STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	1010 KELLAM RD CENTERVILLE, IN 47330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: 11/13, 11/14, 11/15, 11/19 and 11/21/12 Facility Number: 012633 Provider Number: 15G805 AIMS Number: 201072030 Surveyors: Paula Chika, Medical Surveyor III-Team Leader Keith Briner, Medical Surveyor III These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/3/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W0125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS 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. Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2) and 2 additional clients (#3 and #4), the facility failed to ensure the rights of clients in regard to locking of food, locked cleaning supplies and in regard to use of a door alarm. Findings include: 1. During the 11/14/12 observation period between 5:58 AM and 8:45 AM, at the group home at 6:59 AM, staff #2 unlocked a closet in the kitchen to get cereal out of the closet for client #4. At 7:26 AM, client #3 was in the kitchen fixing his breakfast. Client #3 asked staff to unlock the kitchen closet so he could get the oatmeal out for his breakfast. At 7:28 AM, client #3 asked staff #2 to unlock the kitchen cabinet again. Client #3 then turned to staff #4, who was in the kitchen, and stated "Why can't I have a key to unlock the door to get my own food?" Client #3 stated in a loud tone "They steal food, I don't. That's why it's locked." Client #3 then started	W0125	**CORRECTION:** *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.* Specifically, the interdisciplinary team has determined that with current levels of supervision and monitoring in the home, the assessed need to secure chemicals and hygiene supplies is no longer indicated. Therefore the facility no longer stores household cleaning materials and personal hygiene supplies in a locked cabinet. Door alarms remain in place at the facility with the approval of the Human Rights Committee, the clients and their legal representatives. **PREVENTION:** The QDDPD will be retrained regarding the need to ensure due process occurs before the team implements rights restrictions. Members of the Operations and Quality Assurance Teams will review rights restrictions, Human Rights Committee Records, and consent forms as part of a monthly and quarterly audit process to assure that due process occurs. **RESPONSIBLE PARTIES:**	12/21/2012

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	complaining there was no sugar and how staff did not keep the sugar in the cabinet as another client would use it all. Staff #2 went to the back office area and came back with a bag of sugar. The staff placed some sugar into a small container and placed the container into the kitchen cabinet. At 7:50 AM, staff unlocked the closet/pantry for client #2 to get cereal out to fix his breakfast. The locked kitchen closet/pantry contained canned goods, cereal, oatmeal bread, snack foods, and etc. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's 3/2/12 Behavior Support Plan (BSP) indicated client #2 demonstrated the behavior of hoarding food ("any time he removes food from kitchen area that is not eaten immediately or within a half hour, which is found to be hidden in any of his personal belongings, bedroom and/or in the furniture, i.e. living room couch where he rests and sleeps.... ") Client #2's BSP indicated "If [client #2] is observed removing food items from the kitchen, staff is to monitor for hoarding behaviors, i.e. not consuming item immediately and/or within half-hour. If [client #2] is observed putting/hiding unopened/unconsumed food items in his personal belongings, bedroom and/or in the furniture, i.e. living room couch where		QDDPD, Team Lead, Direct Support Professionals, Quality Assurance Team, Operations Team	

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	he rests and sleeps, staff should: -Provide gentle prompts to [client #2], to consume the food item. Provide gentle prompts and reminders to dispose of wrapper/package/trash properly. -Provide gentle prompts to return the unopened/unused food item to the kitchen and place item in a location of his choosing until he is ready to consume it. -If he refuses, repeat prompts every 15 minutes until he returns the unopened/unconsumed food item to the kitchen area. -If he continues to refuse and becomes agitated, stop prompts, and document behavior(s)." Client #2's 3/2/12 BSP did not indicate food items should be locked. Client #2's BSP and/or 12/28/11 ISP indicated client #2 was his own guardian. Client #2's 3/2/12 BSP and/or 12/28/11 ISP did not indicate the client gave written informed consent to lock food items. The facility's Human Rights Committee (HRC) notes were reviewed on 11/14/12 at 12:15 PM. The facility's 4/9/12 phone log for calling the Human Rights members indicated the facility obtained approval to lock up snacks in the storage area due to client #2's behavior. The 4/9/12 log sheet, 12/28/11 ISP and/or 3/2/12 BSP did not indicate what client #2 would have to do to earn his right back			

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	to have "snack foods " unlocked. Client #4's record was reviewed on 11/14/12 at 2:38 PM. Client #4's 10/25/11 ISP and/or 3/2/12 BSP did not indicate food should be locked. Client #4's ISP indicated client #4's mother was the client's guardian. The 10/25/11 ISP and/or the 3/2/12 BSP did not indicate the client's guardian gave written informed consent for the restrictive practice of locking food. The client's BSP and/or ISP did not indicate the facility's HRC reviewed and/or approved the rights restriction. Interview with staff #3 on 11/14/12 at 8:35 AM indicated the food closet/pantry was locked in the kitchen due to client #2. Staff #3 stated "He (client #2) will get in there and eat anything in there. He will eat all day long." Staff #3 indicated clients #1, #3 and #4 did not have access to the locked pantry except to have staff unlock the door. Interview with Qualified Mental Retardation Professional (QMRP) #1 and administrative staff #2 on 11/14/12 at 1:45 PM indicated client #2 demonstrated the behavior of food hoarding. QMRP #1 stated "[Client #2] would eat food. He would eat constantly. He eats at all hours." QMRP #1 stated the facility had			

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	obtained HRC approval to lock "snacks." Administrative staff #2 stated "Food locking can be done through monitoring." Administrative staff #2 indicated clients #1, #3 and #4 should have access to food in their home. QMRP #1 indicated client #2 and/or client #4's guardian had not given written informed consent in regard to locking food. QMRP #1 indicated the practice of locking food had not been reviewed by the facility's HRC to ensure clients' rights were not violated other than to approve the locking of snacks. Administrative staff #2 indicated there was nothing in the plan which indicated how client #2 could earn the right to have access to snacks back. 2. Interview with staff #2 on 11/14/12 at 8:35 AM indicated cleaning supplies were kept locked under the kitchen sink and in the back office area. Staff #2 indicated the cleaning supplies were locked for safety reasons. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's 10/28/11 ISP and/or 3/2/12 BSP did not indicate client #2 had a need to have cleaning supplies locked. The ISP and/or BSP indicated client #2 was his own guardian. The ISP/BSP indicated client #2 did not give consent to lock cleaning supplies nor did the client's ISP/BSP			

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	indicate the facility's HRC reviewed/approved the restrictive practice of locking the cleaning supplies. Client #4's record was reviewed on 11/14/12 at 2:38 PM. Client #4's 3/2/12 BSP and/or 10/25/11 ISP did not indicate client #4 had the need to have cleaning supplies locked. Client #4's 10/25/11 ISP did not indicate the client had a training objective to teach the client how to use cleaning supplies safely. Client #4's ISP indicated client #4's mother was his guardian. Client #4's ISP/BSP did not indicate the client's guardian gave written informed consent to lock cleaning supplies. The client's ISP/BSP also did not indicate the facility's HRC reviewed and/or approved the practice of locking cleaning supplies. Interview with administrative staff #2 and QMRP #1 on 11/14/12 at 1:45 PM indicated the cleaning supplies were locked at the group home. QMRP #1 stated clients #1 and #4 were "not safe with chemicals. They may not know what bleach is used for." QMRP #1 indicated client #4 did not have a formal training goal in place to teach the client how to use cleaning supplies/be safe around cleaning supplies. Administrative staff #2 and QMRP #1 indicated locking of the cleaning supplies had not been approved			

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	by the facility's HRC. QMRP #1 indicated the clients and/or guardians had not given written consent to lock cleaning supplies. 3. During the 11/14/12 observation period between 5:58 AM and 8:45 AM, in the group home, a door alarm on the front door could be heard when anyone entered and/or exited the group home. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's 3/2/12 BSP indicated the client demonstrated the behavior of "...Leaving Assigned Ares (sic): any time he leaves a designated area including the home, or areas the group (defined as the staff that are with him on a community outing) is at. This is to include walking out of the house to check the mail without notifying staff...." Client #2's 3/2/12 BSP and /or 10/28/11 ISP indicated client #2 was his own guardian. The ISP/BSP did not indicate client #2 required the use of a door alarm, and/or indicate the client gave written consent for the restrictive practice. Client #2's 10/28/11 ISP and/or 3/2/12 BSP did not indicate the facility's HRC reviewed and approved the restrictive use of a door alarm. Interview with administrative staff #2 and QMRP #1 on 11/14/12 at 1:45 PM			

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	indicated the facility's behavior specialist was in the process of putting the door alarms in the behavior plans of the clients. QMRP #1 indicated the door alarms were in place due to the elopement behaviors of clients (#1, #3 and #4). QMRP #1 and administrative staff #2 indicated the facility had not obtained written informed consent from the clients and/or their guardians. QMRP #1 and administrative staff #2 indicated the facility's HRC had not reviewed the restrictive practice/use of the door alarms to ensure clients' rights. 4. Observations were conducted at the group home on 11/13/12 from 5:40 PM through 6:40 PM. Clients #1, #2, #3 and #4 were present in the home throughout the observation period. At 5:40 PM upon entering the group home through the front door an alarm sounded throughout the house as the door was open and shut. At 6:40 PM upon exiting the group home through the front door an alarm sounded throughout the house as the door was open and shut. Client #1's record was reviewed on 11/14/12 at 9:43 AM. Client #1's 7/19/12 revised Behavior Support Plan (BSP) indicated client #1 demonstrated "Leaving Assigned Areas" which was defined as walking off of the grounds or down the			

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	street. Client #1's 7/19/12 BSP and/or 10/11/11 ISP (Individual Support Plan) did not indicate the doors in the home should have alarms, refrigerator should be locked, or cleaning supplies should be locked. Client #1's 10/11/11 ISP indicated client #1 had a guardian. Client #1's 7/19/12 BSP and/or 10/11/11 ISP did not indicate client #1's guardian gave written informed consent and/or indicate the facility's HRC (Human Rights Committee) reviewed and approved the systemic restrictions of locking the kitchen cabinets, locking the chemicals, and placing alarms on the doors. Interview with QMRP #1 (Qualified Mental Retardation Professional) on 11/14/12 at 3:45 PM indicated the group home doors had alarms, kitchen cabinets were locked, and chemicals were locked in the group home. 9-3-2(a)			

