.M.. Client #6's entire nose was observed to have a bright red sore.</p> <p>A review of client #6's record was conducted on 9/27/11 at 1:30 P.M.. Client #6's record failed to indicate a nursing assessment to address the sore on her nose.</p> <p>The facility's "Nursing Services Governance Policy #210" no date noted was reviewed on 9/27/11 at 6:00 PM. The policy indicated: "[Facility name] will provide Nursing Services to consumers who are participating in ICF/DD (Intermediate Care Facilities/Developmental Disabilities) group homes in accordance with their individualized needs...Nursing staff working with the agency will participate</p>				

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	<p>in the development, review, and update of each consumer's Individualized Support Plan (ISP). The nursing staff will conduct quarterly health status review on each consumer and document their findings using an agency provided form. Results and recommendations of the review will result in referral action to the consumer's primary care physician if appropriate."</p> <p>An interview with the QMRP/GHM was conducted on 9/29/11 at 1:40 P.M.. The QMRP/GHM indicated the nursing staff does not document in each client's record and does not participate in each client's ISP meetings.</p> <p>9-3-1(a)</p>				
W0122	<p>The facility must ensure that specific client protections requirements are met.</p> <p>Based on record review and interview, the Condition of Participation, Client Protections, is not met as the facility failed to protect 3 of 6 clients (client #1, #2 and #5) living in the home from</p>	W0122	<p>Peak Community Services is committed to ensuring that specific client protections requirements are met.</p> <p>1) Peak Community Services reviewed the Incident Management Tracking system in place, which</p>	11/02/2011	

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	<p>physical aggression at the group home and at day programming and neglected to provide adequate health care for 1 of 6 clients (client #4), who needed medical attention.</p> <p>Findings include:</p> <p>1. Please refer to W149. The facility failed to implement their abuse/neglect policy to ensure 3 of 6 clients (clients #1, #2 and #5) living in the group home were free from physical aggression and neglected to provide adequate health care for 1 of 6 clients (client #4), who needed medical attention.</p> <p>2. Please refer to W157 as the facility failed to take effective corrective action to protect 3 of 6 clients (clients #1, #2 and #5) living in the home from physical aggression.</p> <p>9-3-2(a)</p>		<p>included looking at patterns of behavior within the month of behaviors reviewed. Effective November 1, for the review of all October incidents, the BDDS Incident Report Review Committee will analyze numbers of aggressive behaviors per person and patterns of whether any person is targeted by any one person. This will be done using sort methods of the behavior data by name and by incident type. Several of the past months have been compiled and will be reviewed for each client at the November meeting. The Director of Support and Quality Assurance is responsible for this as chairperson of the BDDS Incident Report Review Committee beginning with the review of October, 2011 data and will continue for each monthly BDDS Incident Report Review Committee meeting.</p> <p>Additionally, to address the high behavior incidence an increase of staffing for client #5 is being considered. Client #5's team met on 10-20-11 to consider adding a medication to aid in control of her aggressive behaviors and the Primary Care Physician recommended to start the medication. This is approved by the guardian and will be presented to the Human Rights Committee for approval on 10-26-11. The supporting document will be complete by 11-02-11.</p>		

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			<p>Previous interventions that have been tried to address the high client to client aggression at the day service program include: visits to the Primary Care Physician to review medications; make-up of the groups being changed several times; staff-client rearrangements were revised. These actions will continue. On 10-04-11, a Behavior Review Committee began meeting weekly, bringing the team together to discuss incidents that occurred; interventions that were used; how effective Behavior Support Plans were; what changes were recommended. Members of the Committee include: QMRP, Behavior Specialist, Residential Coordinator, and Day Service Coordinator. Minutes are kept on a Behavior Review Committee form on each client who displays aggressive behaviors that week. Behavior Review Committee minutes on client #5 for 10-04-11, 10-10-11 and 10-18-11 are included in supporting documentation.</p> <p>The Day Service team (Day Service Coordinator, QMRP and all Day Service Direct Support Professionals) meets twice weekly in addition to the Behavior Review Committee meeting on Day Service Programming. One of these meetings is to specifically review effectiveness of Behavior Support Plans, to retrain on each plan, and devise any recommendations for</p>	

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			<p>improvement in implementing the plans.</p> <p>The Administration Team will review their "Abuse / Neglect / Exploitation / Mistreatment of an Individual / Violation of an Individual's Rights: Investigations (Governance Policy 21.0)" policy and procedures that address neglect when one client was aggressive to another and revise the policy as needed. This review process will begin by 11-02-11.</p> <p>2) A swallow study for Client #4 was previously addressed with the Primary Care Physician, but not documented with the nurse. The nurse will request a Speech evaluation to address the choking issue and obtain further input for a swallow study. During the two to three months gap in the weights noted, Client #4 had gall bladder surgery and has been stable since then. Client #4 has had a CT scan of the abdominal area with results pending. The Primary Care Physician is reviewing client #4's medications to see if they could be causing a problem.</p> <p>To prevent the reoccurrence of regular weight checks being omitted, each home will have an annual calendar to record all weights weekly which will be provided for the nurse to review at her visits. The Residential Coordinator will be responsible for these to be completed weekly and submitted to the nurse.</p>	

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W0125	<p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview, for 1 of 3 sampled clients (client #1), the facility failed to ensure the clients' rights by not obtaining a legally sanctioned decision maker to assist in financial decisions.</p> <p>Findings include:</p>	W0125	<p>Peak Residential staff will be instructed on when to call a nurse. A new form for when to call a nurse will be put into place to document the calls by 11-02-11. The Community Services Manager will instruct the day service and residential staff on communication log entry, including timeliness of relating information, clarity of all significant medical and behavioral events, and importance of the sharing of information. Person Responsible: Connie English, Director of Support and Quality Assurance Raina Daily, Behavior Specialist Michel Thompson, Residential Coordinator Kelly Bendel, Day Service Coordinator Sandra Beckett, QMRP Kathi Thompson, Director of Operations</p> <p>Peak Community Services is committed to ensuring the rights of all clients. An informed consent assessment and recommendation states that client #1 needs help making major life decisions. The Inter Disciplinary Team (IDT) has tried to communicate documents in appropriate formats for the client to</p>	11/02/2011

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	<p>A review of client #1's record was conducted at the facility's administrative office on 9/27/11 at 11:30 A.M.. Client #1's record indicated she was an emancipated adult. The "Informed Consent" dated 2/1/11 indicated:</p> <p>"Understands the use of money...N-No she is passive/relies on others to do or make these decisions. Uses the next dollar concept...N-No she is passive/relies on others to do or make these decisions...Person needs a Guardian."</p> <p>The "Comprehensive Functional Assessment" (CFA) dated 2/1/11 indicated: "Knows money is for purchases, No. Identifies different denominations of bills, No. Identifies different coins, No. Understands value of bills, No. Understands value of coins, No. Understands that 2 quarters = 50 cents, No. Understands that 4 quarters = \$1, No...Makes change for \$1 with coins, No. Counts up to \$5 using ones, No. Uses vending machines for purchases, No. Knows that checks = money, No. Is able to complete a check, No. Identifies items to be purchased, No. Finds needed items in store, No."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was completed at the facility's administrative office on 9/29/11 at 2:40 P.M.. The QMRP indicated client #1 did not have legally sanctioned decision maker to assist her with financial decisions. The QMRP further indicated client #1 was unable to manage her finances independently.</p> <p>9-3-2(a)</p>		<p>understand as well as possible. The Case Coordination Manual states, "For those assessed to be unable to make informed consent and who do not have an advocate or guardian, the team will act in the best interest of the consumer. The consumer will continue to sign forms as a part of the training process." The IDT has held discussions with the family encouraging guardianship for client #1 on several previous occasions. On 10-11-11 another attempt was made with the family to address the need for a guardian. On 10-18-11, a discussion was held with the family offering free and reduced legal services information which might allow guardianship to become financially feasible to them. The family is considering taking the step to establish guardianship. If they do not commit by 11-02-11 to establishing guardianship, the QMRP will contact the Director of Operations and Community Services Manager who will then seek out other resources to obtain a potential guardian for client #1. Person Responsible: Sandra Beckett, QMRP Kris Myers, Community Services Manager Kathi Thompson, Director of Operations</p>		

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W0140	<p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based upon record review and interview, the facility failed to maintain an accurate accounting system for 6 of 6 clients residing at the group home (clients #1, #2, #3, #4, #5 and #6), for whom the facility managed their funds.</p> <p>Findings include:</p> <p>On 9/26/11 at 7:30 A.M., a review of client #2's personal petty cash financial records was completed. Review of client #2's record dated 9/13/11 indicated an ending balance of \$50.53 on the financial ledger. The staff indicated there should be \$50.53 available for client #2 but counted \$39.53 in her petty cash/personal financial funds pouch.</p> <p>A review of the facility's records was conducted at the facility's administrative office on 9/27/11 at 10:05 A.M.. A request for client #1, #2, #3, #4, #5 and #6's financial records was made. No financial records were available for review to indicate the facility kept an accurate accounting system of client #1,</p>	W0140	<p>Peak Community Services is committed to establishing and maintaining a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Client #2's money was discovered misfiled on 09-26-11. There was \$50.53 available in her petty cash/ personal financial funds pouch, when this money was located, which rendered the account accurate. The Residential Coordinator has re-emphasized with staff on the importance of taking care when handling client finances. The auditor has returned the financial documents for all consumers making the months of 4/11, 5/11, 6/11, 7/11, and 8/11 available for review. The auditor has these documents for only a short period of time. These audits are a part of the financial procedures revised and implemented in October, 2010.</p> <p>Person Responsible: Michel Thompson, Residential Coordinator Kris Myers, Community Services Manager</p>	11/02/2011

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W0149	<p>#2, #3, #4, #5 and #6's personal finances for the months of 4/11, 5/11, 6/11, 7/11 and 8/11.</p> <p>An interview with the Group Home Manager (GHM) was conducted at the facility's administrative office on 9/29/11 at 12:40 P.M.. The GHM she did not have the records for the months of 4/11, 5/11, 6/11, 7/11 and 8/11 because they were at the auditor's office. The GHM further indicated the facility managed each client's personal petty cash funds. No further documentation was available for review to indicate an accurate accounting system for client #1, #2, #3, #4, #5 and #6's personal petty cash funds.</p> <p>9-3-2(a)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review, the facility failed for 3 of 6 clients living at the group home (clients #1, #2 and #5), 1. to develop and implement policy which resulted in an incident management system which tracked or investigated reports of client to client aggression in</p>	W0149	<p>Peak Community Services is committed to developing and implementing written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>1) Peak Community Services reviewed the Incident Management Tracking system in place, which</p>	11/02/2011	

