

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G410	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2014
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NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN 47446
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: December 15, 16, 17 and 19, 2014.</p> <p>Survey Team: Dotty Walton, QIDP-TC David Piotrowski, QIDP-Federal Surveyor</p> <p>Facility Number: 000924 AIM Number: 100244510 Provider Number: 15G410</p> <p>These federal deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/20/15 by Ruth Shackelford, QIDP.</p>	W000000		
W000125	<p>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</p>			

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

TITLE

(X6) DATE

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

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	<p>citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#2) the facility failed to ensure the client had a surrogate to assist her in decision making.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 12/15/14 at 10:00 AM. Her Risk Management Assessment and program plan dated 6/16/14 revision date of 11/03/14 indicated she required 24 hour 7 days a week supervision. The record indicated client #2 received medication for behavior management, Vyvanse for attention deficit disorder and Prozac for depression. The assessment indicated she presented a risk in regards to defending herself against abuse/exploitation due to her poor behavior/decision making. She exhibited poor judgement, was at risk for sexual exploitation and had a history of making false allegations. The assessment indicated she lacked comprehensive understanding of personal finances and could not recognize or report mismanagement of her money. The record indicated the client had no surrogate to assist her with decision making.</p>	W000125	<p>An assessment for the need for guardianship was completed on 1/28/15 for Client 2. Guardianship is being pursued for Client 2 to assist in decision making. Responsible Party: Program Director</p>	01/30/2015

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W000149	<p>Interview with Facility Administrator #1 on 12/17/14 at 2:30 PM indicated client #2 was in need of someone to assist her with making decisions and she was at risk for exploitation.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review the facility failed to implement policies and procedures which prohibited abuse and neglect for clients. The facility failed to thoroughly investigate one of two allegations of abuse and one medication error (neglect) it reported during the time parameter of 12/2013 through 12/14/14. This affected one client in the core sample, (Client #1) and two clients outside the sample, (Clients #7 and #8).</p> <p>Findings include:</p>	W000149	The Program Director was retrained on completing thorough investigations on 1/28/14. The Program Director will meet with the Area Director weekly to review all incidents and investigations. The Area Director will ensure that all needed investigations are completed for any incidents that require them. All future investigations will be reviewed for completeness and thoroughness by the Area Director and Quality Assurance Specialist. The Area Director will review all investigations to ensure they are submitted timely and will follow up with necessary corrective action as needed at weekly PD/AD meeting.	01/30/2015	

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	<p>1. On 12/15/14 at 11:38 AM during review of incidents/allegations reported by the facility, the facility reported an incident of potential abuse on 11/12/14 wherein a staff member allegedly gave two clients (Clients #1 and #7) a dollar each to eat a pellet of hermit crab food. The investigation indicated staff members and clients were interviewed. Clients #1 and #7 both indicated they ate food pellets and were given a dollar by the staff member.</p> <p>The alleged perpetrator (AP/staff #12) indicated both clients were joking when they asked "to try it" referring to eating the hermit crab food pellets. The AP also indicated she only observed Client #1 putting a food pellet in her mouth. This was followed by Client #1 spitting the food out stating "it was nasty." The AP denied giving Clients #1 and #7 any money as an incentive to eat the food pellets.</p> <p>In the "Conclusion" section of the investigative report it indicated, "There is evidence to support that it is likely that (AP) did play a part in the incident with</p>		Responsible Party: Program Director, Area Director, Quality Assurance Specialist				

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	<p>the clients eating the hermit crab food and likely gave them money to try it. There is no evidence that (AP) did so with malicious intent or to cause harm."</p> <p>In an interview with the Facility Administrator (FA #1) on 12/15/14 at 12:05 PM, the FA was asked if the investigation determined whether any ingredients in the food pellets were harmful for human consumption. The FA indicated that aspect had not been investigated. When the FA was asked if any nursing exam had been included as part of the investigation to verify if any harm was caused, the FA indicated that also had not been considered.</p> <p>An internet search of the product "Tetra fauna hermit crab food pellets" conducted by the surveyor on 12/16/14 at 4:26 PM indicated the following: "Feeding Directions: Keep out of reach of children" with the additional explicit statement, "For animal use only."</p> <p>2. On 11/18/14 the facility completed a medication error report for Client #8. The report identified: Metoprolol - 25</p>				