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W0126	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Based on record review and interview for 2 of 2 sampled clients (#1 and #2), the facility failed to ensure clients were taught to manage their money. Findings include: 1. Client #1's record was reviewed on 11/14/12 at 9:43 AM. Client #1's undated Financial Assessment (FA) indicated client #1 was not able to identify a penny through a quarter, five dollar bill through twenty dollar bill, was not able to make change from twenty five cents through a twenty dollar bill, was not able to identify the amount of money needed to make a purchase for more than one dollar and could not independently complete a transaction. Client #1's CFA (Comprehensive Functional Assessment) dated 10/10/12 indicated client #1 could not use money, could not budget money, could maintain a bank account with assistance and could make a purchase with "close" supervision. Client #1's ISP (Individual Support Plan) dated 10/11/11 did not indicate money management	W0126	**CORRECTION:** *The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.* Specifically, the interdisciplinary team has developed and implemented money management objectives for Client #1 and Client #2. **PREVENTION:** The QDDPD will be retrained regarding the need to provide measurable money management training to all clients. Members of the Operations and Quality Assurance Teams will review facility support documents as part of a monthly and quarterly audit process to assure that money management skill deficits are addressed with formal objectives. **RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Quality Assurance Team, Operations Team	12/21/2012

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	training through informal or informal goals/objectives. QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 11/14/12 at 3:45 PM. When asked if client #1 had a money management goal, QMRP #1 stated, "No, as of right now, that's something we haven't been tracking." 2. Client #2's financial records were reviewed on 11/13/12 at 4:23 PM and on 11/14/12 at 10:04 AM. Client #2's financial records indicated the facility kept client #2's cash on hand locked at the group home. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's 12/28/11 Individual Support Plan (ISP) indicated client #2 did not receive training in regard to money management. Interview with Qualified Mental Retardation Professional (QMRP) #1 indicated client #2's money was kept at the group home and the client had a savings account at a bank in the community. QMRP #1 indicated client #2 did not have a money training objective in place. QMRP #1 indicated client #2 should have an objective to teach the client to manage his money to			

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	the extent he was capable. 9-3-2(a)			

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W0137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2) and for 1 additional client (#4), the facility failed to ensure the clients had access to their personal hygiene supplies/kits. Findings include: During the 11/14/12 observation period between 5:58 AM and 8:45 AM, at the group home, staff #4 retrieved the client #4's personal hygiene kit from the office area. Once client #4 finished taking his shower, client #4 returned his hygiene kit to the office to staff. Staff #3 placed the hygiene kit in the medication closet of the office. Interview with staff #3 on 11/14/12 at 8:35 AM indicated client #1, #2 and #4's hygiene kits were kept in the medication office area. Staff #3 stated client #1 would throw his hygiene kit at others and client #4 "needs prompting when showering." Staff #3 indicated client #2 would refuse to shower. Staff #3 indicated only staff had keys to access the locked closet in the locked office.	W0137	**CORRECTION:** *The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.* Specifically, the interdisciplinary team has determined that with current levels of supervision and monitoring in the home, the assessed need to secure hygiene supplies is no longer indicated. Therefore the facility no longer stores personal hygiene supplies in a locked cabinet. **PREVENTION:** The QDDPD will be retrained regarding the need to assure that rights restrictions occur only when the team has assessed a threat to clients' health and safety is at risk and only after prior written informed consent is obtained. Members of the Operations and Quality Assurance Teams will review assessment data as part of a monthly and quarterly audit process to assure that rights restrictions do not occur without appropriate justification and due process. **RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Quality Assurance Team, Operations Team	12/21/2012

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	Client #1's record was reviewed on 11/14/12 at 9:43 AM. Client #1's 7/19/12 BSP (Behavior Support Plan) and/or 10/11/11 ISP (Individual Support Plan) did not indicate client #1 needed to be restricted from access to his personal hygiene items. Client #1's record did not indicate the facility's HRC (Human Rights Committee) reviewed or approved restricting client #1's access to his personal hygiene items. Client #1's ISP indicated the client had a guardian. The ISP did not indicate the client's guardian gave written informed consent for client #1's locked hygiene supplies. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's 12/28/11 ISP and/or 3/2/12 BSP did not indicate client #2 required/needed his hygiene supplies kit locked. Client #2's ISP indicated client #2 was his own guardian, and client #2 did not give written informed consent to lock his hygiene supplies/kit. Client #2's ISP and/or BSP did not indicate the facility's Human Rights Committee (HRC) reviewed and/or approved the rights restriction. Client #4's record was reviewed on 11/14/12 at 2:38 PM. Client #4's 10/25/11 ISP did not indicate the client had required/needed his hygiene			

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	supplies/kit locked. Client #4's ISP indicated the client's mother was his guardian. The ISP did not indicate the facility obtained written informed consent in regard to locking the client's hygiene supplies/kit. Client #4's ISP/3/2/12 BSP also did not indicate the facility's HRC reviewed and/or approved the right restriction. Interview with the Qualified Mental Retardation Professional (QMRP) #1 on 11/14/12 at 1:45 PM indicated client #1, #2 and #4's hygiene supplies were locked at the group home. When asked why the clients' hygiene supplies/kits were locked, QMRP #1 stated "Best place to put it. They have a history of throwing items." QMRP #1 indicated the facility had not obtained written informed consent from the guardians and/or clients in regard to the locked supplies, and/or had the facility's HRC review the practice of locking clients' personal hygiene supplies/kits to ensure clients' rights were not violated. 9-3-2(a)			

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W0140	483.420(b)(1)(i) CLIENT FINANCES 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 on interview and record review for 1 of 2 sampled clients (#1) and for 1 additional client (#3), the facility failed to maintain a complete accounting of all the clients' funds. Findings include: 1. Client #1's financial records were reviewed on 11/13/12 at 4:23 PM and on 11/14/12 at 10:04 AM. Client #1's Resident Fund Management Service statement indicated a check was written for $53.00 on 10/31/12 for clothes, activities and music. Client #1's 11/12 Resource Ledger sheet and/or savings account ledger indicated client #1's $53 had not been deposited into the group home account and/or the client's savings account. Client #1's financial records did not indicate the group home accounted for and/or had receipts for the $53.00. Interview with Qualified Mental Retardation Professional (QMRP) #1 on 11/14/12 at 10:40 AM indicated he did not know anything about the $53 check	W0140	**CORRECTION:** *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.* Specifically, for Clients #1, #2 and #3, the Team Lead will maintain an up to date ledger to track purchases for all clients including a sign-out log for money to be spent at day service and workshops. All staff will assure that clients provide receipts for purchases as appropriate and the QDDPD will maintain copies of receipts for purchases recorded on the ledgers. Additionally, the QDDPD will remain in communication with the agency's Office Coordinator to assure that all Resident Financial Management System checks are processed in a timely manner. **PREVENTION:** The Team Lead will maintain responsibility for maintaining client financial records and the QDDP will audit these records no less than weekly. All staff will be retrained regarding the need to assist clients with budgeting and collecting receipts. The QDDP will turn in client financial records to the Business Manager no less than monthly for review and filing. Additionally, members of the Operations and Quality Assurance Teams will include audits of client finances as part of an ongoing facility audit process	12/21/2012

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	for client #1. QMRP #1 indicated he did not request the check and did not have the check at the group home. QMRP #1 indicated the money may have been requested by administrative staff #1 for the client and had not come to the group home yet. Interview with administrative staff #1 on 11/15/12 at 3:09 PM indicated she was not aware of a $53 check for client #1. Administrative staff #1 indicated she did not know why the check would not be at the group home and deposited into client #1's savings account and/or account at the group home. 2. Client #3's financial records were reviewed on 11/13/12 at 4:23 PM and on 11/14/12 at 10:04 AM. Client #3's 11/12 cash on hand Resource Ledger sheet indicated client #3 should have $37.67 cash on hand. Client #3's cash on hand totaled $38.67. Interview with QMRP #1 on 11/14/12 at 10:25 AM indicated he could not explain the discrepancy on why client #1 had a dollar more than indicated. 9-3-2(a)		**RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Quality Assurance Team, Operations Team	

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W0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review for 1 additional client (#3), the facility failed to implement its financial policy and procedure to prevent potential abuse of the client's funds in that the facility was holding onto uncashed checks. Findings include: Client #3's finances were reviewed on 11/13/12 at 4:23 PM and on 11/14/12 at 10:04 AM. Client #3's financial book indicated the client had the following uncashed checks in his financial book and/or savings book: -8/31/12 $500.00 -8/31/12 $500.00 (a second check) -9/28/12 $18.83 -10/26/12 $127.38 -11/9/12 $8.81 Client #3's financial records (Resource Ledger sheets and/or savings account sheet) indicated the above mentioned checks, which totaled $1155.02, had not been documented and/or logged in as being present in the group home. Client #3's Resident Fund Management Service (RFMS) account indicated the	W0149	**CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.* Specifically, the facility will deposit any un-cashed checks for Client #3 and assure that Client #3 deposits all future checks into his bank account without delay **PREVENTION:** The QDDP will be re-trained on the agency's policies and procedures for monitoring and assisting with client finances with emphasis on the need to deposit Resident Financial Management System (RFMS) checks in client bank accounts upon receipt. Additionally, if unexpected delays in depositing a RFMS check occur, they will be returned to the agency's core office for re-deposit in the client's RFMS account. **RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Behavior Clinician, Quality Assurance Team, Operations Team	12/21/2012

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	facility dispersed the checks on 8/31/12 ($2000) for the client to purchase a refrigerator, DVD, furniture, bike, games, clothes, Wii game and music. Client #3's savings account ledger indicated $500 was deposited on 9/28/12 and another $500 was deposited on 10/25/12. Interview with Qualified Mental Retardation Professional (QMRP) #1 on 11/14/12 at 10:20 AM stated they were "holding the checks in the home." QMRP #1 indicated the two 8/31/12 $500 checks (spend down checks) were received in September 2012 and the checks had not been deposited into client #3's account as of November 2012. QMRP #1 indicated the checks written on 9/28/12, 10/26/12 and 11/9/12 were client #3's workshop checks. QMRP #1 indicated client #3 still needed to deposit all 5 checks into his savings account. QMRP #1 indicated there was no documentation in client #3's financial records which indicated the group home was holding $1155.02 of client #3's money. QMRP #1 stated "It was a struggle to get him (client #3) to spend money. He wants to save." QMRP #1 also indicated client #3 would have problems when he went to the bank to deposit money. QMRP #1 indicated client #3's undocumented checks totaling $1155.02 were kept in the group home's safe.			