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	<p>order to rule out neglect, or to determine what additional supports and services were required to keep clients free from abuse and/or neglect and 2. neglected to provide adequate health care for 1 of 6 clients (client #4), who needed medical attention.</p> <p>Findings include:</p> <p>1. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted at the facility's administrative office on 9/26/11 at 10:05 A.M.. Review of the reports dated 3/21/11 to 9/21/11 indicated the following incidents:</p> <p>Incidents involving client #1:</p> <p>Incident dated 5/15/11: "[Client #5] had thrown clothes all over the hallway and bathroom, staff approached [client #5] and asked her to pick the clothes up. [Client #5] became verbally and physically aggressive with staff. Staff attempted to redirect [client #5], [client #5] turned and struck another consumer [client #1]." Further review indicated no injury noted.</p> <p>Incident dated 5/21/11: "[Client #5] took a guitar from another consumer, [client #1]. Staff intervened to have the guitar</p>		<p>included looking at patterns of behavior within the month of behaviors reviewed. Effective November 1, for the review of all October incidents, the BDDS Incident Report Review Committee will analyze numbers of aggressive behaviors per person and patterns of whether any person is targeted by any one person. This will be done using sort methods of the behavior data by name and by incident type. Several of the past months have been compiled and will be reviewed for each client at the November meeting. The Director of Support and Quality Assurance is responsible for this as chairperson of the BDDS Incident Report Review Committee beginning with the review of October, 2011 data and will continue for each monthly BDDS Incident Report Review Committee meeting.</p> <p>The Director of Support and Quality Assurance reviewed the Peak Community Services Abuse/ Neglect/ Exploitation/ Mistreatment of an Individual's Rights: Reporting/ Investigations Procedure for specific information to rule out neglect when one client was aggressive to another. The Director of Support and Quality Assurance will address with the Administrative Team to review on 10-31-11.</p> <p>Additionally, to address the high behavior incidence an increase of</p>		

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	<p>returned. When [client #1] approached to retrieve the guitar, [client #5] smacked her in the chest." Further review indicated no injury noted.</p> <p>Incidents involving client #2:</p> <p>Incident dated 3/27/11: "On March 27, 2011 while at home [client #2] was doing her laundry when another consumer [client #5] went into the laundry room and attempted to open the dryer door. [Client #2] told [client #5] that was her stuff to (sic) for her to get out. Staff intervened verbally and asked [client #5] to come out of the laundry room-[client #5] became physically aggressive and struck out at staff...[Client #5] appeared to be calm left the laundry room and when she saw [client #2], [client #5] hit [client #2] on the right side of the head leaving a small red mark."</p> <p>Incident dated 6/23/11: "While in the kitchen taking dirty dishes out of her lunch box, staff asked [client #5] to please take the dirty dishes out of the cabinet and to put them into the sink-[client #5] became upset/agitated and struck another housemate [client #2] in the back." Further review indicated no injury noted.</p> <p>Incident dated 9/8/11: "While in group</p>		<p>staffing for client #5 is being considered. Client #5's team met on 10-20-11 to consider adding a medication to aid in control of her aggressive behaviors and the Primary Care Physician recommended to start the medication. This is approved by the guardian and will be presented to the Human Rights Committee for approval on 10-26-11.</p> <p>Previous interventions that have been tried to address the high client to client aggression at the day service program include: visits to the Primary Care Physician to review medications; make-up of the groups being changed several times; staff-client rearrangements were revised. These actions will continue. On 10-04-11, a Behavior Review Committee began meeting weekly, bringing the team together to discuss incidents that occurred; interventions that were used; how effective Behavior Support Plans were; what changes were recommended. Members of the Committee include: QMRP, Behavior Specialist, Residential Coordinator, and Day Service Coordinator. Minutes are kept on a Behavior Review Committee form on each client who displays aggressive behaviors that week. Behavior Review Committee minutes on client #5 for 10-04-11, 10-10-11 and 10-18-11 are included in supporting documentation.</p>		

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	<p>[client #5] became upset started yelling and then hit a co-worker [client #2]." Further review indicated no injury noted.</p> <p>Incident dated 9/21/11: "While in group [client #5] struck a co-worker [client #2] on the left side." Further review indicated no injury noted.</p> <p>Incidents involving client #5:</p> <p>Incident dated 4/21/11: "[Client #5] was sitting next to [day program client] during group. [Day program client] touched on (sic) of [client #5]'s items [client #5] responded verbally. [Day program client] became physically aggressive-putting her hand in [client #5]'s face and pushing her away. When [day program client] put her hand on [client #5]'s face this caused [client #5]'s glasses to slid (sic) down her face and the nose piece left a mark under [client #5]'s nose."</p> <p>Incident dated 6/13/11: "While in group [client #5] became upset and pounded on the table. This caused another consumer [day program client] to become upset and he yelled at [client #5]. When [client #5] began to pound on the table again, [day program client] wheeled around the table where [client #5] was and yelled at her again. [Day program client] verbally threatened to cause bodily harm to [client</p>		<p>The Day Service team (Day Service Coordinator, QMRP and all Day Service Direct Support Professionals) meets twice weekly in addition to the Behavior Review Committee meeting on Day Service Programming. One of these meetings is to specifically review effectiveness of Behavior Support Plans, to retrain on each plan, and devise any recommendations for improvement in implementing the plans.</p> <p>The Administration Team will review their "Abuse / Neglect / Exploitation / Mistreatment Of An Individual / Violation Of An Individual's Rights: Investigations (Governance Policy 21.0)" policy and procedures that address neglect when one client was aggressive to another and revise the policy as needed. This review will begin by 11-02-11.</p> <p>2) A swallow study for Client #4 was previously addressed with the Primary Care Physician, but not documented with the nurse. The nurse will request a Speech evaluation to address the choking issue and obtain further input for a swallow study. During the two to three months gap in the weights noted, Client #4 had gall bladder surgery and has been stable since then. Client #4 has had a CT scan of the abdominal area with results pending. The Primary Care Physician is reviewing client #4's medications to see if they could be causing a</p>				

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	<p>#5]."</p> <p>Incident dated 6/13/11: "While in group [client #5] became upset and raised her fist at another consumer. Staff immediately intervened and stepped in between the consumers-the other consumer reached over staff's arm and struck [client #5] in the face leaving a red mark, and walked away."</p> <p>Incident dated 7/28/11: "While in group [client #5] was hit in the right arm by another coworker [day program client]." Further review indicated no injury noted.</p> <p>Incident dated 8/24/11: "While in morning group [day program client] grabbed another co-worker [client #5] on the right arm-leaving a red mark."</p> <p>The Qualified Mental Retardation Professional (QMRP), was interviewed on 9/27/11 at 11:40 A.M.. The QMRP was asked to provide, for review, a copy of facility policy or directions to staff about actions needed to be taken to rule out neglect when one client was aggressive to another client.</p> <p>A review of the facility's "Abuse Neglect/Exploitation/Mistreatment of an Individual/Violation of an Individual's Rights Investigation Procedure" no date</p>		<p>problem.</p> <p>To prevent the reoccurrence of regular weight checks being omitted, each home will have an annual calendar to record all weights weekly which will be provided for the nurse to review at her visits. The Residential Coordinator will be responsible for these to be completed weekly and submitted to the nurse.</p> <p>Person Responsible: Connie English, Director of Support and Quality Assurance Raina Daily, Behavior Specialist Michel Thompson, Residential Coordinator Kelly Bendel, Day Service Coordinator Sandra Beckett, QMRP</p>		

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	<p>noted was completed at the facility's administrative office on 9/27/11 at 3:00 P.M.. A review of the facility's policy indicated: "All [Facility name] staff and contracted agents are required to report immediately any situations of abuse, neglect, sexual exploitation, financial exploitation, mistreatment of a consumer, or violation of a consumer's rights...Definition of Abuse-The intentional or willful infliction of physical injury...Verbal or demonstrative harm caused by oral or written language, or gestures with disparaging or derogatory implications." Further review of the policy did not address actions needed to be taken to rule out neglect when one client was aggressive to another.</p> <p>The QMRP was interviewed at 9/29/11 at 1:40 P.M.. When asked if the analysis of the incident management system used by the provider provided information about which clients were aggressive to other clients and/or which clients were aggressed against one another, the QMRP indicated every client who exhibited aggressive behavior had a behavior management plan and the facility tracked targeted behaviors. When asked if information maintained by the provider could show which clients were the " aggressors " and which were " aggressed against, " the QMRP indicated she did</p>			

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	<p>not.</p> <p>When asked if the facility conducted any type of investigation to determine if the client to client aggression involving client #5 resulted from lack of staff, inadequately trained staff or failure to implement the behavior support plan of the client who exhibited the aggressive behavior, the QMRP indicated the efforts taken by various staff were not documented beyond what might be recorded in the record of the client who was aggressive. When asked if the team for client #5 met to discuss supports she might need or changes that might need to be made to reduce the likelihood of recurrence of client to client aggression, the QMRP indicated the team was not convened.</p> <p>2. A review of the facility's records was conducted at the facility's administrative office on 9/26/11 at 10:01 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports indicated:</p> <p>Incident dated 4/5/11: "On April 5, 2011 while eating lunch [client #4] choked 3 separate times. Staff intervened on the first 2 episodes and administered 3 back blows each time; on the 3rd episode no intervention was needed."</p>				

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	<p>Incident dated 5/2/11: "On May 2, 2011 [client #4] was lethargic; having difficulty swallowing her medications and fluids; her skin appeared to be discolored."</p> <p>Incident dated 8/17/11: "While eating lunch, [client #4] was trying to talk to others around her and subsequently began choking on her food. She signaled to those around her that she was choking and a Direct Support Professional, providing supervision at the time, immediately intervened. The Direct Support Professional administered 5 back blows, dislodging the obstruction and allowing [client #4] to resume breathing. No further medical attention was sought due to there being no further medical issues noted after the intervention took place."</p> <p>A review of client #4's record was completed on 9/27/11 at 12:45 P.M.. The "Annual Nutrition Assessment" dated 6/30/11 indicated: "Assessment: Weight changes: down 19 # (pounds) in 1 year, down 16# in 3 months (13.3%) x 3 months, down (12% in 5 months)...[Client #4] has had significant weight loss in the past 3 months...Questioned staff possible if [client #4] is showing silent aspiration as to why she is not eating and discussed doing a swallow study to rule out reason for not eating, discussed appetite</p>			

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	<p>stimulants as an option as well...Recommendations: Swallow study to determine if there is silent aspiration going on...Check TSH d/t (due to unintentional weight loss and dx (due to history) of thyroid problems...Monitor weight weekly." Review of the record indicated "Nursing Progress Notes" which indicated:</p> <p>"Nursing Progress Notes" dated 3/26/22: "[Client #4]...weight: 120 pounds."</p> <p>"Nursing Progress Notes" dated 6/14/11: "[Client #4]...weight 105 pounds."</p> <p>Further review of the record indicated a "1 Weekly Weights" log dated 2011 which indicated: "1/2/11...118 pounds" "1/30/11...122 ponds" "3/6/11...120 pounds" "6/19/11...104 pounds" "7/7/11...104 pounds" "7/14/11...105 pounds" "7/21/11...105.5 pounds" "7/28/11...106 pounds" "8/14/11...106 pounds" "8/21/11...106.5 pounds" "8/28/11...106 pounds" "9/28/11...106 pounds"</p> <p>A review of client #4's record was conducted on 9/27/11 at 12:45 P.M.. Review of client #4's record failed to</p>			

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W0157	<p>indicate an intake/output chart. Further review of client #4's record failed to indicate she had a swallow study completed and failed to indicate she was weighed weekly.</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 9/28/11 at 6:55 P.M.. The LPN indicated she wasn't sure if client #4 was taken to have a swallow study completed and wasn't sure if she was being weighed every week. No further documentation was available for review to indicate client #4's dietary/medical needs were further assessed.</p> <p>9-3-2(a)</p> <p>If the alleged violation is verified, appropriate corrective action must be taken. Based on record review, observation and</p>	W0157	Peak Community Services is	11/02/2011	