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	Interview with administrative staff #1 on 11/15/12 at 3:09 PM indicated the group home should not be holding large sums of money and/or checks in the group home. Administrative staff #1 indicated the checks should be deposited into the client's account within 48 hours of receiving the checks. The facility's financial policy and procedures were reviewed on 11/15/12 at 3:14 PM. The facility's 12/12/07 policy entitled Client Finance Management including RFMS indicated "...6. Once an RFMS check is issued, it will be handed out to the PD (Program Director) and a signature will be obtained. Receipt signature will be attached to the check request and will be filed in the RFMS office for back up. 7. The RFMS check will then be deposited into the client's local bank account...." The facility's 12/12/07 policy indicated the group home would document all deposits, withdrawals and/or transaction on a separate Resource Ledger sheet for cash on hand and/or the client's outside/savings account. 9-3-2(a)			

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W0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on 8 of 28 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct investigations in regard to allegations of client to client abuse/aggression, an elopement incident and in regard to an injury of unknown source for clients #1, #2 and #4. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 11/13/12 at 2:00 PM. The facility's reportable incident reports and/or investigations indicated the following: -1/24/12 Client #4 was asked why he (client #4) peed on the floor and the toilet. When client #4 was redirected, "...[Client #4] said 'h...no,' turned around and pushed housemate [client #1] to the ground. [Client #1] landed on his elbows and knees hard...." The reportable incident report indicated client #1 received a 2 inch bruise on his right elbow and a 1 inch bruise on his left elbow with a dime sized bruise on his right knee. The 1/24/12 reportable incident report also indicated client #1 received a red mark on	W0154	**CORRECTION:** *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically, the facility will investigate incidents of client to client aggression that occurred on 1/24/12, 3/10/12, 3/18/12, 7/7/12 and 7/9/12, an injury of unknown origin discovered on 4/9/12, and an incident of elopement that occurred on 5/10/12. **PREVENTION:** Professional staff will be retrained regarding the criteria for conducting investigations at the facility and will receive guidance toward development of a tracking system to assure thorough investigations are conducted within required timeframes. The QDDP will turn in copies of completed investigations to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up. **RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Quality Assurance Team, Operations Team	12/21/2012

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	his left knee. The 1/24/12 did not indicate any further documentation of an investigation. -5/10/12 "Three direct support staff and the QMRP (Qualified Mental Retardation Professional) were on duty. Two staff were involved in cleaning the bathroom and securing cleaning supplies and the QMRP was meeting privately with the remaining direct support staff. While the staff on duty were occupied, [client #1] (individual supported by ResCare) walked out of the home's unlocked front door. Within one minute, staff noticed that [client #1] was no longer in line of sight. Staff searched the house and the back yard and determined he had left the property. Within 5 minutes, staff observed [client #1] walking up the gravel drive behind the house. He had been to the [name of local store] around the corner to purchase a soft drink with a dollar that his grandmother had sent him in the mail. [Client #1] was not injured and was in good spirits when he returned home. The interdisciplinary team has assessed [client #1] as requiring 24-hour staff supervision. Although he was not a danger to others while away from the house without supervision, he has poorly developed pedestrian safety skills. Due to the location of the [name of the store], [client #1] did not need to walk along or			

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	cross a road...." The 5/10/12 reportable incident report did not indicate any additional documentation in regard to an investigation in regard to client #1's elopement/possible neglect. -7/7/12 "[Client #1] (individual supported by ResCare) crossed the living room and before staff could intervene, he scratched [client #4] on the leg. Staff separated the two individuals immediately and provided [client #4] with emotional support. He was not injured as a result of being scratched...." The 7/7/12 reportable incident report did not indicate any additional documentation of an investigation in regard to the client to client allegation of abuse/incident. -7/9/12 "[Client #1] (individual supported by ResCare) sat down at the dining room table across from [client #4] (individual supported by ResCare). Without apparent antecedent, [client #1] reached across the table and scratched [client #4] on the right arm. Staff redirected [client #1] verbally and he apologized. [Client #4] was not injured and did not appear to experience any emotional discomfort as result of the incident. The team will investigate the circumstances of the incident and will meet to discuss strategies to prevent [client #1] from targeting [client #4]." The 7/9/12 reportable incident report did			

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	not indicate any additional documentation of an investigation. Interview with QMRP #1 on 11/14/12 at 1:45 PM indicated he had conducted investigations in regard to the above mentioned incidents. QMRP #1 indicated he was not able to locate the investigations as the folder, he had placed the investigations in, had been lost. 2. The facility's reportable incident reports (Bureau of Developmental Disabilities Services-BDDS) and/or investigations were reviewed on 11/13/12 at 2:00 PM. The facility's BDDS reports and/or investigations indicated the following: -BDDS report dated 3/11/12 indicated on 3/10/12, "[Client #1] and [client #2] were sitting in different bench seats on the SGL (Supported Group Living) facility's van. Staff was sitting next to [client #1] and before staff could intervene, [client #1] reached forward and scratched [client #2]'s neck. [Client #2] did not react to the incident and staff were able to keep the two individuals separated for the remainder of the trip. [Client #2] sustained a four inch scratch as a result of the incident. Resolution: The team has initiated an investigation into the circumstances of the			

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	incident and will meet to discuss methods to engineer a safe environment while transporting individuals in the van." The facility's 3/11/12 reportable incident report did not indicate any additional information and/or documentation of an investigation. -BDDS report dated 3/18/12 indicated on 3/18/12, "[Client #4] became verbally and physically aggressive toward staff. [Client #4] threw a cup of juice that hit the wall and ceiling. [Client #4] came toward staff, hit her in the head and face and pulled her hair. Housemate, [client #2], was sitting in the living room. [Client #2] came over and hit [client #4] in the face. Staff used YSIS (You're Safe, I'm Safe) behavior intervention techniques to physically redirect [client #4]. [Client #2] was asked to go to another room and he did. [Client #2] was not injured during the incident. [Client #4] was taken to [hospital] ER (Emergency Room) for evaluation and treatment. Resolution: [Client #4] was evaluated and released. No acute trauma was noted." The facility's 3/18/12 reportable incident report did not indicate any additional information and/or documentation of an investigation. -BDDS report dated 4/10/12 indicated on 4/9/12, "During a body assessment, staff			

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	noted that [client #1's] right wrist was swollen. After staff examined the wrist [client #1] became agitated and swung his jump rope at staff." The BDDS report dated 4/9/12 indicated, "On the morning of 4/10/11 (sic), staff took [client #1] to urgent care to have his wrist evaluated. X-rays showed no evidence of fracture...." The BDDS report dated 4/10/12 indicated, "The team has initiated an investigation into the origin of [client #1's] injury." The facility's 4/10/12 reportable incident report did not indicate any additional information and/or documentation of an investigation. QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 11/14/12 at 3:45 PM. QMRP #1 indicated there were no additional investigations available for review. 9-3-2(a)			

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W0159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2) and for 2 additional clients (#3 and #4), the facility's Qualified Mental Retardation Professional (QMRP) failed to monitor clients' programs in regard to development/addressing identified needs, program revision, placing needed supports in a program plan, and to ensure data was collected for formal objectives. The QMRP failed to integrate and/or coordinate clients' programs in regard to ensuring a guardian participated in interdisciplinary team meetings, to ensure the facility's Human Rights Committee reviewed restrictive practices and programs and to obtain written informed consent for restrictive medications and/or interventions within the clients' behavior/program plans. Findings include: 1. The QMRP failed to ensure client #1's guardian attended and/or participated in their IDT (Interdisciplinary Team Meetings). Please see W209. 2. The QMRP failed to ensure client #1's	W0159	**CORRECTION:** *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically, the facility will investigate incidents of client to client aggression that occurred on 1/24/12, 3/10/12, 3/18/12, 7/7/12 and 7/9/12, an injury of unknown origin discovered on 4/9/12, and an incident of elopement that occurred on 5/10/12. **PREVENTION:** Professional staff will be retrained regarding the criteria for conducting investigations at the facility and will receive guidance toward development of a tracking system to assure thorough investigations are conducted within required timeframes. The QDDP will turn in copies of completed investigations to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up. **RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Quality Assurance Team, Operations Team	12/21/2012

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	ISP (Individual Support Plan) and BSP (Behavior Support Plan) addressed the clients' identified behavioral needs regarding hand washing. The facility failed to ensure client #2's ISP and BSP addressed the clients' identified behavioral needs regarding day time/leisure skill training. The facility failed to ensure client #4's ISP and BSP addressed the clients' identified behavioral needs regarding the use of cleaning supplies/chemicals. Please see W227. 3. The QMRP failed to ensure the client's Individual Support Plan (ISP) indicated what facility staff were to do if client #2 refused to bathe for days and/or weeks. Please see W240. 4. The QMRP failed to monitor a client's programs in regards to data collection for client #1. Please see W252. 5. The QMRP failed to revise clients' Individual Support Plan (ISP) objectives when clients #1 and #2 failed to demonstrate progress after a reasonable effort had been made. Please see W257. 6. The QMRP failed to ensure client #1's ISP (Individual Support Plan) was current. Please see W260.			

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	7. The QMRP failed to ensure the facility's HRC (Human Rights Committee) reviewed, approved and monitored restrictive programs for clients #1 and #2. Please see W262. 8. The QMRP failed to obtain written informed consent from the client and/or their guardians prior to implementing the restrictive medications and/or programs/interventions for clients #1, #2 and #4. Please see W263. 9. The QMRP failed to have its Human Rights Committee review/approve clients' restrictive programs and systemic practices for clients #1, #2, #3 and #4. Please see W264. 9-3-3(a)			

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W0209	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. Based on record review and interview for 1 of 2 sampled clients (#1), the facility failed to ensure client #1's guardian attended and/or participated in their IDT (Interdisciplinary Team Meetings). Findings include: Client #1's record was reviewed on 11/14/12 at 9:43 AM. Client #1's record indicated the following IDT (Interdisciplinary Team) meetings: -4/23/12 IDT form indicated monthly review for medications, behavior and workshop attendance. The 4/23/12 IDT form indicated QMRP #1, a representative from BDDS (Bureau of Developmental Disabilities Services) and the facility behavior consultant were in attendance. Client #1 and/or client #1's guardians were not indicated in the attendance roster. -6/8/12 IDT form indicated monthly review for behavior, medications and contact with family. The 6/8/12 IDT form indicated QMRP #1, a representative	W0209	**CORRECTION:** *Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.* Specifically, The QDDPD will assure that both of Client #1's guardians receive written invitations to attend all interdisciplinary meetings and that they receive the opportunity for input when they are unable to attend in person. **PREVENTION:** The QDDPD will be retrained regarding the need to assure complete interdisciplinary team involvement, including co-guardians, in decision making. Members of the Operations and Quality Assurance Teams will review interdisciplinary team notes as meetings occur to assure guardian representation occurs. **RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Behavior Clinician, day service staff, Quality Assurance Team, Operations Team	12/21/2012

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	from BDDS, and the facility behavior consultant were in attendance. Client #1 and/or client #1's guardians were not indicated in the attendance roster. -7/25/12 IDT form indicated monthly review for behavior, medications and contact with family. The 7/25/12 IDT form indicated QMRP #1, a representative from BDDS, and the facility behavior consultant were in attendance. Client #1 and/or client #1's guardians were not indicated in the attendance roster. -10/23/12 IDT form indicated monthly review for behavior, medications and contact with family. The 10/23/12 IDT form indicated QMRP #1, a representative from BDDS, and the facility behavior consultant were in attendance. Client #1 and/or client #1's guardians were not indicated in the attendance roster. Client #1's record did not indicate an annual or additional IDT notes for review. Client #1's record did not indicate documentation of client #1's guardian participate in the facility's IDT regarding the development of client #1's 10/11/11 ISP (Individual Support Plan), objectives or ongoing supports.			