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	<p>interview, the facility failed for 3 of 6 clients residing at the group home (clients #1, #2 and #5) to take effective corrective action for 11 of 11 reported incidents of client to client aggression.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted at the facility's administrative office on 9/26/11 at 10:05 A.M.. Review of the reports dated 3/21/11 to 9/21/11 indicated the following incidents:</p> <p>Incidents involving client #1:</p> <p>Incident dated 5/15/11: "[Client #5] had thrown clothes all over the hallway and bathroom, staff approached [client #5] and asked her to pick the clothes up. [Client #5] became verbally and physically aggressive with staff. Staff attempted to redirect [client #5], [client #5] turned and struck another consumer [client #1]." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incident dated 5/21/11: "[Client #5] took a guitar from another consumer, [client #1]. Staff intervened to have the guitar</p>		<p>committed to ensuring that if the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Effective November 1, for the review of all October incidents, the BDDS Incident Report Review Committee will analyze numbers of aggressive behaviors per person and patterns of whether any person is targeted by any one person. This will be done using sort methods of the behavior data by name and by incident type. Several of the past months have been compiled and will be reviewed for each client at the November meeting. The Director of Support and Quality Assurance is responsible for this as chairperson of the BDDS Incident Report Review Committee beginning with the review of October, 2011 data and will continue for each monthly BDDS Incident Report Review Committee meeting.</p> <p>Additionally, to address the high behavior incidence an increase of staffing for client #5 is being considered. Client #5's team met on 10-20-11 to consider adding a medication to aid in control of her aggressive behaviors and the Primary Care Physician recommended to start the medication. This is approved by the guardian and will be presented to the Human Rights Committee for approval on 10-26-11.</p> <p>Previous interventions that have</p>		

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	<p>returned. When [client #1] approached to retrieve the guitar, [client #5] smacked her in the chest." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incidents involving client #2:</p> <p>Incident dated 3/27/11: "On March 27, 2011 while at home [client #2] was doing her laundry when another consumer [client #5] went into the laundry room and attempted to open the dryer door. [Client #2] told [client #5] that was her stuff to (sic) for her to get out. Staff intervened verbally and asked [client #5] to come out of the laundry room-[client #5] became physically aggressive and struck out at staff...[Client #5] appeared to be calm left the laundry room and when she saw [client #2], [client #5] hit [client #2] on the right side of the head leaving a small red mark." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incident dated 6/23/11: "While in the kitchen taking dirty dishes out of her lunch box, staff asked [client #5] to please take the dirty dishes out of the cabinet and to put them into the sink-[client #5] became upset/agitated and struck another</p>		<p>been tried to address the high client to client aggression at the day service program include: visits to the Primary Care Physician to review medications; make-up of the groups being changed several times; staff-client rearrangements were revised. These actions will continue. On 10-04-11, a Behavior Review Committee began meeting weekly, bringing the team together to discuss incidents that occurred; interventions that were used; how effective Behavior Support Plans were; what changes were recommended. Members of the Committee include: QMRP, Behavior Specialist, Residential Coordinator, and Day Service Coordinator. Minutes are kept on a Behavior Review Committee form on each client who displays aggressive behaviors that week. Behavior Review Committee minutes on client #5 for 10-04-11, 10-10-11 and 10-18-11 are included in supporting documentation. The Day Service team (Day Service Coordinator, QMRP and all Day Service Direct Support Professionals) meets twice weekly in addition to the Behavior Review Committee meeting on Day Service Programming. One of these meetings is to specifically review effectiveness of Behavior Support Plans, to retrain on each plan, and devise any recommendations for improvement in implementing the</p>	

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	<p>housemate [client #2] in the back." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incident dated 9/8/11: "While in group [client #5] became upset started yelling and then hit a co-worker [client #2]." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incident dated 9/21/11: "While in group [client #5] struck a co-worker [client #2] on the left side." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incidents involving client #5:</p> <p>Incident dated 4/21/11: "[Client #5] was sitting next to [day program client] during group. [Day program client] touched on (sic) of [client #5]'s items [client #5] responded verbally. [Day program client] became physically aggressive-putting her hand in [client #5]'s face and pushing her away. When [day program client] put her hand on [client #5]'s face this caused [client #5]'s glasses to slid (sic) down her face and the nose piece left a mark under</p>		<p>plans.</p> <p>Person Responsible: Connie English, Director of Support and Quality Assurance Raina Daily, Behavior Specialist Michel Thompson, Residential Coordinator Kelly Bendel, Day Service Coordinator Sandra Beckett, QMRP</p>	

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	<p>[client #5]'s nose." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incident dated 6/13/11: "While in group [client #5] became upset and pounded on the table. This caused another consumer [day program client] to become upset and he yelled at [client #5]. When [client #5] began to pound on the table again, [day program client] wheeled around the table where [client #5] was and yelled at her again. [Day program client] verbally threatened to cause bodily harm to [client #5]." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incident dated 6/13/11: "While in group [client #5] became upset and raised her fist at another consumer. Staff immediately intervened and stepped in between the consumers-the other consumer reached over staff's arm and struck [client #5] in the face leaving a red mark, and walked away." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incident dated 7/28/11: "While in group</p>				

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	<p>[client #5] was hit in the right arm by another coworker [day program client]." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incident dated 8/24/11: "While in morning group [day program client] grabbed another co-worker [client #5] on the right arm-leaving a red mark." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 9/29/11 at 1:40 P.M.. The QMRP indicated there was no documentation available for review to indicate the facility took effective/sufficient corrective action to address each of these incidents involving clients #1, #2 and #5.</p> <p>9-3-2(a)</p>				

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W0194	<p>Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.</p> <p>Based on observation, record review, and interview for 2 of 3 sampled clients (clients #1 and #3), the facility failed to assure staff demonstrated skills and techniques to implement program plans.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/26/11 from 6:00 A.M. until 8:00 A.M. and on 9/26/11 from 3:05 P.M. until 5:30 P.M.. During both observation periods clients #1 and #3 were observed not communicating in their home.</p> <p>A review of client #3's record was conducted on 9/27/11 at 10:31 A.M.. Client #3's Behavioral Support Plan (BSP) dated 2/2/10 indicated: "Staff learn sign alphabet...Incorporate simple sign/words into daily living." Client #3's ISP dated 3/4/11 indicated: "To improve communication, [client #3] will use sign language to express her wants and needs, each day."</p> <p>A review of client #1's record was conducted on 9/27/11 at 11:30 A.M.. Client #1's "Speech assessment" dated 2/2/10 indicated: "Staff learn sign alphabet...Incorporate simple sign/words into daily activities for [client #1]."</p> <p>A request for staff training records for all staff at the group home was made on 9/27/11. Staff training records were reviewed on 9/27/11 at 9:40 A.M.. Review of staff #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10's records failed to indicate staff were provided training on sign language.</p>	W0194	<p>Peak Community Services is committed to the ability to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.</p> <p>Staff will learn the sign alphabet and incorporate simple sign/ words into daily living at home and at work. Sign language will be utilized with client #1 and client #3 as well as other clients who have limited communication skills. The sign language will be accompanied with verbalizations to link words using various learning modalities. A first sign language training has been scheduled for 11-08-11.</p> <p>Person Responsible: Kathi Thompson, Director of Operations Michel Thompson, Residential Coordinator Kelly Bendel, Day Service Coordinator</p>	11/02/2011

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W0207	<p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted at the facility's administrative office on 9/29/11 at 1:40 P.M.. The QMRP indicated the staff were not trained in sign language. The QMRP further indicated staff should be trained in sign language to teach client #1 and #3 to communicate.</p> <p>9-3-3(a)</p> <p>Appropriate facility staff must participate in interdisciplinary team meetings.</p> <p>Based on record review and interview, the facility failed for 3 of 3 sampled clients residing at the group home (clients #1, #2 and #3) to ensure nursing staff participated in the annual Individual Support Plan (ISP) meetings.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted at the facility's administrative office on 9/27/11 at 11:30 A.M.. Review of client #1's ISP dated 2/1/11 indicated: "Insomnia, Epilepsy, Gastroesophageal Reflux, Constipation, Agitation, Pica, Avitaminosis and Behaviors." The ISP did not indicate nursing staff participation. Further review of client #1's record indicated a "Psychotropic Medication Review" form dated 6/3/11</p>	W0207	<p>Peak Community Services is committed to ensuring that appropriate facility staff must participate in interdisciplinary team meetings.</p> <p>The QMRP is inviting the nurse to all ISP/ Annual meetings where there is a nursing need or involvement. If the nurse is unable to attend the meeting, she will be asked to provide a report for all items in need of addressing. This procedure has been put into place since September 2011.</p> <p>To prevent the reoccurrence of nurses not providing input for annual meetings and documentation not to occur, the Director of Support and Quality Assurance will check files on a quarterly basis to assure the nurse was present at the annual meetings and/ or provided input for the meetings. If the ISP Meeting Records' do not show nurse</p>	11/02/2011	

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	<p>which indicated client #1 will continue Seroquel 500 milligrams (mg) at bedtime and Namenda 10 mg once daily.</p> <p>A review of client #2's record was conducted at the facility's administrative office on 9/27/11 at 12:20 P.M.. Review of client #2's ISP dated 8/31/11 indicated: "Will improve self medication skills...Seizure disorder/Epilepsy." The ISP did not indicate nursing staff participation.</p> <p>A review of client #3's record was conducted at the facility's administrative office on 9/27/11 at 10:31 P.M.. Review of client #3's ISP dated 3/4/11 indicated: "To improve medication administration will complete steps to taking her medication." The ISP did not indicate nursing staff participation. Further review of the record indicated a Behavior Support Plan (BSP) dated 3/11 which indicated: "Klonopin .5 mg two times a day and 1 mg at bedtime."</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 9/28/11 at 6:55 P.M.. The LPN indicated she did not participate in the annual ISP meetings.</p> <p>9-3-4(a)</p>		<p>involvement, the QMRP will be retrained in this procedure. If there is no annual nurse's report, the Community Services Manager will be notified and address this with the nurse.</p> <p>Person Responsible: Michel Thompson, Residential Coordinator Kris Myers, Community Services Manager Sandra Beckett, QMRP Connie English, Director of Support and Quality Assurance</p>		

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W0217	<p>The comprehensive functional assessment must include nutritional status.</p> <p>Based on record review, and interview the facility failed to assess the dietary needs for 1 of 6 clients (client #4) who resided in the group home.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 9/26/11 at 10:01 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports indicated:</p> <ol style="list-style-type: none"> <li>1. Incident dated 4/5/11: "On April 5, 2011 while eating lunch [client #4] choked 3 separate times. Staff intervened on the first 2 episodes and administered 3 back blows each time; on the 3rd episode no intervention was needed."</li> <li>2. Incident dated 5/2/11: "On May 2, 2011 [client #4] was lethargic; having difficulty swallowing her medications and fluids; her skin appeared to be discolored."</li> <li>3. Incident dated 8/17/11: "While eating lunch, [client #4] was trying to talk to others around her and subsequently began choking on her food. She signaled to those around her that she was choking and</li> </ol>	W0217	<p>Peak Community Services is committed to ensuring that the comprehensive functional assessment includes nutritional status.</p> <p>A swallow study for Client #4 was previously addressed with the Primary Care Physician, but not documented with the nurse. The nurse will request a Speech evaluation to address the choking issue and obtain further input for a swallow study. During the two to three months gap in the weights noted, Client #4 had gall bladder surgery and has been stable since then. Client #4 has had a CT scan of the abdominal area with results pending. The Primary Care Physician is reviewing client #4's medications to see if they could be causing a problem.</p> <p>To prevent the reoccurrence of regular weight checks being omitted, each home will have an annual calendar to record all weights weekly which will be provided for the nurse to review at her visits. The Residential Coordinator will be responsible for these to be completed weekly and submitted to the nurse.</p> <p>Peak Residential staff will be instructed on when to call a nurse. A new form for when to call a nurse will be put into place to document the calls by 11-02-11.</p>	11/02/2011	

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	<p>a Direct Support Professional, providing supervision at the time, immediately intervened. The Direct Support Professional administered 5 back blows, dislodging the obstruction and allowing [client #4] to resume breathing. No further medical attention was sought due to there being no further medical issues noted after the intervention took place."</p> <p>A review of client #4's record was completed on 9/27/11 at 12:45 P.M.. The "Annual Nutrition Assessment" dated 6/30/11 indicated: "Weight changes: Down 19 # (pounds) in 1 year...down 16# in 3 months (13.3% in 3 months)...down 14# (12% in 5 months)...Assessment: [Client #4] has had significant weight loss in the past 3 months...Questioned staff possible if [client #4] is showing silent aspiration as to why she is not eating and discussed doing a swallow study to rule out reason for not eating, discussed appetite stimulants as an option as well...Recommendations: Swallow study to determine if there is silent aspiration going on...Check TSH d/t (due to unintentional weight loss and dx (due to history) of thyroid problems...Monitor weight weekly." Further review of the record indicated:</p> <p>"Nursing Progress Notes" dated 3/26/22: "[Client #4]...weight: 120 pounds."</p>		<p>The nursing assessment form is being revised to include the current check on health status at the time of the nurse visit and will expand to include a quarterly review of all medical and nursing events of the quarter. This new form will be in place by 11-02-11. The Community Services Manager will monitor that the new nursing assessment forms are being utilized.</p> <p>Person Responsible: Connie English, Director of Support and Quality Assurance Michel Thompson, Residential Coordinator Kris Myers, Community Services Manager Sandra Beckett, QMRP</p>		

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	<p>"Nursing Progress Notes" dated 6/14/11: "[Client #4]...weight 105 pounds."</p> <p>Further review of the record indicated a "1 Weekly Weights" log dated 2011 which indicated: "1/2/11...118 pounds" "1/30/11...122 ponds" "3/6/11...120 pounds" "6/19/11...104 pounds" "7/7/11...104 pounds" "7/14/11...105 pounds" "7/21/11...105.5 pounds" "7/28/11...106 pounds" "8/14/11...106 pounds" "8/21/11...106.5 pounds" "8/28/11...106 pounds" "9/28/11...106 pounds"</p> <p>A review of client #4's record was conducted on 9/27/11 at 12:45 P.M.. Review of client #4's record failed to indicate she had a swallow study completed and failed to indicate she was weighed weekly.</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 9/28/11 at 6:55 P.M.. The LPN indicated she wasn't sure if client #4 was taken to have a swallow study completed and wasn't sure if she was being weighed every week. No further documentation was available for review to indicate client #4's</p>			

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W0242	<p>dietary needs were further assessed.</p> <p>9-3-4(a)</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 3 sampled clients (client #1) to ensure a formal communication goal/objective was implemented in the Individualized Support Plan (ISP).</p> <p>Findings include:</p>	W0242	<p>Peak Community Services is committed to ensuring that the individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming and communication of</p>	11/02/2011	

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W0248	<p>Observations were conducted at the group home on 9/26/11 from 6:00 A.M. until 8:00 A.M. and on 9/26/11 from 3:05 P.M. until 5:30 P.M.. During both observation periods client #1 was observed not communicating in her home.</p> <p>A review of client #1's record was conducted on 9/27/11 at 11:30 A.M.. Client #1's "Speech Assessment" dated 2/2/10 indicated: "Staff learn sign alphabet...incorporate simple sign/words into daily activities for [client #1]." The Individual Support Plan (ISP) dated 3/4/11 did not indicate a communication goal.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 9/27/11 at 2:40 P.M.. The QMRP indicated client #1 was non-verbal and did not a formal communication objective in her ISP.</p> <p>9-3-4(a)</p> <p>A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.</p>		<p>basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>A communication goal has been put in place for client #1. Goal included. The QMRP and Residential Coordinator will review each client's individual program plans to find areas of need and new goals will be developed for any areas identified that do not currently have goals. The QMRP will take special care when developing new individual program plans assuring goals are developed for all identified areas of need.</p> <p>Person Responsible: Sandra Beckett, QMRP Michel Thompson, Residential Coordinator</p>	

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	<p>Based on record review and interview, the facility failed to have updated Individual Support Plans (ISP) for 6 of 6 clients residing at the group home (clients #1, #2, #3, #4, #5 and #6), available for all staff who worked at the group home.</p> <p>Findings include:</p> <p>Client #1, #2, #3, #4, #5 and #6's records were reviewed at the group home on 9/26/11 at 3:35 P.M. Review of client #1's record indicated no ISP available for review. Review of client #2's record indicated no ISP available for review. Review of client #3's record indicated no ISP available for review. Review of client #4's record indicated no ISP available for review. A review of client #5's record indicated no ISP available for review. A review of client #6's record indicated no ISP available for review. No further documentation was available for review to indicate client #1, #2, #3, #4, #5 and #6's current ISPs were available for staff who worked with the clients at the group home.</p> <p>Interview with the Group Home Manager (GHM) was conducted on 9/26/11 at 3:40 P.M.. The GHM indicated client #1, #2,</p>	W0248	<p>Peak Community Services is committed to ensuring that a copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. The Individual Support Plans for all six clients were placed in the home files. Filing will be kept current so information will be kept in place and available for review by staff when needed.</p> <p>The Residential Coordinator will complete checks of home files following each annual planning meeting to assure the individual plans have been placed in the home files.</p> <p>Person Responsible: Sandra Beckett, QMRP Michel Thompson, Residential Coordinator</p>	11/02/2011	

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	<p>#3, #4, #5 and #6's most current ISPs were not available for the group home staff.</p> <p>A review of client #1's record was conducted at the facility's administrative office on 9/27/11 at 11:30 A.M.. The record indicated a most current ISP dated 2/1/11.</p> <p>A review of client #2's record was conducted at the facility's administrative office on 9/27/11 at 12:20 P.M.. The record indicated a most current ISP dated 8/31/11.</p> <p>A review of client #3's record was conducted at the facility's administrative office on 9/27/11 at 10:31 A.M.. The record indicated a most current ISP dated 3/4/11.</p> <p>A review of client #4's record was conducted at the facility's administrative office on 9/27/11 at 12:45 P.M.. The record indicated a most current ISP dated 5/31/11.</p> <p>A review of client #5's record was conducted at the facility's administrative office on 9/27/11 at 1:10 P.M.. The record indicated a most current ISP dated 7/21/11.</p>				

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W0249	<p>A review of client #6's record was conducted at the facility's administrative office on 9/27/11 at 1:30 P.M.. The record indicated a most current ISP dated 4/5/11.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 9/29/11 at 2:40 P.M.. The QMRP indicated the group home staff should have updated ISPs for clients #1, #2, #3, #4, #5 and #6.</p> <p>9-3-4(a)</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview, the facility failed to assure 1 of 3 sampled clients (client #3) received training and services consistent with her Individual Support Plan (ISP).</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 9/26/11 from 6:00 A.M. until 8:00 A.M.. During the entire</p>	W0249	<p>Peak Community Services is committed to ensuring that 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>The Behavior Specialist inserviced</p>	11/02/2011

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	<p>observation period, client #3 was not observed to use sign language to express her wants and needs and was not observed to be prompted by staff to do so. Direct Support Professionals (DSP) #1, #2 and #3 failed to implement a communication training objective for client #3.</p> <p>An evening observation was conducted at the group home on 9/26/11 from 3:05 P.M. until 5:30 P.M.. During the entire observation period, client #3 was not observed to use sign language to express her wants and needs and was not observed to be prompted by staff to do so. Direct Support Professionals (DSP) #1, #2 and #3 failed to implement a communication training objective for client #3.</p> <p>A review of client #3's record was conducted on 9/27/11 at 10:35 A.M.. Client #3's ISP dated 3/4/11 indicated: "To improve communication, [client #3] will use sign language to express her wants and needs each day."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 9/29/11 at 1:40 P.M.. The QMRP indicated group home staff should implement active treatment training objectives during formal and informal opportunities.</p>		<p>residential staff on client #3's Behavior Support Plan which includes picture board usage on 10-18-11. Supporting documentation included. The Behavior Specialist inserviced day service staff on client #3 Behavior Support Plan and picture board usage on 10-12-11. Supporting documentation is currently unavailable. It will be accessible by 11-02-11.</p> <p>The QMRP and Residential Coordinator will spot check staff while in the home to assure the picture board is being implemented. Staff will learn the sign alphabet and incorporate simple sign/ words into daily living at home and at work. Sign language will be utilized with client #3 as well as other clients who have limited communication skills. The sign language will be accompanied with verbalizations to link words using various learning modalities. A first sign language training has been scheduled for 11-08-11.</p> <p>Person Responsible: Sandra Beckett, QMRP Michel Thompson, Residential Coordinator Kathi Thompson, Director of Operations</p>		

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W0250	<p>9-3-4(a)</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>Based on record review and interview, the facility failed for 6 of 6 clients residing at the group home (clients #1, #2, #3, #4, #5 and #6) to have Active Treatment Schedules (ATS).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 9/26/11 at 3:35 P.M.. Client #1's record failed to have an ATS.</p> <p>Client #2's record was reviewed on 9/26/11 at 3:40 P.M.. Client #2's record failed to have an ATS.</p> <p>Client #3's record was reviewed on 9/26/11 at 3:45 P.M.. Client #3's record failed to have an ATS.</p> <p>Client #4's record was reviewed on 9/26/11 at 3:50 P.M.. Client #4's record failed to have an ATS.</p> <p>Client #5's record was reviewed on</p>	W0250	<p>Peak Community Services is committed to ensuring that the facility develops an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>The Community Services Manager will complete Active Treatment Schedules for clients #1, 2, 3, 4, 5, and 6 by 11-02-11. The Residential Coordinator will carry out the Active Treatment Schedules and assure that staff are doing so. The Active Treatment Schedule is included in supporting documentation. - Person Responsible: Kris Myers, Community Services Manager Michel Thompson, Residential Coordinator</p>	11/02/2011

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W0261	<p>9/26/11 at 3:55 P.M.. Client #5's record failed to have an ATS.</p> <p>Client #6's record was reviewed on 9/26/11 at 4:00 P.M.. Client #6's record failed to have an ATS.</p> <p>An interview with the Group Home Manager (GHM) was conducted on 9/26/11 at 4:00 P.M.. The GHM indicated there was no ATS for clients #1, #2, #3, #4, #5 and #6.</p> <p>9-3-4(a)</p> <p>The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.</p> <p>Based on record review and interview the facility failed to have a family member and client member serve on the Human Rights Committee for 6 of 6 clients (clients #1, #2, #3, #4, #5 and #6) residing at the group home.</p> <p>Findings include:</p>	W0261	Peak Community Services is committed to ensuring that the facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change	11/02/2011	