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	QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 11/14/12 at 3:45 PM. When asked if the facility had conducted an IDT for the development of client #1's 10/11/11 ISP, QMRP #1 stated, "We have had annuals, we meet more than quarterly." When asked if the client #1's guardian was invited to attend, QMRP #1 indicated client #1's guardian had not been invited/encouraged to attend or participate. Client #1's guardian was interviewed on 11/19/12 at 10:12 AM. Client #1's guardian indicated he had not been invited to participate in client #1's IDT or meetings. Client #1's guardian indicated he was not aware of client #1's goals/training objectives. Client #1's guardian indicated he would like to participate in client #1's ISP development and program. 9-3-4(a)			

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W0227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 2 of 2 sampled clients (#1 and #2) plus one additional client (#4), the facility failed to ensure client #1's ISP (Individual Support Plan) and BSP (Behavior Support Plan) addressed the clients' identified behavioral needs regarding hand washing. The facility failed to ensure client #2's ISP and BSP addressed the clients' identified behavioral needs regarding day time/leisure skill training. The facility failed to ensure client #4's ISP and BSP addressed the clients' identified behavioral needs regarding the use of cleaning supplies/chemicals. Findings include: 1. Client #1's record was reviewed on 11/14/12 at 9:43 AM. Client #1's RV (Record of Visit) form dated 2/7/12 indicated client #1 had been diagnosed with pink eye. Client #1's RV dated 5/22/12 indicated client #1 had been diagnosed with pink eye. Client #1's RV dated 10/25/12 indicated client #1 had been diagnosed with pink eye. Client #1's	W0227	**CORRECTION:** *The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.* Specifically the interdisciplinary team will develop prioritized objectives for Client #1 to develop hand washing skills and Client #2 to develop daytime leisure skills. **PREVENTION:** The QDDPD will receive training on the need to develop appropriate training programs for assessed needs. The Operations and Quality Assurance Teams will conduct active treatment observations and review assessment and support documents on an ongoing basis but no less than monthly to assure training programs meet the needs of all clients. **RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Behavior Clinician, Quality Assurance Team, Operations Team	12/21/2012

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	10/11/11 ISP and/or 5/24/12 BSP did not address hand washing training. Client #1's 10/11/11 ISP and/or 5/24/12 BSP did not indicate training or supports to encourage client #1 from rubbing his eyes with his hands. QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 11/14/12 at 3:45 PM. QMRP #1 indicated client #1 had been diagnosed with pink eye three times within the last year. QMRP #1 stated, "[Client #1] constantly uses his hands to rub his eyes. [Client #1] always has his hands in his eyes. [Client #1] doesn't have good hygiene. [Client #1's] hands are generally not washed and he rubs his eyes constantly." QMRP #1 indicated client #1 did not have training to teach him to wash his hands or supports to encourage him to keep his hands away from his eyes. 2. During the 11/14/12 observation period between 5:58 AM and 8:45 AM, at the group home, client #2 sat in his bedroom in a recliner without an activity, sat drinking juice in a cup, laid back in the recliner, and/or carried around an empty lunch bag without redirection to participate in a more meaningful activity except to independently fix his own breakfast, to water his plants and to state what his pills were for. Client #2 refused			

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	to state why he took any of his medications. During the above mentioned observation period, the client remained at home and did not attend the local workshop. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's Progress Notes indicated the following (not all inclusive): -11/9/12 Client #2 refused to work on a puzzle and stayed in his room all day watching TV. -11/8/12 "[Client #2] watched TV, laid in his bed after supper then got back up to get a snack." -11/7/12 "[Client #2] refused to participate in any activities. He sat in his recliner & (and) watched TV from his door way." -11/6/12 "...[client #2] was in his room all evening...." -11/4/12 "...[Client #2] sat in his chair all evening with his sleeping bag and watched TV...." Client #2's 3/2/12 Behavior Support Plan (BSP) indicated "...[Client #2] has a history of preferring to be alone...In,			

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	addition, he prefers to be alone and interacts little with staff and peers...." The BSP indicated the client enjoyed motorcycles, gardening, spending time alone and watching TV. Client #2's 12/28/11 Individual Support Plan (ISP) did not indicate the client had a formal leisure skill training objective to teach/assist the client to interact with others. Client #2's ISP also did not specifically indicate what training was to occur with client #2 during the day to ensure the client received a continuous aggressive active treatment program. Interview with Qualified Mental Retardation Professional (QMRP) #1 on 11/14/12 at 1:45 PM indicated client #2 would sit in his bedroom and refused to participate in activities. QMRP #1 indicated client #2 did not have any leisure skill training in place to increase the client's leisure skills/interactions with others. QMRP #1 indicated client #2 did not attend any workshops and/or day programs. QMRP #1 indicated client #2 did not like to leave the group home due to the client's paranoia and delusions. QMRP #1 indicated client #2's 12/28/11 ISP did not specifically indicate what training was to occur with the client during the day.			

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	3. Interview with staff #2 on 11/14/12 at 8:35 AM indicated cleaning supplies were kept locked under the kitchen sink and in the back office area. Staff #2 indicated the cleaning supplies were locked for safety reasons. Client #4's record was reviewed on 11/14/12 at 2:38 PM. Client #4's 3/2/12 BSP and/or 10/25/11 ISP did not indicate client #4 had the need to have cleaning supplies locked. Client #4's 10/25/11 ISP did not indicate the client had a training objective to teach the client how to use cleaning supplies safely. Interview with administrative staff #2 and QMRP #1 on 11/14/12 at 1:45 PM indicated the cleaning supplies were locked at the group home. QMRP #1 stated client #4 was "not safe with chemicals. They may not know what bleach is used for." QMRP #1 indicated client #4 did not have a formal training goal in place to teach the client how to use cleaning supplies/be safe around cleaning supplies. 9-3-4(a)			

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W0240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 1 of 2 sampled clients (#2), the client's Individual Support Plan (ISP) failed to indicate what facility staff were to do if the client refused to bathe for days and/or weeks. Findings include: During the 11/14/12 observation period between 5:58 AM and 8:45 AM, at the group home, at 8:26 AM, client #2 was sitting in his recliner in his bedroom. When speaking with client #2 in his bedroom, client #2's room had a slight body odor smell. Facility staff did not encourage client #2 to bathe/shower during the observation period. Client #2's records were reviewed on 11/14/12 at 11:24 AM. Client #2's Progress Notes indicated the following (not all inclusive): -11/11/12 "...Still refused a shower...." -11/10/12 "...[Client #2] was asked to take a shower (sic) he refused." -11/9/12 Daily Information section	W0240	**CORRECTION:** *The individual program plan must describe relevant interventions to support the individual toward independence.* Specifically, the behavior clinician will work with the interdisciplinary team to develop strategies to address Client #2's ongoing refusals to bathe. Staff will be trained on proper implementation of these strategies. **PREVENTION:** The QDDPD and behavioral clinician will receive training regarding the need to develop specific supports to address health, safety and dignity issues as assessed by the interdisciplinary team. The Operations and Quality Assurance Teams will conduct active treatment observations and review assessment and support documents on an ongoing basis but no less than monthly to assure training programs and interventions are in place to support health, safety and dignity. **RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Quality Assurance Team, Operations Team	12/21/2012

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	indicated client #2 did not bathe/shower, perform hair care and/or skin care. -11/8/12 Client #2 refused to shower. -11/7/12 The daily Information section indicated client #2 did not shower/bathe, perform hair care and/or skin care. -11/6/12 "[Client #2] was in his room all evening and refused to shower...." -11/5/12 "With multiple attempts to get [client #2] to take a shower, he refused...." -11/4/12 "[Client #2] was asked on several occasion if he would like to shower and he said 'Nope' both times...." -11/3/12 The daily Information section indicated client #2 did not shower/bathe, perform hair care and/or skin care. -11/2/12 The daily Information section indicated client #2 did not shower/bathe, perform hair care and/or skin care. -11/1/12 Client #2 refused to shower. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's 12/28/11 ISP indicated the client had an objective to take a shower, wash all areas of his body and shampoo his hair at least			

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	50% of the time for 6 consecutive months. The ISP objective indicated "[Client #2] will go days and even months without taking a shower. Without support, [client #2] would develop skin integrity issues and would be at great risk of fungus and other skin problems...." Client #2's 9/12 data indicated client #2 showered one time on 9/9/12. Client #2's 10/12 data to the present (11/14/12) indicated client #2 had not showered since his colonoscopy on 10/23/12. Client #2's 3/2/12 Behavior Support Plan (BSP) indicated client #2 demonstrated non-compliance which was defined as any time he refuses to begin a task after he was given 3 verbal prompts with the prompts spaced over 15 minutes. Client #2's 3/2/12 BSP did not specifically address client #2's refusals to bathe, and/or indicate what facility staff should do if the client refused to bathe for days and/or weeks (have client wash certain parts, physically assist and/or etc.). Interview with administrative staff #2 and Qualified Mental Retardation Professional (QMRP) #2 on 11/14/12 at 1:45 PM indicated client #2 would refuse to bathe/shower for weeks due to the client's mental illness/paranoia. QMRP #1 indicated client #2 last had a shower			

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	on 10/23/12 prior to his colonoscopy appointment due to a toileting accident for taking the preparation medication. QMRP #1 indicated client #2's ISP did not specifically address and/or indicate what facility staff were to do to assist the client to bathe/shower. 9-3-4(a)			

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W0252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on record review and interview for 1 of 2 sampled clients (#1), the facility failed to monitor clients' programs in regards to data collection. Findings include: Client #1's record was reviewed on 11/14/12 at 9:43 AM. Client #1's 10/11/11 ISP (Individual Support Plan) indicated, "Through review of visual cues and three verbal prompts, [client #1] will identify its purpose and one side effect at each medication pass daily." Client #1's Monthly QMRP (Qualified Mental Retardation Professional) Summary sheets for October 2012, September 2012, August 2012, July 2012 and June 2012 did not indicate review or tracking regarding medication administration training objectives. Client #1's record did not indicate a training objective tracking sheet for client #1's medication administration goal. QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 11/14/12 at 3:45 PM. QMRP #1 indicated	W0252	**CORRECTION:** *Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.* Specifically, a tracking sheet is in place for Client #1's medication administration goal. **PREVENTION:** The QDDPD will be retrained regarding the need to track and monitor progress on all client learning objectives. As part of a monthly audit process, members of the Operations and Quality Assurance Team will review support documents to assure data collection grids are in place for all learning objectives. **RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Behavior Clinician, Quality Assurance Team, Operations Team	12/21/2012

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	client #1 had a medication administration training objective. QMRP #1 indicated he had not been tracking the medication administration training objective. 9-3-4(a)			

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	15G805		11/21/2012

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W0257	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. Based on interview and record review for 2 of 2 sampled clients (#1 and #2), the Qualified Mental Retardation Professional (QMRP) failed to revise clients' Individual Support Plan (ISP) objectives when the clients failed to demonstrate progress after a reasonable effort had been made. Findings include: 1. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's 12/28/11 ISP indicated the client had an objective to take a shower, wash all areas of his body and shampoo his hair at least 50% of the time for 6 consecutive months. Client #2's 11/12 data for the above mentioned objective indicated the client had refused to shower/bathe from 11/1 to 11/14/12. Client #2's Monthly QMRP Summaries indicated the following: October 2012 - 3.22% September 2012 - 0%	W0257	**CORRECTION:** *The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.* Specifically, Client #1's showering and meal preparation and client #2's bathing objective will be revised based on lack of progress. **PREVENTION:** The QDDP will receive training regarding the need to maintain copies of monthly/quarterly summaries in each client's record to be available for review by appropriate parties upon request, as well as the need to revise objectives no less than quarterly based on current assessment data. Additionally, members of the Operations and Quality Assurance Teams will conduct periodic reviews of individual support plans and monthly/quarterly ISP reviews on an ongoing basis to assure the QDDP and Behavioral clinician are monitoring progress on	12/21/2012

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	August 2012 - 0% July 2012 - 0% June 2012 - 0% May 2012 - 0% April 2012 - 0% Client #2's 10/4/12 monthly summary indicated "...[Client #2] continues to refuse to take showers, but he did take a shower because of having an accident after taking the preparation meds for his colonoscopy...." Client #2's 10/4/12 monthly indicated the QMRP failed to revise the client's training objective as the client had not progressed toward the stated criteria of 50% since April 2012. Interview with QMRP #1 on 11/14/12 at 1:45 PM indicated client #2 continued to work on the above stated objective. QMRP #1 indicated client #2 would refuse to shower/bathe on a daily basis. QMRP #1 indicated client #2's objective would need to be revised. 2. Client #1's record was reviewed on 11/14/12 at 9:43 AM. Client #1's 10/11/11 ISP (Individual Support Plan) indicated the client had the following objectives: -Will pick up his clothes after his shower and put them in his laundry basket at least 90% of the time for six consecutive		client's learning objectives and behavior trends and making appropriate modifications as needed. **RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Behavior Clinician, Quality Assurance Team, Operations Team	

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	months. -Will help set the table for at least one meal per day and take his plate to the sink after each meal at least 90% of the time for six consecutive months. Client #1's Monthly QMRP (Qualified Mental Retardation Professional) Summary form for October 2012 indicated the following training objective tracking: -Showering 35.48% -Meal prepare/clean up, no data entered. Client #1's Monthly QMRP Summary form for September 2012 indicated the following training objective tracking: -Showering, 50.00% -Meal prepare/clean up, 62.5% Client #1's Monthly QMRP Summary form for August 2012 indicated the following training objective tracking: -Showering, 51.60% -Meal prepare/clean up, 75.27% Client #1's Monthly QMRP Summary			

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	form for July 2012 indicated the following training objective tracking: -Showering, 74.19% -Meal prepare/clean up, 69.89% Client #1's Monthly QMRP Summary form for June 2012 indicated the following training objective tracking: -Showering, 66/67% -Meal prepare/clean up, 73.33% Client #1's record indicated the QMRP had not updated/revised client #1's training objectives when client #1 failed to make progress toward skill acquisition. QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 11/14/12 at 3:45 PM. QMRP #1 indicated client #1 had not achieved his training objective criteria. QMRP #1 indicated he had not revised or updated client #1's goals. 9-3-4(a)			

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W0260	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. Based on record review and interview for 1 of 2 sampled clients (#1), the facility failed to ensure the client's ISP (Individual Support Plan) was current. Findings include: Client #1's record was reviewed on 11/14/12 at 9:43 AM. Client #1's ISP was dated 10/11/11. QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 11/14/12 at 3:45 PM. QMRP #1 indicated client #1 did not have more current ISP to review. QMRP #1 indicated ISP's should be reviewed and updated annually. 9-3-4(a)	W0260	**CORRECTION:** *At least annually, the individual program plan must be revised, as appropriate.* Specifically, Client #1's ISP has been revised. **PREVENTION:** The QDDPD will be retrained regarding the fact that Individual Support Plans need to be modified no less than annually. Members of the Operations and Quality Assurance Team will monitor facility support documents as needed but no less than monthly to assure all ISPs are current. **RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Behavior Clinician, Quality Assurance Team, Operations Team	12/21/2012

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W0262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview for 2 of 2 sampled clients (#1 and #2), the facility's HRC (Human Rights Committee) failed to review, approve and monitor restrictive programs. Findings include: 1. Client #1's record was reviewed on 11/14/12 at 9:43 AM. Client #1's 3/3/12 BSP (Behavior Support Plan) revised on 5/24/12 and 7/19/12 indicated client #1 was on behavioral medications which included: Divalproex, Benztropine, Clonazepam, Namenda, Sertraline, Loxapine, Aricept and Buspirone for the following behaviors: physical aggression, verbal aggression and property disruption. The BSP signature page was dated 7/19/12. Client #1's HRC meeting minutes indicated the following HRC meetings: -4/9/12, HRC meeting regarding the locking of snack food items in the storage room.	W0262	**CORRECTION:** *The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.* Specifically, Client #1 and Client #2's restrictive programs were reviewed and approved consensually by the Human Rights Committee at their quarterly meeting on 12/11/12. **PREVENTION:** The QDDPD will be retrained regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Administrative staff will conduct visits to the facility as needed but no less than monthly. **RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Behavior Clinician, Human Rights Committee, Quality Assurance Team, Operations Team	12/21/2012

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	-4/17/12, HRC meeting regarding changes in Klonopin dosage amounts. -5/18/12, HRC meeting regarding approval for the use of a face shield while having behaviors. -6/1/12, HRC meeting regarding approval for medication change from Miritazapine to Zoloft. -6/21/12, HRC meeting regarding changes for Depakote dosage amounts. -8/10/12, HRC meeting regarding changes for Depakote dosage amounts. -10/1/12, HRC meeting regarding the discontinuation of Trazodone and the start of Ambien CR (Controlled Release) (Sedative). Client #1's HRC meeting minutes indicated each member of the HRC was individually notified via phone. The HRC minutes did not indicate documentation of dialogue or consensus among members for approvals. Client #1's record did not indicate HRC review/approval of client #1's BSP. Interview with QMRP (Qualified Mental			

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	Retardation Professional) #1 on 11/14/12 at 3:45 PM indicated the HRC conference call was completed by contacting each member individually and recording their approval. QMRP #1 indicated the HRC was not conducted as a conference call amongst members. QMRP #1 indicated there were no additional HRC minutes to review regarding approval of client #1's BSP or restrictions. 2. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's 3/2/12 Behavior Support Plan (BSP) indicated the client received the following psychotropic medications: -Chlorpromazine (schizophrenia) -Olanzapine (schizophrenia) -Lorazepam (anxiety) -Lexapro (behavior) -Amantadine (side effects of behavioral medications). Client #2's 3/2/12 BSP also indicated client #2 had the following restrictive interventions in his BSP: -Your Safe, I'm Safe (physical intervention/restraint techniques) for physical aggression and property destruction which included, blocking, one person hold and two person hold.			

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	-Calling 911 when client #2's behavior "...jeopardizes the safety and well-being of peers, community members and staff...." -Calling the police to escort/assist the client to attend psychiatric appointments and/or to go to hospital for evaluation. The facility's Human Rights Committee (HRC) notes were reviewed on 11/14/12 at 12:15 PM. The facility's 2/17/12 HRC notes indicated the facility called each HRC member individually to obtain approval for client #2's medications on 2/17/12. The 2/17/12 HRC note did not allow for dialogue between the HRC members and/or a consensus. Client #2's 12/28/11 Individual Support Plan (ISP) and/or BSP indicated the facility's HRC did not approve the above restrictive interventions/techniques outlined in client #2's 3/2/12 restrictive BSP/program. Interview with QMRP (Qualified Mental Retardation Professional) #1 and administrative staff #2 on 11/14/12 at 1:45 PM indicated the facility's HRC was called individually by phone to approve the client's restrictive behavioral medications. QMRP #1 and administrative staff #2 indicated they could not locate documentation where the			

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	facility's HRC approved client #2's restrictive behavior plan/program in regard to using the above mentioned restrictive interventions/techniques. 9-3-4(a)			

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W0263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on interview and record review for 2 of 2 sampled clients (#1 and #2) and for 1 additional client (#4), with restrictive programs, the facility failed to obtain written informed consent from the client and/or their guardians prior to implementing the restrictive medications and/or programs/interventions. Findings include: 1. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's 3/2/12 Behavior Support Plan (BSP) indicated the client received the following psychotropic medications: -Chlorpromazine (schizophrenia) -Olanzapine (schizophrenia) -Lorazepam (anxiety) -Lexapro (behavior) -Amantadine (side effects of behavioral medications). Client #2's 3/2/12 BSP also indicated client #2 had the following restrictive interventions in his BSP:	W0263	**CORRECTION:** *The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.* Specifically, The QDDPD will obtain written informed consent from Client #1 and Client #2 and Client #1's guardians for all current restrictive programs. **PREVENTION:** Professional staff will be retrained regarding the need to obtain prior written informed consent for all restrictive programs prior to implementation. Retraining will focus on assuring that the QDDPD has a clear understanding of what specifically constitutes a restrictive program and proper preparation for presenting program modifications to the individuals and their legal representatives. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Administrative staff will conduct visits to the facility as needed but no less than monthly. **RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Behavior Clinician, Human Rights Committee, Quality Assurance Team, Operations Team	12/21/2012

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	-Your Safe, I'm Safe (physical intervention/restraint techniques) for physical aggression and property destruction which included, blocking, one person hold and two person hold. -Calling 911 when client #2's behavior "...jeopardizes the safety and well-being of peers, community members and staff...." -Calling the police to escort/assist the client to attend psychiatric appointments and/or to go to hospital for evaluation. Client #2's 12/28/11 Individual Support Plan (ISP) indicated client #2 was his own guardian. Client #2's 12/25/11 ISP and/or 3/2/12 BSP did not indicate client #2 gave written informed consent in regard to his restrictive BSP as no signature sheets were attached to the ISP and/or BSP. 2. During the 11/14/12 observation period between 5:58 AM and 8:45 AM, at the group home at 6:59 AM, staff #2 unlocked a closet in the kitchen to get cereal out of the closet for client #4. At 7:26 AM, client #3 was in the kitchen fixing his breakfast. Client #3 asked staff to unlock the kitchen closet so he could get the oatmeal out for his breakfast. At 7:28 AM, client #3 asked staff #2 to unlock the kitchen cabinet again. Client #3 then turned to staff #4, who was in the kitchen, and stated "Why can't I have a			

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	key to unlock the door to get my own food?" Client #3 stated in a loud tone "They steal food, I don't. That's why it's locked." Client #3 then started complaining there was no sugar and how staff did not keep the sugar in the cabinet as another client would use it all. Staff #2 went to the back office area and came back with a bag of sugar. The staff placed some sugar into a small container and placed the container into the kitchen cabinet. At 7:50 AM, staff unlocked the closet/pantry for client #2 to get cereal out to fix his breakfast. The locked kitchen closet/pantry contained canned goods, cereal, oatmeal bread, snack foods, and etc. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's 3/2/12 Behavior Support Plan (BSP) indicated client #2 demonstrated the behavior of hoarding food ("any time he removes food from kitchen area that is not eaten immediately or within a half hour, which is found to be hidden in any of his personal belongings, bedroom and/or in the furniture, i.e. living room couch where he rests and sleeps.... ") Client #2's BSP and/or 12/28/11 ISP indicated client #2 was his own guardian. Client #2's 3/2/12 BSP and/or 12/28/11 ISP did not indicate the client gave written informed consent to lock food items.			