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	<p>A review of the facility's records was conducted at the facility's administrative office on 9/27/11 at 9:30 A.M.. A review of the facility's "Human Rights Committee Meeting Minutes" indicated the following:</p> <p>Meeting Date: 1/26/11: Review of the 1/26/11 minutes indicated no family member or client in attendance.</p> <p>Meeting Date 2/23/11: Review of the 2/23/11 minutes indicated no family member or client in attendance.</p> <p>Meeting Date 3/30/11: Review of the 3/30/11 minutes indicated no family member in attendance.</p> <p>Meeting Date 4/27/11: Review of the 4/27/11 minutes indicated no family member or client in attendance.</p> <p>Meeting Date 5/25/11: Review of the 5/25/11 minutes indicated no family member or client in attendance.</p> <p>Meeting Date 6/29/11: Review of the 6/29/11 minutes indicated no family member or client in attendance.</p> <p>Meeting Date 7/27/11: Review of the 7/27/11 minutes indicated no family</p>		<p>inappropriate client behavior, and persons with no ownership or controlling interest in the facility. The Director of Support and Quality Assurance met with the consumer representative of the Human Rights Committee prior to the September, 2011 meeting about attendance. A new system of transportation has been worked out to assist the consumer representative in attending the meetings more regularly.</p> <p>The Human Rights Committee chairperson has discussed with the family member of the Human Rights Committee the poor attendance issues and the need for a stronger commitment to attending. Such a commitment has been given by the family member on 10-24-11. If poor attendance continues, the Human Rights Committee will look at alternate meeting times and/ or search for another family member representative.</p> <p>Person Responsible: Kris Myers, Community Services Manager Connie English, Director of Support and Quality Assurance</p>		

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W0289	<p>member or client in attendance.</p> <p>Meeting Date 8/31/11: Review of the 8/31/11 minutes indicated no client in attendance.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 9/27/11 at 2:40 P.M.. When asked if the facility's HRC had a client representative and a family member/guardian, QMRP indicated the facility's HRC did have a client representative and family member/guardian but they did not participate in the HRC meetings mentioned.</p> <p>9-3-4(a)</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.</p> <p>Based on record review and interview for 2 of 6 clients residing at the group home (clients #3 and #4), the facility failed to ensure systematic interventions in the Behavior Support Plans (BSP) were specifically written in the BSP's.</p>	W0289	Peak Community Services is committed to ensuring that 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.	11/02/2011	

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	<p>Findings include:</p> <p>1. A review of client #3's record was conducted on 9/27/11 at 10:15 A.M.. Review of her BSP dated 3/11 indicated: "Current Psychotropic Medications: Klonopin .5 mg (milligrams) two times a day and 1 mg at bedtime...Behaviors: Physical Aggression/Outbursts...Risk/Benefit Statement: The following restrictions are included in this Behavior Support Plan: Use of psychotropic medication, use of CPI (Crisis Prevention Intervention) holds, techniques." Further review of the BSP failed to indicate specific interventions.</p> <p>2. A review of client #4's record was conducted on 9/27/11 at 12:45 P.M.. Review of her BSP dated 4/11 indicated: "Overview of target Behaviors: Temper Tantrums...Obsessive/Compulsive acts/vocalizations...Wetting on self...Self-injurious behaviors...Risk/Benefit Statement: The following restrictions are included in this Behavior Support Plan: Use of psychotropic medication, use of CPI (Crisis Prevention Intervention) holds, techniques...use of protective gloves when injuring self." Further review of the BSP failed to indicate specific interventions.</p>		<p>Behavior Support Plans will be revised to include more specific information on the CPI (Crisis Prevention Institute) techniques used. The use of the least restrictive strategies should be used prior to the most restrictive strategies; the use of reactive strategies should be used after all proactive strategies have been utilized; specific techniques will be explained in further detail on Behavior Support Plans. All staff have been trained in CPI and use these techniques in this manner, as trained. The QMRP has requested the behavior consultant to revise the Behavior Support Plans for client #3 and client #4, as well as other clients' plans. They will be presented at the Human Rights Committee meeting which meets monthly, as the plans become available. At least one client plan will be approved at the 10-26-11 meeting; the rest will follow. The QMRP will spot check Behavior Support Plans in the future to assure the CPI techniques are explained fully in the plans.</p> <p>Person Responsible: Sandra Beckett, QMRP</p>		

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W0318	<p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 9/27/11 at 2:40 P.M.. The QMRP indicated client #3 and #4's BSP failed to indicate which specific CPI holds/techniques were approved and would be implemented when needed.</p> <p>9-3-5(a)</p> <p>The facility must ensure that specific health care services requirements are met. Based on record review and interview, the Condition of Participation, Health Care Services, is not met as the facility failed to provide adequate nursing services for 5 of 6 clients (clients #1, #2, #3, #4 and #6).</p> <p>Findings include:</p> <p>Please refer to W322: The facility failed for 2 of 3 sampled clients (client #2 and #3), to have a mammogram as recommended by her primary care physician (PCP) and to follow up with dental recommendations made by a</p>	W0318	<p>Peak Community Services is committed to ensuring that specific health care services requirements are met.</p> <p>The Residential Coordinator took Client #2 for a mammogram; it did not get completed; an appointment will be scheduled by 10-26-11 to complete a mammogram.</p> <p>For client #3 – failed to follow up with dental recommendations. This was complete, but a copy of the document was previously unavailable. Document attached of 01-20-11 dental appointment where restoration was completed on</p>	11/02/2011	

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	<p>dentist.</p> <p>Please refer to W331. The facility failed for 2 of 3 sampled clients and 2 additional clients (clients #1, #2, #3, #4 and #6) by not ensuring they received nursing services according to their medical needs.</p> <p>Please refer to W346. The facility failed for 1 of 6 clients residing at the group home (client #4), to have a Registered Nurse (RN) available for verbal or onsite consultation to the Licensed Practical Nursing (LPN) staff.</p> <p>Please refer to W356: The facility failed to ensure dental care included the evaluation of restoration of a broken tooth for 1 of 3 sampled clients (client #3).</p> <p>Please refer to W363: The facility failed to report the pharmacist recommendations to the prescribing physician and Interdisciplinary Team for 3 of 6 clients residing at the group home (clients # 1, #3 and #5).</p> <p>9-3-6(a)</p>		<p>tooth.</p> <p>A swallow study for Client #4 was previously addressed with the Primary Care Physician, but not documented with the nurse. The nurse will request a Speech evaluation to address the choking issue and obtain further input for a swallow study. During the two to three months gap in the weights noted, Client #4 had gall bladder surgery and has been stable since then. Client #4 has had a CT scan of the abdominal area with results pending. The Primary Care Physician is reviewing client #4's medications to see if they could be causing a problem.</p> <p>To prevent the reoccurrence of regular weight checks being omitted, each home will have an annual calendar to record all weights weekly which will be provided for the nurse to review at her visits. The Residential Coordinator will be responsible for these to be completed weekly and submitted to the nurse.</p> <p>Peak Residential staff will be retrained on when to call a nurse. A new form for when to call a nurse will be put into place to document the calls by 11-02-11.</p> <p>The nursing assessment form is being revised to include the current check on health status at the time of the nurse visit and will expand to include a quarterly review of all medical and nursing events of the</p>	

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			<p>quarter. This new form will be in place by 11-02-11. The Community Services Manager will monitor that the new nursing assessment forms are being utilized.</p> <p>Peak Community Services CEO is actively recruiting for a registered nurse to be available for verbal or onsite consultation to the LPN. Director of Operations is actively recruiting for a registered nurse, having made several inquiries in the area. Several contacts have been made and meetings have been held with potential individuals and companies to contract with. The new Director of Operations will continue to spearhead this recruitment effort.</p> <p>When hired, the registered nurse will consult with the LPN for timely completion of quarterly nursing assessments, annual physicals, annual vision exams, and other required and needed medical events for clients #1, 2, 3, 4, 5 and 6. For client #3 – failed to follow up with dental recommendations. This was complete, but a copy of the document was previously unavailable. Document attached of 01-20-11 dental appointment where restoration was completed on tooth.</p> <p>The Community Services Manager will assist the Residential Coordinator in using a prompting system to follow through with medical professional</p>	

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			<p>recommendations.</p> <p>Peak Community Services is changing the procedure for drug regimen review to assure better follow-up starting 11-01-11. The Director of Operations will meet with the pharmacist regularly and follow up with the primary care physician on any irregularities noted.</p> <p>For client #3, the Residential Coordinator will make an appointment with the primary care physician to determine the corresponding diagnoses for her medications: famotidine and probiotic lactobacillus. The appointment will be made by 11-02-11.</p> <p>For client #1, no psychotropic med review for Abilify and Seroquel was located at the time of the survey. A psychotropic medication Review completed 01-04-11 was located on a Health Visit Report where a review of these medications was noted by the primary care physician. Supporting documentation included.</p> <p>For client #5, a dosage change was recommended for Lovastatin and the change was never made. A 10-05-11 Health Visit Report was located where the primary care physician notes, "does not need to change lovastatin dosage". Supporting documentation included.</p> <p>Person Responsible: Connie English, Director of Support and Quality Assurance</p>	

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W0322	<p>The facility must provide or obtain preventive and general medical care.</p> <p>Based on record review and interview, the facility failed for 2 of 3 sampled clients (client #2 and #3) 1. to have a mammogram as recommended by her primary care physician (PCP) and 2. to follow up with dental recommendations made by a dentist.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. A review of client #2's record was conducted at the facility's administrative office on 9/27/11 at 12:20 P.M.. A review of client #2's record indicated a most current physical exam completed on 3/23/11 with the recommendation of: "Recommendations: Mammogram." Further review of the record failed to indicate client #2 had a mammogram completed.</li> <li>2. A review of client #3's record was conducted at the facility's administrative office on 9/27/11 at 10:31 A.M.. A review of client #3's record indicated a</li> </ol>	W0322	<p>Michel Thompson, Residential Coordinator Kris Myers, Community Services Manager Sandra Beckett, QMRP Kathi Thompson, Director of Operations Don Weikle, CEO</p> <p>Peak Community Services is committed to ensuring that the facility must provide or obtain preventive and general medical care. The Residential Coordinator took Client #2 for a mammogram; it did not get completed; an appointment will be scheduled by 10-26-11 to complete a mammogram. For client #3 – failed to follow up with dental recommendations. This was complete, but a copy of the document was previously unavailable. Document attached of 01-20-11 dental appointment where restoration was completed on tooth.</p> <p>Person Responsible: Michel Thompson, Residential Coordinator</p>	11/02/2011

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	<p>most current dental exam completed on 1/6/11 with the recommendation of: "Patient has broken tooth on lower right that should be restored." Further review of the record failed to indicate client #3 had the tooth restored as recommended by the dentist.</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 9/28/11 at 6:55 P.M.. Nursing staff indicated she was not sure if client #2 had a mammogram completed or if #3 had her tooth restored. No documentation was available for review to indicate client #2 had a mammogram completed as recommended by her PCP or to indicate client #3 had her tooth restored as recommended by the dentist.</p> <p>9-3-6(a)</p>				
W0331	<p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview, the facility failed for 3 of 6 clients residing at the home (clients #3, #4 and #6) by not</p>	W0331	Peak Community Services is committed to ensuring that the facility must provide clients with nursing services in accordance with	11/02/2011	

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	<p>ensuring they received nursing services according to their medical needs.</p> <p>Findings include:</p> <p>1. A morning observation was conducted at the group home on 9/26/11 from 6:00 A.M. until 8:00 A.M.. During the entire observation period client #4 cried and screamed she did not feel well.</p> <p>An evening observation was conducted at the group home on 9/26/11 from 3:05 P.M. until 5:30 P.M.. During the entire observation period client #4 cried and screamed she did not feel well.</p> <p>A review of client #4's record was conducted at the facility's administrative office on 9/27/11 at 12:45 P.M.. Review of the record indicated:</p> <p>a. First Aid Report dated 7/5/11: "[Client #4] bit herself on the right wrist." Further review of the report failed to indicate the nurse was contacted or nursing involvement.</p> <p>b. Health Concern Case Note dated 7/6/11: "[Client #4] stated her stomach hurts, she was crying and after three verbal prompts stated that her stomach hurts." Further review of the report failed to indicate the nurse was contacted or nursing involvement.</p> <p>c. Health Concern Case Note dated 7/14/11: "[Client #4]'s color is so pale-also very tired today-she has a puffy area on right eyelid which seems to be larger than before." Further review of the report failed to indicate the nurse was contacted or nursing involvement.</p> <p>d. First Aid Report dated 7/18/11: "Has a small sore on top of her right foot." Further review of</p>		<p>their needs.</p> <p>A swallow study for Client #4 was previously addressed with the Primary Care Physician, but not documented with the nurse. The nurse will request a Speech evaluation to address the choking issue and obtain further input for a swallow study. During the two to three months gap in the weights noted, Client #4 had gall bladder surgery and has been stable since then. Client #4 has had a CT scan of the abdominal area with results pending. The Primary Care Physician is reviewing client #4's medications to see if they could be causing a problem.</p> <p>To prevent the reoccurrence of regular weight checks being omitted, each home will have an annual calendar to record all weights weekly which will be provided for the nurse to review at her visits. The Residential Coordinator will be responsible for these to be completed weekly and submitted to the nurse.</p> <p>Peak Residential staff will be instructed on when to call a nurse. A new form for when to call a nurse will be put into place to document the calls by 11-02-11.</p> <p>The nursing assessment form is being revised to include the current check on health status at the time of the nurse visit and will expand to include a quarterly review of all medical and nursing events of the</p>	

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	<p>the report failed to indicate the nurse was contacted or nursing involvement.</p> <p>e. Health Concern Case Note dated 7/25/11: "[Client #4] talking about a stomach ache all morning." Further review of the report failed to indicate the nurse was contacted or nursing involvement.</p> <p>f. Health Concern Case Note dated 7/27/11: "[Client #4] stated that her stomach hurt-pointing to her lower stomach." Further review of the report failed to indicate the nurse was contacted or nursing involvement.</p> <p>g. Health Concern Case Note dated 7/28/11: "8:40 A.M.-[Client #4] stated several times her lower right side of her stomach hurt real bad...9:40 A.M.-[Client #4] complained again-lower right side of stomach hurt...12:40 P.M.-[Client #4] saying again lower right side of her stomach hurts...1:45 P.M.-[Client #4] saying again-lower right side of her stomach hurts." Further review of the report failed to indicate the nurse was contacted or nursing involvement.</p> <p>h. Health Concern Case Note dated 8/1/11: "[Client #4] complained of her stomach hurting this A.M.." Further review of the report failed to indicate the nurse was contacted or nursing involvement.</p> <p>i. First Aid Report dated 8/2/11: "[Client #4]...Open infected wound." Further review of the report failed to indicate the nurse was contacted or nursing involvement.</p> <p>j. First Aid Report dated 8/3/11: "[Client #4]...Wound." Further review of the report failed to indicate the nurse was contacted or nursing involvement.</p>		<p>quarter. This new form will be in place by 11-02-11. The Community Services Manager will monitor that the new nursing assessment forms are being utilized.</p> <p>Person Responsible: Connie English, Director of Support and Quality Assurance Michel Thompson, Residential Coordinator Kris Myers, Community Services Manager Sandra Beckett, QMRP</p>	

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	<p>involvement..</p> <p>k. Health Concern Case Note dated 8/4/11: "At lunch time @ (at) 11:04 [client #4] started crying and slapping staff on the arm saying her stomach hurt. Further review of the report failed to indicate the nurse was contacted or nursing involvement.</p> <p>l. First Aid Report dated 8/17/11: "[Client #4] was at lunch and was talking with food in her mouth. [Client #4] started choking, staff started the back throws and the pizza came out." Further review of the report failed to indicate the nurse was contacted or nursing involvement.</p> <p>m. First Aid Report dated 8/23/11: "Staff was changing [client #4]'s bandage on her right wrist." Further review of the report failed to indicate the nurse was contacted or nursing involvement.</p> <p>n. First Aid Report dated 8/31/11: "[Client #4] was finishing her lunch when staff, who was sitting next to [client #4], noticed her lips were a lilac/blue color. [Client #4] didn't choke, cough or anything while she was eating lunch. Staff called for other staff to take a look and agreed about color of lips. [Client #4] was breathing and eating fine." Further review of the report failed to indicate the nurse was contacted or nursing involvement.</p> <p>Further review of client #4's record failed to indicate any nursing assessments for client #4's health concerns.</p> <p>2. A review of the facility's records was conducted at the facility's administrative office on 9/26/11 at 10:01 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS)</p>				

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	<p>reports indicated:</p> <p>a. Incident dated 4/5/11: "On April 5, 2011 while eating lunch [client #4] choked 3 separate times. Staff intervened on the first 2 episodes and administered 3 back blows each time; on the 3rd episode no intervention was needed." Further review of the report failed to indicate the nurse was contacted or involved in the incident.</p> <p>b. Incident dated 5/2/11: "On May 2, 2011 [client #4] was lethargic; having difficulty swallowing her medications and fluids; her skin appeared to be discolored." Further review of the report failed to indicate the nurse was contacted or involved in the incident.</p> <p>c. Incident dated 8/17/11: "While eating lunch, [client #4] was trying to talk to others around her and subsequently began choking on her food. She signaled to those around her that she was choking and a Direct Support Professional, providing supervision at the time, immediately intervened. The Direct Support Professional administered 5 back blows, dislodging the obstruction and allowing [client #4] to resume breathing. No further medical attention was sought due to there being no further medical issues noted after the intervention took place." Further review of the report failed to indicate the nurse was contacted or involved in the incident.</p> <p>A review of client #4's record was completed on 9/27/11 at 12:45 P.M.. The "Annual Nutrition Assessment" dated 6/30/11 indicated: "Weight changes: down 19# (pounds) in 1 year, down 16# in 3 months (13.3% in 3 months), down 14# (12% in 5 months)...Assessment: [Client #4] has had significant weight loss in the past 3 months...Questioned staff possible if [client #4] is</p>				

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	<p>showing silent aspiration as to why she is not eating and discussed doing a swallow study to rule out reason for not eating, discussed appetite stimulants as an option as well...Recommendations: Swallow study to determine if there is silent aspiration going on...Check TSH d/t (due to) unintentional weight loss and dx (due to history) of thyroid problems...Monitor weight weekly." Further review of the record indicated a "1 Weekly Weights" log dated 2011 which indicated:</p> <p>"1/2/11...118 pounds" "1/30/11...122 ponds" "3/6/11...120 pounds" "6/19/11...104 pounds" "7/7/11...104 pounds" "7/14/11...105 pounds" "7/21/11...105.5 pounds" "7/28/11...106 pounds" "8/14/11...106 pounds" "8/21/11...106.5 pounds" "8/28/11...106 pounds" "9/28/11...106 pounds"</p> <p>A review of client #4's record was conducted on 9/27/11 at 12:45 P.M.. Review of client #4's record failed to indicate an intake/output chart. Further review of client #4's record failed to indicate she had a swallow study completed and failed to indicate she was weighed weekly.</p> <p>3. A morning observation was conducted at the group home on 9/26/11 from 6:00 A.M. until 8:00 A.M.. Client #6's entire nose was observed to have a bright red sore.</p> <p>A review of client #6's record was conducted on 9/27/11 at 1:30 P.M.. Client #6's record failed to indicate a nursing assessment to address the sore</p>						

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W0336	<p>on her nose.</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 9/28/11 at 6:55 P.M.. The LPN indicated she was not aware of all the mentioned documented incidents. The LPN further indicated she was not aware if client #4 had the recommended swallow study completed and further indicated client #6's injury was not assessed.</p> <p>9-3-6(a)</p> <p>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.</p> <p>Based on record review and interview the facility failed for 3 of 3 sampled clients and 1 additional client (clients #1, #2, #3 and #4) with medical conditions, to have quarterly nursing assessments completed in a timely fashion.</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 9/27/11 at 11:30 A.M.. The record review failed to indicate the quarterly nursing</p>	W0336	<p>Peak Community Services is committed to ensuring that 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.</p> <p>The QMRP and Residential Coordinator will monitor dates of nursing assessments to ensure that assessments are completed at least quarterly.</p> <p>To prevent reoccurrence, the</p>	11/02/2011

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	<p>assessments had been completed timely. Client #1's quarterly nursing assessments were dated 6/7/10, 11/18/10, 3/26/11 and 6/14/11. Further review of client #1's record indicated he was not in need of a medical care plan and an annual physical dated 3/31/11. No further documentation was available for review to indicate client #1 had a nursing quarterly completed for the month of 9/10 and 2/11.</p> <p>Client #2's records were reviewed on 9/27/11 at 12:20 P.M.. The record review failed to indicate the quarterly nursing assessments had been completed timely. Client #2's quarterly nursing assessments were dated 6/7/10, 11/18/10, 3/26/11 and 6/14/11. Further review of client #2's record indicated he was not in need of a medical care plan and an annual physical dated 9/14/11. No further documentation was available for review to indicate client #2 had a nursing quarterly completed for the month of 9/10 and 2/11.</p> <p>Client #3's records were reviewed on 9/27/11 at 10:31 A.M.. The record review failed to indicate the quarterly nursing assessments had been completed timely. Client #3's quarterly nursing assessments were dated 6/17/10, 11/18/10, 3/26/11 and 6/14/11. Further review of client #3's record indicated he was not in need of a medical care plan and an annual physical</p>		<p>Community Services Manager and Residential Coordinator will develop and follow a tracking system on the house calendar on a monthly basis to assure the assessments are getting scheduled and completed. Person Responsible: Sandra Beckett, QMRP Michel Thompson, Residential Coordinator Kris Myers, Community Services Manager</p>		