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	Interview with Qualified Mental retardation Professional (QMRP) #1 and administrative staff #2 on 11/14/12 at 1:45 PM indicated client #2 demonstrated the behavior of food hoarding. QMRP #1 indicated client #2 did not give written informed consent in regard to locking food. 3. During the 11/14/12 observation period between 5:58 AM and 8:45 AM, in the group home, a door alarm on the front door could be heard when anyone entered and/or exited the group home. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's 3/2/12 BSP indicated the client demonstrated the behavior of "...Leaving Assigned Ares (sic): any time he leaves a designated area including the home, or areas the group (defined as the staff that are with him on a community outing) is at. This is to include walking out of the house to check the mail without notifying staff...." Client #2's 3/2/12 BSP and /or 10/28/11 ISP indicated client #2 was his own guardian. The ISP/BSP did not indicate client #2 required the use of a door alarm, and/or indicate the client gave written consent for the restrictive practice. Interview with administrative staff #2 and			

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	QMRP #1 on 11/14/12 at 1:45 PM indicated the facility's behavior specialist was in the process of putting the door alarms in the behavior plans of the clients. QMRP #1 and administrative staff #2 indicated the facility had not obtained written informed consent from client #2 for the use of the door alarms. 4. Interview with staff #2 on 11/14/12 at 8:35 AM indicated cleaning supplies were kept locked under the kitchen sink and in the back office area. Staff #2 indicated the cleaning supplies/chemicals were locked for safety reasons. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's 10/28/11 ISP and/or 3/2/12 BSP did not indicate client #2 had a need to have cleaning supplies locked. The ISP and/or BSP indicated client #2 was his own guardian. The ISP/BSP indicated client #2 did not give consent to lock cleaning supplies. Client #4's record was reviewed on 11/14/12 at 2:38 PM. Client #4's 3/2/12 BSP and/or 10/25/11 ISP did not indicate client #4 had the need to have cleaning supplies locked. Client #4's ISP indicated client #4's mother was his guardian. Client #4's ISP/BSP did not indicate the client's guardian gave written informed			

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COMMUNITY ALTERNATIVES ADEPT	1010 KELLAM RD CENTERVILLE, IN 47330

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	consent to lock cleaning supplies/chemicals. Interview with administrative staff #2 and QMRP #1 on 11/14/12 at 1:45 PM indicated the cleaning supplies were locked at the group home. QMRP #1 indicated the client #2 and client #4's guardian did not give written informed consent to lock chemicals/cleaning supplies at the group home. 5. Observations were conducted at the group home on 11/13/12 from 5:40 PM through 6:40 PM. Clients #1, #2, #3 and #4 were present in the home throughout the observation period. At 5:40 PM upon entering the group home through the front door an alarm sounded throughout the house as the door was open and shut. At 6:40 PM upon exiting the group home through the front door an alarm sounded throughout the house as the door was open and shut. Client #1's record was reviewed on 11/14/12 at 9:43 AM. Client #1's 10/11/11 ISP indicated client #1 had a guardian. Client #1's 3/3/12 BSP (Behavior Support Plan) revised on 5/24/12 and 7/19/12 indicated client #1 was on behavioral medications which included: Divalproex, Benztropine, Clonazepam, Namenda, Sertraline,			

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	Loxapine, Aricept and Buspirone for the following behaviors: physical aggression, verbal aggression and property disruption. The BSP signature page was dated 7/19/12 and was not signed by client #1 or client #1's guardian. Client #1's 7/19/12 BSP and/or 10/11/11 ISP did not indicate client #1's guardian gave written informed consent regarding the systemic restrictions of locking the kitchen cabinets, locking the chemicals, locking personal hygiene items and placing alarms on the doors. Interview with QMRP #1 (Qualified Mental Retardation Professional) on 11/14/12 at 3:45 PM indicated the group home doors had alarms, kitchen cabinets were locked, and chemicals were locked in the group home. QMRP #1 indicated client #1 used psychotropic medications for behavior management. QMRP #1 indicated client #1's BSP and the facility's systemic restrictions of locking the kitchen cabinets, locking the chemicals, locking personal hygiene items and placing alarms on the doors should not be implemented without written informed consent from client #1's guardian. 9-3-4(a)			

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W0264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.			
	Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2) and for 2 additional clients (#3 and #4), the facility failed to have its Human Rights Committee review/approve clients' restrictive programs and systemic practices. Findings include: 1. During the 11/14/12 observation period between 5:58 AM and 8:45 AM, at the group home, staff #4 retrieved the client #4' s personal hygiene kit from the office area. Once client #4 finished taking his shower, client #4 returned his hygiene kit to the office to staff. Staff #3 placed the hygiene kit in the medication closet of the office. Interview with staff #3 on 11/14/12 at 8:35 AM indicated client #1, #2 and #3's hygiene kits were kept in the medication office area. Staff #3 stated client #1 would throw his hygiene kit at others and client #4 "needs prompting when showering." Staff #3	W0264	**CORRECTION:** *The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.* Specifically, personal hygiene kits and household cleaning supplies are no longer stored in a locked cabinet. The Human Rights Committee has reviewed the use of door alarms and agrees the restriction remains appropriate. **PREVENTION:** Professional staff will be retrained regarding the need to obtain prior written informed consent and Human Rights Committee approval for all restrictive programs prior to implementation. Retraining will focus on assuring that the QDDPD has a clear understanding of what specifically constitutes a restrictive program and proper preparation for presenting program modifications to the Human Rights Committee. The training will also focus on helping	12/21/2012

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	indicated client #2 would refuse to shower. Staff #3 indicated only staff had keys to access the locked closet in the locked office. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's 12/28/11 Individual Support Plan (ISP) and/or 3/2/12 Behavior Support Plan (BSP) did not indicate the facility's Human Rights Committee (HRC) reviewed and/or approved the systemic practice of locking the client ' s personal hygiene supplies/kit. Client #4's record was reviewed on 11/14/12 at 2:38 PM. Client #4's 10/25/11 ISP did not indicate the HRC reviewed and/or approved the systemic practice of locking the client's personal hygiene supplies/kit. Interview with the Qualified Mental Retardation Professional (QMRP) #1 on 11/14/12 at 1:45 PM indicated client #1, #2 and #4's hygiene supplies were locked at the group home. When asked why the clients' hygiene supplies/kits were locked, QMRP #1 stated "Best place to put it. They have a history of throwing items." QMRP #1 indicated the facility's HRC did not review the practice of locking clients' personal hygiene supplies/kits to ensure clients' rights were not violated.		professional staff develop adequate record keeping practices to assure that HRC approval records are available for review. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Administrative staff will conduct visits to the facility as needed but no less than monthly. **RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Human Rights Committee, Behavior Clinician, Quality Assurance Team, Operations Team	

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	2. During the 11/14/12 observation period between 5:58 AM and 8:45 AM, at the group home at 6:59 AM, staff #2 unlocked closet in the kitchen to get cereal out of the closet for client #4. At 7:26 AM, client #3 was in the kitchen fixing his breakfast. Client #3 asked staff to unlock the kitchen closet so he could get the oatmeal out for his breakfast. At 7:28 AM, client #3 asked staff #2 to unlock the kitchen cabinet again. Client #3 then turned to staff #4, who was in the kitchen, and stated "Why can't I have a key to unlock the door to get my own food?" Client #3 stated in a loud tone "They steal food, I don't. That's why it's locked." Client #3 then started complaining about there was no sugar and how staff did not keep the sugar in the cabinet as another client would use it all. Staff #2 went to the back office area and came back with a bag of sugar. The staff placed some sugar into a small container and placed the container into the kitchen cabinet. At 7:50 AM, staff unlocked the closet/pantry for client #2 to get cereal out to fix his breakfast. The locked kitchen closet/pantry contained canned goods, cereal, oatmeal, bread, snack foods, and etc. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's 3/2/12			

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	Behavior Support Plan (BSP) indicated client #2 demonstrated the behavior of hoarding food ("any time he removes food from kitchen area that is not eaten immediately or within a half hour, which is found to be hidden in any of his personal belongings, bedroom and/or in the furniture, i.e. living room couch where he rests and sleeps.... ") Client #2's BSP indicated "If [client #2] is observed removing food items from the kitchen, staff is to monitor for hoarding behaviors, i.e. not consuming item immediately and/or within half-hour. If [client #2] is observed putting/hiding unopened/unconsumed food items in his personal belongings, bedroom and/or in the furniture, i.e. living room couch where he rests and sleeps, staff should: -Provide gentle prompts to [client #2], to consume the food item. Provide gentle prompts and reminders to dispose of wrapper/package/trash properly. -Provide gentle prompts to return the unopened/unused food item to the kitchen and place item in a location of his choosing until he is ready to consume it. -If he refuses, repeat prompts every 15 minutes until he returns the unopened/unconsumed food item to the kitchen area. -If he continues to refuse and becomes agitated, stop prompts, and document behavior(s)." Client #2's 3/2/12 BSP did			

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	not indicate food items should be locked. The facility's Human Rights Committee (HRC) notes were reviewed on 11/14/12 at 12:15 PM. The facility's 4/9/12 phone log for calling the Human Right members indicated the facility obtained approval to lock up snacks in the storage area due to client #2's behavior. Client #2's ISP/BSP did not indicate the facility's HRC reviewed the systemic practice of locking food up. Client #4's record was reviewed on 11/14/12 at 2:38 PM. Client #4's 10/25/11 ISP and/or 3/2/12 BSP did not indicate food should be locked. The client's BSP and/or ISP did not indicate the facility's HRC reviewed and/or approved the right restriction. Interview with Qualified Mental retardation Professional (QMRP) #1 and administrative staff #2 on 11/14/12 at 1:45 PM indicated client #2 demonstrated the behavior of food hoarding. QMRP #1 stated "[Client #2] would eat food. He would eat constantly. He eats at all hours." QMRP #1 stated the facility had obtained HRC approval to lock "snacks." QMRP #1 indicated the systemic practice of locking food had not been reviewed by the facility's HRC to ensure clients' rights were not violated.			