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	<p>dated 3/23/11. No further documentation was available for review to indicate client #3 had a nursing quarterly completed for the month of 9/10 and 2/11.</p> <p>Client #4's records were reviewed on 9/27/11 at 12:45 P.M.. The record failed to indicate the quarterly nursing assessments had been completed timely. Client #4's quarterly nursing assessments were dated 6/17/10, 11/18/10, 3/26/11 and 6/14/11. Further review of client #4's record indicated he was not in need of a medical care plan and an annual physical dated 9/14/11. No further documentation was available for review to indicate client #3 had a nursing quarterly completed for the month of 9/10 and 2/11.</p> <p>The nurse was interviewed on 9/28/11 at 6:55 P.M.. The nurse indicated the nursing assessments were not completed quarterly. The nurse further indicated nursing quarterlies are to be completed every quarter.</p> <p>9-3-6(a)</p>			

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W0338	<p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems).</p> <p>Based on record review and interview, the facility's nursing services failed for 1 of 1 client with significant weight loss (client #4), to make appropriate referrals to address her identified health concerns.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 9/26/11 at 10:01 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports indicated:</p> <p>a. Incident dated 4/5/11: "On April 5, 2011 while eating lunch [client #4] choked 3 separate times. Staff intervened on the first 2 episodes and administered 3 back blows each time; on the 3rd episode no intervention was needed."</p> <p>b. Incident dated 5/2/11: "On May 2, 2011 [client #4] was lethargic; having difficulty swallowing her medications and fluids; her skin appeared to be</p>	W0338	<p>Peak Community Services is committed to ensuring that nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems).</p> <p>A swallow study for Client #4 was previously addressed with the Primary Care Physician, but not documented with the nurse. The nurse will request a Speech evaluation to address the choking issue and obtain further input for a swallow study. During the two to three months gap in the weights noted, Client #4 had gall bladder surgery and has been stable since then. Client #4 has had a CT scan of the abdominal area with results pending. The Primary Care Physician is reviewing client #4's medications to see if they could be causing a problem.</p> <p>To prevent the reoccurrence of regular weight checks being omitted, each home will have an annual calendar to record all weights weekly which will be provided for</p>	11/02/2011

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	<p>discolored."</p> <p>c. Incident dated 8/17/11: "While eating lunch, [client #4] was trying to talk to others around her and subsequently began choking on her food. She signaled to those around her that she was choking and a Direct Support Professional, providing supervision at the time, immediately intervened. The Direct Support Professional administered 5 back blows, dislodging the obstruction and allowing [client #4] to resume breathing. No further medical attention was sought due to there being no further medical issues noted after the intervention took place."</p> <p>A review of client #4's record was completed on 9/27/11 at 12:45 P.M.. Review of client #4's record indicated she was not in need of a medical care plan. The "Annual Nutrition Assessment" dated 6/30/11 indicated: "Weight changes: Down 19 # (pounds) in 1 year...down 16# in 3 months (13.3% in 3 months)...down 14# (12% in 5 months)...Assessment: [Client #4] has had significant weight loss in the past 3 months...Questioned staff possible if [client #4] is showing silent aspiration as to why she is not eating and discussed doing a swallow study to rule out reason for not eating, discussed appetite stimulants as an option as well...Recommendations: Swallow study</p>		<p>the nurse to review at her visits. The Residential Coordinator will be responsible for these to be completed weekly and submitted to the nurse.</p> <p>Peak Residential staff will be instructed on when to call a nurse. A new form for when to call a nurse will be put into place to document the calls by 11-02-11.</p> <p>The nursing assessment form is being revised to include the current check on health status at the time of the nurse visit and will expand to include a quarterly review of all medical and nursing events of the quarter. This new form will be in place by 11-02-11. The Community Services Manager will monitor that the new nursing assessment forms are being utilized.</p> <p>Person Responsible: Connie English, Director of Support and Quality Assurance Michel Thompson, Residential Coordinator Kris Myers, Community Services Manager Sandra Beckett, QMRP</p>		

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	<p>to determine if there is silent aspiration going on...Check TSH d/t (due to unintentional weight loss and dx (due to history) of thyroid problems...Monitor weight weekly." Further review of the record indicated:</p> <p>"Nursing Progress Notes" dated 3/26/11: "[Client #4]...weight: 120 pounds...Nutritional Assessment: No problems noted...Appetite: Good."</p> <p>"Nursing Progress Notes" dated 6/14/11: "[Client #4]...weight 105 pounds...Nutritional Assessment: No problems noted...Appetite: Good.""</p> <p>Further review of the record indicated a "1 Weekly Weights" log dated 2011 which indicated: "1/2/11...118 pounds" "1/30/11...122 ponds" "3/6/11...120 pounds" "6/19/11...104 pounds" "7/7/11...104 pounds" "7/14/11...105 pounds" "7/21/11...105.5 pounds" "7/28/11...106 pounds" "8/14/11...106 pounds" "8/21/11...106.5 pounds" "8/28/11...106 pounds" "9/28/11...106 pounds"</p> <p>The nurse was interviewed on 9/28/11 at 6:55 P.M.. The nurse indicated nursing</p>			

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W0346	<p>service did not ensure outside referrals were completed to assess client #4's health care needs.</p> <p>9-3-6(a)</p> <p>If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse.</p> <p>Based on record review and interview the facility failed for 6 of 6 clients residing at the group home (clients #1, #2, #3, #4, #5 and #6), to have a Registered Nurse (RN) available for verbal or onsite consultation to the Licensed Practical Nursing (LPN) staff.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 9/26/11 from 6:00</p>	W0346	<p>Peak Community Services is committed to ensuring that if the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse.</p> <p>Peak Community Services CEO is actively recruiting for a registered nurse to be available for verbal or onsite consultation to the LPN.</p>	11/02/2011

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	<p>A.M. until 8:00 A.M.. At 6:15 A.M., client #6 was observed to have a bright red sore covering her entire nose. Client #4 was observed during the entire observation period crying and complaining of not feeling well.</p> <p>A review of client #1's record was conducted on 7/28/11 at 10:00 A.M.. No documentation was available in client #1's record to indicate any RN consultation throughout the record.</p> <p>A review of client #2's record was conducted on 7/28/11 at 10:15 A.M.. No documentation was available in client #2's record to indicate any RN consultation throughout the record.</p> <p>A review of client #3's record was conducted on 7/28/11 at 10:15 A.M.. No documentation was available in client #3's record to indicate any RN consultation throughout the record.</p> <p>A review of client #4's record was conducted on 7/28/11 at 10:15 A.M.. No documentation was available in client #4's record to indicate any RN consultation throughout the record.</p> <p>A review of client #5's record was conducted on 7/28/11 at 10:15 A.M.. No documentation was available in client #5's</p>		<p>Director of Operations is actively recruiting for a registered nurse, having made several inquiries in the area. Several contacts have been made and meetings have been held with potential individuals and companies to contract with. The new Director of Operations will continue to spearhead this recruitment effort.</p> <p>When hired, the registered nurse will consult with the LPN for timely completion of quarterly nursing assessments, annual physicals, annual vision exams, and other required and needed medical events for clients #1, 2, 3, 4, 5 and 6.</p> <p>Person Responsible: Kathleen Thompson, Director of Operations Don Weikle, CEO Kris Myers, Community Services Manager</p>		

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	<p>record to indicate any RN consultation throughout the record.</p> <p>A review of client #6's record was conducted on 7/28/11 at 10:15 A.M.. No documentation was available in client #6's record to indicate any RN consultation throughout the record.</p> <p>An interview with the facility's human resource staff was conducted on 9/27/11 at 10:30 A.M.. The human resource staff submitted a contract dated 2/1/11 with the LPN for review. The human resource staff indicated the facility did not have a RN. No documentation was available for review to indicate the facility had a current RN/Consultant for verbal onsite consultation for the facility's LPN staff. No further information was available for review to indicate communication between a RN/Consultant and the facility's contracted LPN staff.</p> <p>9-3-6(a)</p>				

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W0356	<p>The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>Based upon record review and interview, the facility failed to ensure dental care included the evaluation of restoration of a broken tooth for 1 of 3 sampled clients (client #3).</p> <p>Findings include:</p> <p>A review of client #3's record was conducted on 9/27/11 at 10:31 A.M.. Review of her record indicated a most current dental visit dated 1/6/11 which indicated: "Patient has broken tooth on lower right that should be restored."</p> <p>Further review of client #3's record failed to indicate documentation that her tooth was restored as recommended.</p> <p>The Licensed Practical Nurse (LPN) was interviewed on 9/28/11 at 6:55 P.M.. The LPN indicated she was not sure if client #3 had her tooth restored as recommended by the dentist.</p> <p>An interview with the Group Home Manager (GHM) was conducted on 9/29/11 at 1:40 P.M.. The GHM indicated client #3 had her tooth restored but further indicated there was no</p>	W0356	<p>Peak Community Services is committed to ensuring that the facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>For client #3 – failed to follow up with dental recommendations. This was complete, but a copy of the document was previously unavailable. Document attached of 01-20-11 dental appointment where restoration was completed on tooth.</p> <p>The Community Services Manager will assist the Residential Coordinator in using a prompting system to follow through with medical professional recommendations.</p> <p>Person Responsible: Michel Thompson, Residential Coordinator Kris Myers, Community Services Manager</p>	11/02/2011

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W0363	<p>evidence/documentation available for review to indicate client #3 had her tooth restored.</p> <p>9-3-6(a)</p> <p>The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team. Based on observation, record review, and interview the facility failed to report the pharmacist recommendations to the prescribing physician and Interdisciplinary Team for 3 of 6 clients residing at the group home (clients # 1, #3 and #5).</p> <p>Findings include:</p> <p>A review of the facility's pharmacy reviews was conducted on 9/26/11 at 11:30 A.M.. The consulting pharmacist indicated:</p> <p>Consultation Report dated 1/5/11: "[Client #3]-There appears to be no diagnosis which supports use of Famotidine 20 mg (milligrams) and Probiotic Lactobacillus 1 tablet at bedtime. Was this for an acute GI (Gastro</p>	W0363	<p>Peak Community Services is committed to ensuring that the pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team. Peak Community Services is changing the procedure for drug regimen review to assure better follow-up starting 11-01-11. The Director of Operations will meet with the pharmacist regularly and follow up with the primary care physician on any irregularities noted.</p> <p>For client #3, the Residential Coordinator will make an appointment with the primary care physician to determine the corresponding diagnoses for her medications: famotidine and probiotic lactobacillus. The appointment will be made by 11-02-11.</p> <p>For client #1, no psychotropic med</p>	11/02/2011

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	<p>intestinal) illness or ongoing condition?"</p> <p>Consultation Report dated 4/8/11: "[Client #1] takes an antipsychotic, Abilify 30 mg at bedtime and Seroquel 300 mg 2 tablets (600 mg) at bedtime. There is no psychotropic medication review in her chart, she has been here for a year."</p> <p>Consultation Report dated 4/8/11: "[Client #5] takes a statin, Lovastatin, which is currently administered in the morning at 7:00 A.M.: Recommendation: Please change time of dosing to be given WITH the evening meal per manufacturer recommendations, 6 P.M.."</p> <p>A review of client #5's record was conducted on 9/26/11 at 4:10 P.M.. Review of her Medication Administration Record (MAR) dated 9/1/11 to 9/30/11 indicated: "Lovastatin 10 mg tablet...Take 1 tablet by mouth everyday...7:00 A.M.."</p> <p>An interview with the Group Home Manager (GHM) was conducted on 9/26/11 at 4:15 P.M.. The GHM indicated client #5 took her Lovastatin at 7:00 A.M..</p> <p>A review of client #1's record was conducted on 9/27/11 at 11:30 A.M..</p>		<p>review for Abilify and Seroquel was located at the time of the survey. A psychotropic medication Review completed 01-04-11 was located on a Health Visit Report where a review of these medications was noted by the primary care physician. Supporting documentation included. For client #5, a dosage change was recommended for Lovastatin and the change was never made. A 10-05-11 Health Visit Report was located where the primary care physician notes, "does not need to change lovastatin dosage". Supporting documentation included. Person Responsible: Michel Thompson, Residential Coordinator Kris Myers, Community Services Manager Kathi Thompson, Director of Operations</p>				