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	3. During the 11/14/12 observation period between 5:58 AM and 8:45 AM, in the group home, a door alarm on the front door could be heard when anyone entered and/or exited the group home. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's 3/2/12 BSP indicated the client demonstrated the behavior of "...Leaving Assigned Ares (sic): any time he leaves a designated area including the home, or areas the group (defined as the staff that are with him on a community outing) is at. This is to include walking out of the house to check the mail without notifying staff...." Client #2's 3/2/12 BSP and /or 10/28/11 ISP did not indicate client #2 required the use of a door alarm. Client #2's 10/28/11 ISP and/or 3/2/12 BSP did not indicate the facility's HRC reviewed and approved the restricted use of a door alarm. Interview with administrative staff #2 and QMRP #1 on 11/14/12 at 1:45 PM indicated the facility's behavior specialist was in the process of putting the door alarms in the behavior plans of the clients. QMRP #1 and administrative staff #2 indicated the facility's HRC had not reviewed the restrictive practice/use of the door alarms to ensure clients' rights.			

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	4. Interview with staff #2 on 11/14/12 at 8:35 AM indicated cleaning supplies were kept locked under the kitchen sink and in the back office area. Staff #2 indicated the cleaning supplies were locked for safety reasons. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's 10/28/11 ISP and/or 3/2/12 BSP did not indicate client #2 had a need to have cleaning supplies locked. The ISP/BSP did not indicate the facility's HRC reviewed/approved the restrictive practice of locking cleaning supplies. Client #4's record was reviewed on 11/14/12 at 2:38 PM. Client #4's 3/2/12 BSP and/or 10/25/11 ISP did not indicate client #4 had the need to have cleaning supplies locked. The client's ISP/BSP also did not indicate the facility's HRC reviewed and/or approved the practice of locking cleaning supplies. Interview with administrative staff #2 and QMRP #1 on 11/14/12 at 1:45 PM indicated the cleaning supplies were locked at the group home. QMRP #1 stated clients #1 and #4 were "not safe with chemicals. They may not know what bleach is used for." Administrative staff #2 and QMRP #1 indicated locking of the cleaning supplies had not been approved			

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	by the facility's HRC. 5. Observations were conducted at the group home on 11/13/12 from 5:40 PM through 6:40 PM. Clients #1, #2, #3 and #4 were present in the home throughout the observation period. At 5:40 PM upon entering the group home through the front door an alarm sounded throughout the house as the door was open and shut. At 6:40 PM upon exiting the group home through the front door an alarm sounded throughout the house as the door was open and shut. Client #1's record was reviewed on 11/14/12 at 9:43 AM. Client #1's Physician Script dated 9/17/12 indicated an order for Ambien CR (Controlled Release) 12.5 MG (Milligram) tablet (sedative). Client #1's Physicians Order form dated 10/26/12 indicated client #1 received Zolpidem/Ambien ER (Extended Release) tablet 12.5 MG daily at 10:00 PM. Client #1's Psychiatric Medication Review form dated 10/1/12 indicated, "sleep disturbance, persisting IED (Intermittent Explosive Disorder), start Ambien." Client #1's 3/3/12 BSP (Behavior Support Plan) revised on 5/24/12 and 7/19/12 did not indicate the use of Zolpidem/Ambien ER 12.5 MG was reviewed by the facility's HRC. Client #1's 7/19/12 BSP and/or 10/11/11			

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	ISP did not indicate the systemic restrictions of locking the kitchen cabinets, locking the chemicals, locking personal hygiene items and placing alarms on the doors were reviewed by the facility's HRC committee. Interview with QMRP #1 (Qualified Mental Retardation Professional) on 11/14/12 at 3:45 PM indicated the group home doors had alarms, kitchen cabinets were locked, chemicals were locked in the group home and personal hygiene items were locked. QMRP #1 indicated client #1 received Ambien 12.5 MG at bedtime for nighttime behaviors and insomnia. QMRP #1 indicated client #1's 5/24/12 BSP did not include the use of Ambien 12.5 MG ER had been reviewed by the facility's HRC. QMRP #1 indicated client #1's 7/19/12 BSP did not include facility's systemic restrictions of locking the kitchen cabinets, locking the chemicals, locking personal hygiene items and placing alarms on the doors had not been reviewed by the facility's HRC. 9-3-4(a)			

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W0268	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, interview and record review for 1 of 2 sampled clients (#2), the facility failed to promote and ensure the dignity of the client in regard to bathing and cleanliness as the client refused to bathe/shower. The facility failed to specifically address the client's bathing refusals to ensure the client ' s dignity in regard to cleanliness. Findings include: During the 11/14/12 observation period between 5:58 AM and 8:45 AM, at the group home, at 8:26 AM, client #2 was sitting in his recliner in his bedroom. When speaking with client #2 in his bedroom, client #2's room had a slight odor/smell. Facility staff did not encourage client #2 to bathe/shower during the observation period. Client #2's records was reviewed on 11/14/12 at 11:24 AM. Client #2's Progress Notes indicated the following (not all inclusive): -11/11/12 "...Still refused a shower...." -11/10/12 "...[Client #2] was asked to	W0268	**CORRECTION:** *These policies and procedures must promote the growth, development and independence of the client*. Specifically, the behavior clinician will work with the interdisciplinary team to develop strategies to address Client #2's ongoing refusals to bathe. Staff will be trained on proper implementation of these strategies. **PREVENTION:** The QDDPD and behavioral clinician will receive training regarding the need to develop specific supports to address health, safety and dignity issues as assessed by the interdisciplinary team. The Operations and Quality Assurance Teams will conduct active treatment observations and review assessment and support documents on an ongoing basis but no less than monthly to assure training programs and interventions are in place to support health, safety and dignity. **RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Behavior Clinician, Quality Assurance Team, Operations Team	12/21/2012

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	take a shower he refused." -11/9/12 Daily Information section indicated client #2 did not bathe/shower, perform hair care and/or skin care. -11/8/12 Client #2 refused to shower. -11/7/12 The daily Information section indicated client #2 did not shower/bathe, perform hair care and/or skin care. -11/6/12 "[Client #2] was in his room all evening and refused to shower...." -11/5/12 "With multiple attempts to get [client #2] to take a shower, he refused...." -11/4/12 "[Client #2] was asked on several occasion if he would like to shower and he said 'Nope' both times...." -11/3/12 The daily Information section indicated client #2 did not shower/bathe, perform hair care and/or skin care. -11/2/12 The daily Information section indicated client #2 did not shower/bathe, perform hair care and/or skin care. -11/1/12 Client #2 refused to shower. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's			

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	12/28/11 ISP indicated the client had an objective to take a shower, wash all areas of his body and shampoo his hair at least 50% of the time for 6 consecutive months. The ISP objective indicated "[Client #2] will go days and even months without taking a shower. Without support, [client #2] would develop skin integrity issues and would be at great risk of fungus and other skin problems...." Client #2's 9/12 data indicated client #2 showered one time on 9/9/12. Client #2's 10/12 data to the present (11/14/12) indicated client #2 had not showered since his colonoscopy on 10/23/12. Client #2's Monthly QMRP Summaries indicated the following in regard to the client's above mentioned ISP objective: October 2012 - 3.22% September 2012 - 0% August 2012 - 0% July 2012 - 0% June 2012 - 0% May 2012 - 0% April 2012 - 0% Client #2's 10/4/12 monthly summary indicated "...[Client #2] continues to refuse to take showers, but he did take a shower because of having an accident after taking the preparation meds for his colonoscopy...."			

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	Client #2's 3/2/12 Behavior Support Plan (BSP) indicated client #2 demonstrated non-compliance which was defined as any time he refuses to begin a task after he was given 3 verbal prompts with the prompts spaced over 15 minutes. Client #2's 3/2/12 BSP did not specifically address client #2's refusals to bathe, and/or indicate what facility staff should do if the client refused to bathe for days and/or weeks (have client wash certain parts, physically assist and/or etc.). Interview with administrative staff #2 and Qualified Mental Retardation Professional (QMRP) #2 on 11/14/12 at 1:45 PM indicated client #2 would refuse to bathe/shower for weeks due to the client's mental illness/paranoia. QMRP #1 indicated client #2 last had a shower on 10/23/12 prior to his colonoscopy appointment due to a toileting accident for taking the preparation medication. QMRP #1 indicated the client would wash off at times, but the staff did not document that in the Progress Notes. QMRP #1 indicated client #2's ISP did not specifically address and/or indicate what facility staff were to do to assist the client to bathe/protect his dignity regarding cleanliness. 9-3-5(a)			

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W0289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on interview and record review for 1 of 2 sampled clients, with restrictive interventions (#2), the facility failed to include/incorporate calling the police to assist the client to attend routine medical appointments. Findings include: The facility's reportable incident reports were reviewed on 11/13/12 at 2:00 PM. Client #2's 3/15/12 reportable incident report indicated client #2 saw his primary care doctor on 3/13/12 for an evaluation of his swollen left lower leg. The reportable incident report indicated the client's doctor ordered an ultrasound for 3/14/12 and client #2 refused to go to the appointment. The reportable incident report indicated on 3/15/12, client #2's leg continued to remain swollen and red. The 3/15/12 reportable incident report indicated the facility's nurse and administrative staff directed staff to take the client to a local hospital for	W0289	**CORRECTION:** *The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan.* Specifically, the behavioral clinician will incorporate parameters for the use of non-emergency police personnel to assist Client #2 with attending medical appointments into Client #2's Behavior Support Plan. **PREVENTION:** The behavioral clinician will receive training regarding the need to assure all interventions developed through interdisciplinary team consensus are incorporated into Behavior Support Plans. Members of the Operations and Quality Assurance Teams will review incident data and other documentation and current support documents as needed but no less than monthly to assure that facility practices are developed through the interdisciplinary process and incorporated into support documents. **RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Behavior Clinician, Quality Assurance Team, Operations Team	12/21/2012

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	evaluation, but client #2 refused to leave the house. The reportable incident report indicated " ...Per the protocol established in his BSP (Behavior Support Plan) staff contacted the police to arrange an emergency detention to assure [client #2] received appropriate medical care. Police arrived at the residence and when given a choice to ride to the ER (emergency room) with the Program Coordinator or the police, [client #2] agreed to ride with the PC...." Client #2's 3/29/12 Nurse Quarterly Assessment indicated client #2 "Continues to refuse to go to healthcare appts (appointments)." The 3/29/12 assessment indicated client #2 had to be "escorted" (police called) 2 times for labs, left knee and required CBC (blood count) with differential related to Clozaril (anti-psychotic) medication monitoring. Client #2's 10/4/12 Monthly QMRP (Qualified Mental Retardation Professional) Summary indicated "... [Client #2] continues to refuse at times to go to the doctor and the police are called to convince [client #2] to go to the doctor appointment. When the police come,			

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	[client #2] will do things like pretend to be asleep and he will try to ignore the request to go to the appropriate appointment. Eventually [client #2] will cooperate and go to the appointment...." Client #2's 12/28/11 ISP (individual Support Plan) indicated "...[Client #2] has a history of paranoia and grandious (sic) ideas which causes [client #2] to be suspicious of doctors and other health care professionals which causes [client #2] to refuse to go to doctor's appointments and other medical appointments in the past...." Client #2's 3/2/12 BSP indicated client #2 demonstrated "Non-Compliance: Medical Appointments" which included all scheduled medical appointments, and "Non-Compliance Psychiatric Appointments" which included medication evaluations, routine lab draws (Clozaril) and meeting with psychiatrist or nurse practitioner. Client #2's BSP indicated if client #2 refused to attend a psychiatric related appointment/lab test or medication evaluation, the staff was to start			

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	prompting the client an hour before the scheduled appointment. If the client refused, they were to notify the appropriate administrative staff and nurse and then call the local Sheriff's office non-emergency number to get assistance in transporting the client to the appointment/hospital. Client #2's 3/2/12 BSP did not indicate facility staff were to call the police for assistance with medical appointments (doctor visits, other labs and etc.). Interview with administrative staff #2 and Qualified Mental Retardation Professional (QMRP) #1 on 11/14/12 at 1:45 PM indicated client #2 refused to leave the house to attend doctor appointments. Administrative staff #2 indicated the police were to be called for related psychiatric appointments only. QMRP #1 indicated the police had been called for medical appointments. QMRP #1 indicated client #2 had improved with going to medical appointments, but the police had been called/utilized to assist. QMRP #1 and administrative staff #2 indicated client #2's BSP did not include/incorporate calling the police to			

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	assist client #2 to attend medical appointments and/or other medical labs. 9-3-5(a)			

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W0312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 2 sampled clients (#1) who used behavior controlling medications, the facility failed to ensure the client's program included the use of and withdrawal criteria for psychotropic medication used for behavior management. Findings include: Client #1's record was reviewed on 11/14/12 at 9:43 AM. Client #1's Physician Script dated 9/17/12 indicated an order for Ambien CR (Controlled Release) 12.5 MG (Milligram) tablet (sedative). Client #1's Physicians Order form dated 10/26/12 indicated client #1 received Zolpidem/Ambien ER (Extended Release) tablet 12.5 MG daily at 10:00 PM. Client #1's Psychiatric Medication Review form dated 10/1/12 indicated, "sleep disturbance, persisting IED (Intermittent Explosive Disorder), start Ambien." Client #1's record did not indicate a BSP (Behavior Support Plan)	W0312	**CORRECTION:** *Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.* Specifically, the behavioral clinician will add withdrawal criteria for client #1's Ambien ER **PREVENTION:** The behavioral clinician will receive training regarding the need to incorporate withdrawal criteria for all behavior controlling medications into Behavior Support Plans. Members of the Operations and Quality Assurance Teams will review Behavior Support Plans as part of an ongoing internal audit process that will include withdrawal criteria for behavior controlling drugs. Operations and Quality Assurance Team members will conduct site visits that incorporate BSP reviews no less than monthly. **RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Behavior Clinician, Quality Assurance Team, Operations Team	12/21/2012

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	or medication titration plan regarding the use of Zolpidem/Ambien ER 12.5 MG. QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 11/14/12 at 3:45 PM. QMRP #1 indicated client #1 received Ambien 12.5 MG at bedtime for nighttime behaviors and insomnia. QMRP #1 indicated client #1's 5/24/12 BSP did not include the use or withdrawal criteria for Ambien 12.5 MG ER. 9-3-5(a)			

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W0331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on 2 of 2 sampled clients (#1 and #2), the facility's nursing services failed to develop needed health risk plans, obtain clarification of orders, and to ensure pertinent health records of a client were present in the client's record. Findings include: 1. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's 10/2/12 Record Of Visit (ROV) indicated client #2 saw his doctor for Hypertension, Insomnia and weight loss. The 10/2/12 ROV indicated client #2 was to start Melatonin 1 milligram at bedtime and titrate to 5 milligrams at bedtime for the client ' s Insomnia. Client #2's 11/12 Medication Administration Record (MAR) did not indicate client #2 was receiving the Melatonin as ordered. Interview with RN #1 on 11/14/12 at 2:53 PM, by phone, indicated client #2 was no longer taking the Melatonin at bedtime. RN #1 indicated client #2's doctor discontinued the Melatonin in October 2012. RN #1 indicated client #2's doctor was trying the Melatonin for Insomnia.	W0331	**CORRECTION:** *The facility must provide clients with nursing services in accordance with their needs.* Specifically, a physician's Order for the discontinuation of Client #1's Melatonin has been obtained. Additionally, the facility nurse has developed and implemented comprehensive high risk plans to address Client #1``s GERD and Client #2's Syncope. **PREVENTION:** The facility nurse will be retrained regarding the need to obtain Physician's Orders for all discontinued medication and to include specific care procedures as appropriate when developing comprehensive high risk and care plans. The Nurse Manager will review all revisions to facility nursing care plans for the next ninety days and thereafter will perform spot checks of facility nursing care plans as needed but no less than quarterly. Additionally, Operations and Quality Assurance Team members will review medical documentation, including but not limited to Medication and Treatment Administration Records and current Physician's Orders, while auditing active treatment sessions, no less than monthly, and make recommendations to the Health Services Team as appropriate. **RESPONSIBLE PARTIES:** QDDPD, Team Lead, Direct Support Professionals, Health Services	12/21/2012

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	RN #1 stated "Tried it but it did not work." RN #1 indicated the doctor did not write a refill for the Melatonin so it was to be discontinued when it was done as the medication did not help client #2. RN #1 indicated she did not have a discontinue order on the chart for the Melatonin nor did she seek clarification from the doctor on the Melatonin. 2. Client #2's record was reviewed on 11/14/12 at 11:24 AM. Client #2's 7/10/12 ROV indicated client #2 was seen for follow-up of a hospitalization due to Syncope (loss of consciousness) due to low blood pressure. Client #2's record indicated the last monthly nursing note/assessment/monitoring of client #2's health issues/concerns was dated for 6/12. Client #2's record contained no other nurse monthly summaries. Client #2's 10/11/11 risk plans indicated client #2 had no risk plans for Syncope and/or low blood pressure in the record as the client only had a risk plan for hypertension in the chart which did not address low blood pressure. Interview with RN #1 on 11/14/12 at 2:53 PM, by phone indicated she had completed monthly summaries for client		Team, Quality Assurance Team, Operations Team	

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	#2 since 6/12. RN #1 indicated she had the monthly summaries on her. When asked why the monthly summaries were not part of the client #2's record, RN #1 indicated client #2's nursing monthly summaries should be in the client's record. RN #1 indicated client #2 had problems with low blood pressure and the client's blood pressure medications had been decreased. RN #1 indicated the client's Syncope was caused by the client's low blood pressure. When asked if the client had a risk plan for low blood pressure and Syncope, RN #1 stated "Yes, in the chart." When told the risk plans were not in the chart, RN #1 indicated she was sending them to administrative staff #2 to place in the record. 3. Client #1's record was reviewed on 11/14/12 at 9:43 AM. Client #1's Record of Visit (RV) form dated 8/23/12 indicated the recommendation for client #1 to not lay down after dinner for one hour. Client #1's record did not indicate documentation of a care plan to address GERD/acid reflux for client #1. QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 11/14/12 at 3:45 PM. QMRP #1 indicated client #1 had GERD/acid reflux and had a recommendation to remain upright after meals for one hour. QMRP #1 indicated			

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	there was not a risk plan for GERD for client #1. RN (Registered Nurse) #1 was interviewed on 11/14/12 at 3:15 PM. RN #1 indicated there was not a risk plan for client #1 regarding GERD. 9-3-6(a)			

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W0336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview for 2 of 2 sampled clients (#1 and #2), the facility nurse failed to complete Quarterly Nursing Assessment (QNA) for clients #1 and #2. Findings include: 1. Client #1's record was reviewed on 11/14/12 at 9:43 AM. Client #1's QNA indicated the most recent assessment completed by the facility nurse was 3/29/12. Client #1's QNA or record did not indicate documentation of a nursing assessment since 3/29/12. Interview with AS (Administrative Staff) #1 and RN (Registered Nurse) #1 on 11/14/12 at 3:15 PM indicated clients should have QNA's every quarter. AS #1 and RN #1 indicated client #1's most recent assessment by the facility nurse was completed on 3/29/12. AS #1 and RN #1 indicated there were no additional QNA's available for review. 2. Client #2's record was reviewed on	W0336	**CORRECTION:** *Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.* Specifically, the nurse has completed quarterly examinations for Clients #1 - #4. **PREVENTION:** Copies of quarterly nursing physical examinations will be placed in the each individual's medical chart upon completion. Additionally, Operations and Quality Assurance Team members will review medical documentation while auditing active treatment sessions, no less than monthly, to assure records of quarterly nursing evaluations are completed and filed appropriately. **RESPONSIBLE PARTIES:** QDDPD, Direct Support Professionals, Behavior Clinician, Health Services Team, Quality Assurance Team, Operations Team	12/21/2012

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	11/14/12 at 11:24 AM. Client #2's record indicated the client was not in need of a medical care plan. Client #2's record indicated no nursing quarterly assessments had been completed in regards to the client's health since 3/29/12. The 3/29/12 quarterly nursing assessment was the only nursing quarterly assessment in the record for the past year (11/11 to 11/12). Client #2's 12/25/11 Individual Support Plan (ISP) indicated client #2's diagnoses included, but were not limited to, Depressive Disorder, Asthma, Gastroesophageal Reflux Disorder and Schizophrenia. Client #2's 9/7/12 physician orders also indicated client #2's diagnoses, included, but were not limited to, Hypertension, Constipation, Irritable Bowel Syndrome and Cellulitis of left lower extremity. Client #2's 9/7/12 physician's order indicated the client received routine medications. Interview with administrative staff #2 and the Qualified Mental Retardation Professional on 11/14/12 at 1:45 PM indicated they could not locate any additional quarterly nursing assessments besides the 3/29/12 assessment. Interview with RN #1 on 11/14/12 at 2:53 PM (by phone) indicated client #2 only had the 3/29/12 nurse quarterly			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	1010 KELLAM RD CENTERVILLE, IN 47330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessment. RN #1 stated "Planning to do this week." 9-3-6(a)			