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W0436	<p>Review of client #1's record indicated an admission date of 11/16/10 and a first psychiatric review report dated 6/3/11. No further documentation was available for review to indicate client #1 had a psychiatric review report prior to 6/3/11.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) on 9/29/11 at 1:40 PM indicated the pharmacist's recommendations were not reported to the prescribing physician or the IDT. No further documentation was available for review to indicate the facility reported the pharmacist's recommendations.</p> <p>9-3-6(a)</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, the facility failed to furnish adaptive equipment for 1 of 1 client who was recommended the use a</p>	W0436	Peak Community Services is committed to ensuring that the facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses,	11/02/2011	

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	<p>communication device (client #3).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/26/11 from 6:00 A.M. until 8:00 A.M. and 9/26/11 from 3:05 P.M. until 5:15 P.M.. During both observation periods client #3 was observed to not communicate in her home. Client #3 was not observed utilizing a communication device.</p> <p>A review of client #3's record was conducted at the facility's administrative office on 9/27/11 at 10:31 A.M.. Review of client #3's record indicated a most current "Speech and Language-Communication Assessment" dated 9/14/90 which indicated: "Based on the results of this evaluation, it is recommended that an augmentative communication device be introduced on a trial basis...a device such as the Introtalker that utilizes picture pointing and produces a voice output." The Behavior Support Plan dated 3/2011 indicated: "[Client #3] needs to explore alternate forms of communication...[client #3] would benefit from a communication device that displays both pictures and verbal forms of communication."</p> <p>An interview with the Qualified Mental</p>		<p>hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>The Behavior Specialist inserviced residential staff on client #3's Behavior Support Plan which includes picture board usage on 10-18-11. Supporting documentation included. The Behavior Specialist inserviced day service staff on client #3 Behavior Support Plan and picture board usage on 10-12-11. Supporting documentation is currently unavailable. It will be accessible by 11-02-11.</p> <p>To prevent the reoccurrence of not utilizing the communication device with client #3, the QMRP will spot check during observations at the day program and in the residence to assure staff are attempting to use the picture board with client #3 for communication. Additionally, the Day Service Coordinator will monitor the usage of the communication device in day program and the Residential Coordinator will monitor the usage of the communication device at home by staff on all shifts. Usage of the device will be noted on monthly reports provided to the QMRP. The QMRP will note progress and usage on her monthly reviews.</p> <p>Person Responsible: Raina Daily, Behavior Specialist Kelly Bendel, Day Service</p>				

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W9999	<p>Retardation Professional (QMRP) was conducted at the facility's administrative office on 9/29/11 at 1:40 P.M.. The QMRP indicated client #3 was in need of a communication device and currently did not have one. No further documentation was available for review to indicate when client #3's recommended communication device would be furnished.</p> <p>9-3-7(a)</p> <p>State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(b)</p> <p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This state rule is not met as evidence by:</p> <p>Based on record review and interview, the</p>	W9999	<p>Coordinator Michel Thompson, Residential Coordinator Sandra Beckett, QMRP</p> <p>Peak Community Services is committed to ensuring that the residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>1. The QMRP has developed a more detailed tracking system for filing BDDS follow-up reports in a timely fashion. Peak Community Services wishes to complete all BDDS reports in a prompt manner and will make a more concerted effort to do so.</p> <p>2. Peak Community Services is committed to ensuring that staff persons have a bureau of motor vehicles record check, a criminal history check and three reference checks as a resident protection measure.</p>	11/02/2011	

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	<p>facility failed for 7 of 21 reports reviewed to report Bureau of Developmental Disabilities Services (BDDS) follow up reports in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 9/26/11 at 10:01 A.M.. A review of 7 of 21 BDDS reports reviewed indicated:</p> <p>1. Incident dated 4/5/11: "On April 5, 2011 while eating lunch [client #4] choked 3 separate times. Staff intervened on the first 2 episodes and administered 3 back blows each time; on the 3rd episode no intervention was needed." Further review of the report indicated an e-mail attachment form BDDS dated 4/7/11 which indicated: "Per the incident Management/Reporting Policy, an Incident Follow-Up Report is required to be submitted within 7 days from the date of this email and every 7 days thereafter until the incident is resolved to the satisfaction of all entities." Review of the follow up report indicated a date of 5/12/11.</p> <p>2. Incident dated 4/21/11: "[Client #5] was sitting next to [day program client] during group. [Day program client] then</p>		<p>Director of Operations has obtained a 3 rd reference check for staff #3. Other staff files have been checked to assure three references are completed.</p> <p>Person Responsible: Sandra Beckett, QMRP Kris Myers, Community Services Manager Kathi Thompson, Director of Operations</p>		

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	<p>touched on (sic) of [client #5]'s items, [client #5] responded verbally. [Day program client] became physically aggressive-putting her hand in [client #5]'s face and pushing her away. When [day program client] put her hand on [client #5]'s face this caused [client #5]'s glasses to slid (sic) down her face and the nose piece left a mark under [client #5]'s nose. The glasses were not broken during this altercation." Further review of the report indicated an e-mail attachment form BDDS dated 4/22/11 which indicated: "Per the incident Management/Reporting Policy, an Incident Follow-Up Report is required to be submitted within 7 days from the date of this email and every 7 days thereafter until the incident is resolved to the satisfaction of all entities." Review of the follow up report indicated a date of 5/12/11.</p> <p>3. Incident dated 4/23/11: "[Client #4] came to breakfast. She sat down, she yelled, then bit her right wrist. When staff asked her why she was upset, [client #4] stated she did not want to eat. She wanted to go back to bed. Staff cleaned her wrist with warm soap and water. Staff put peroxide and bandaids on her wrist. [Client #4] has experienced an increase in SIB (Self Injurious Behaviors) and agitation over the past couple of weeks.</p>				

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	<p>[Facility name] has been working with the mental health provider to adjust medications...[Client #4] has been more agitated over the past several weeks and staff are working to figure out the source of this agitation." Further review of the report indicated an e-mail attachment form BDDS dated 4/25/11 which indicated: "Per the incident Management/Reporting Policy, an Incident Follow-Up Report is required to be submitted within 7 days from the date of this email and every 7 days thereafter until the incident is resolved to the satisfaction of all entities." Review of the follow up report indicated a date of 5/12/11.</p> <p>4. Incident dated 5/2/11: "On May 2, 2011, [client #4] was lethargic, having difficulty swallowing her medications and fluids; her skin appeared to be discolored; EMS (Emergency Medical Services) was called. EMS was notified, upon their arrival they completed their assessment and transported [client #4] to [Hospital name]...[client #4] was admitted to the hospital for observation." Further review of the report indicated an e-mail attachment form BDDS dated 5/4/11 which indicated: "Per the incident Management/Reporting Policy, an Incident Follow-Up Report is required to be submitted within 7 days from the date</p>				

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	<p>of this email and every 7 days thereafter until the incident is resolved to the satisfaction of all entities." Review of the follow up report indicated a date of 5/19/11.</p> <p>5. Incident dated 5/21/11: "[Client #5] took a guitar from another consumer, [client #1]. Staff intervened to have the guitar returned. When [client #1] approached to retrieve the guitar, [client #5] smacked her in the chest. Staff physically intervened to block further aggression. After [client #5] calmed, she apologized to [client #1], per her behavior plan." Further review of the report indicated an e-mail attachment form BDDS dated 5/23/11 which indicated: "Per the incident Management/Reporting Policy, an Incident Follow-Up Report is required to be submitted within 7 days from the date of this email and every 7 days thereafter until the incident is resolved to the satisfaction of all entities." Review of the follow up report indicated a date of 6/3/11.</p> <p>6. Incident dated 7/18/11: "An allegation of abuse was made. A consumer [client #5] reported having a urinary accident, staff was informed of situation. After several minutes passed the same consumer reported to another staff member that she had a urinary accident.</p>				

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	<p>The staff that had been made aware of the situation was notified again-that staff stated that the consumer was not wet, when staff was asked if she was sure she pulled the consumer's shirt up and said, "oh what have you done you really are wet now." Further review of the report indicated an e-mail attachment form BDDS dated 7/20/11 which indicated: "Per the incident Management/Reporting Policy, an Incident Follow-Up Report is required to be submitted within 7 days from the date of this email and every 7 days thereafter until the incident is resolved to the satisfaction of all entities." Review of the follow up report indicated a date of 7/29/11.</p> <p>7. Incident dated 8/8/11: "Upon arrival at Day Service, staff noticed several bruises along with some scratches on [client #6]'s left inner arm....due to [client #6]'s limited verbal skills staff was not able to determine the origin of the bruises." Further review of the report indicated an e-mail attachment form BDDS dated 8/10/11 which indicated: "Per the incident Management/Reporting Policy, an Incident Follow-Up Report is required to be submitted within 7 days from the date of this email and every 7 days thereafter until the incident is resolved to the satisfaction of all entities." Review of the follow up report indicated a date of</p>				

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	<p>9/1/11.</p> <p>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 9/28/11 at 5:00 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS.</p> <p><b>Responsible Parties</b></p> <ol style="list-style-type: none"> <li>1. The provider responsible for an individual at the time of the occurrence of a reportable incident shall submit an incident initial report.</li> <li>2. In addition to the provider ' s mandatory reporting, any other person may submit an incident initial report associated with any reportable incident.</li> <li>3. The entity responsible for incident follow-up reports is the individual ' s: <ol style="list-style-type: none"> <li>a. case manager, when receiving waiver funded services;</li> <li>b. residential provider ' s Qualified Developmental Disabilities Professional (QDDP) when receiving State Line Item (SLI), Supervised Group Living (SGL), or other ICF/MR services</li> <li>c. provider staff when receiving Caregiver Supports Services;</li> <li>d. BDDS service coordinator when receiving</li> </ol> </li> </ol>				

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	<p>other services (e.g. Title XX and nursing facilities)."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 9/29/11 at 12:40 P.M.. The QMRP indicated the follow up reports were not submitted within 7 days as requested by BDDS. No further documentation was available for review to indicate the follow up reports were submitted timely to BDDS.</p> <p>9-3-1(b)</p> <p>2. 460 IAC 9-3-2(a) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met: Resident Protections</p> <p>(3) The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check and three references.</p> <p>This rule is not met as evidenced by:</p> <p>Based on record review and interview the facility failed for 1 of 3 sampled facility staff (staff #3) to provide 3 reference checks.</p>				

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	<p>Findings include:</p> <p>Facility personal records were reviewed on 9/27/11 at 9:40 A.M. including the personnel record for staff #3. Staff #3's record did not include 3 references.</p> <p>On 9/27/11 at 10:15 A.M. an interview with the Human Resource staff indicated facility staff #3 did not have 3 references available for review.</p> <p>9-3-2(c)(3)</p>				