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	<p>milligrams (hypertension); a stool softener - 100 milligrams; Amitriptyline - 25 milligrams (anti-depressive); Metformin - 50 milligrams (for diabetes) and Atorvastin - 10 milligrams (for cholesterol) were scheduled to be administered at 8:00 PM on 11/17/14 and were discovered by a night shift employee at 9:00 PM they had not been given.</p> <p>Per interview with the Licensed Practical Nurse (LPN #1) on 12/16/14 at 10:20 AM it was verified those medications had not been dispensed as ordered by Client #8's physician, however though the incident report indicated the error was discovered the night before at 9:00 PM the error was not actually discovered until the next morning when the night shift employee found the medications.</p> <p>Per follow-up interview with the Home Manager (HM #3) and Qualified Intellectual Disabilities Professional (QIDP #4) on 12/17/14 at 8:30 AM, the HM indicated the night shift employee checked the medication administration records (MARs) and discovered the</p>						

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	<p>MAR for Client #8 had been initialed by the previous shift employee indicating 8:00 PM medications were administered. The QIDP indicated there may have been some miscommunication regarding the actual time of discovery and what she had documented on the incident report.</p> <p>The medication error incident report was absent of any clarification regarding the verbal explanations provided on 12/15/14 and 12/16/14 and the report was also absent of any impact that may have occurred when Client #8 failed to receive his evening dose medications.</p> <p>FA #1 was interviewed on 12/15/14 at 12:05 PM. FA #1 indicated the facility's abuse and neglect policy should be implemented.</p> <p>The facility's policies and procedures were reviewed on 12/15/14 at 12:30 PM. The facility's policy entitled, "Quality and Risk Management" dated April 2011 indicated alleged, suspected, or actual abuse, neglect, or exploitation may include, "1. (e) Failure to provide appropriate supervision, care or training;</p>						

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W000154	<p>(g) Failure to provide food and medical services as needed." The facility's policy entitled, "Quality and Risk Management" dated April 2011 indicated, "4. (o) A medication error...as determined by the individual's personal physician, including the following; (2) Failure to administer medication as prescribed."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review the facility failed to thoroughly investigate one of two allegations of abuse and one medication error (neglect) it reported during the time parameter of 12/2013 through 12/14/14. This affected one client in the core sample, (Client #1), and two clients outside the sample, (Clients #7 and #8).</p>	W000154	<p>The Program Director was retrained on completing thorough investigations on 1/28/14. The Program Director will meet with the Area Director weekly to review all incidents and investigations. The Area Director will ensure that all needed investigations are completed for any incidents that require them. All future investigations will be reviewed for completeness and thoroughness by the Area Director</p>	01/30/2015

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	<p>Findings include:</p> <p>1. On 12/15/14 at 11:38 AM during review of incidents/allegations reported by the facility, the facility reported an incident of potential abuse on 11/12/14 wherein a staff member allegedly gave two clients (Clients #1 and #7) a dollar each to eat a pellet of hermit crab food. The investigation indicated staff members and clients were interviewed. Clients #1 and #7 both indicated they ate food pellets and were given a dollar by the staff member.</p> <p>The alleged perpetrator (staff #12) stated both clients were joking when they asked "to try it" referring to eating the hermit crab food pellets. The AP also indicated she only observed Client #1 putting a food pellet in her mouth. This was followed by Client #1 spitting the food out stating "it was nasty." The AP denied giving Clients #1 and #7 any money as an incentive to eat the food pellets.</p> <p>The "Conclusion" section of the investigative report indicated, "There is</p>		<p>and Quality Assurance Specialist. The Area Director will review all investigations to ensure they are submitted timely and will follow up with necessary corrective action as needed at weekly PD/AD meeting.</p> <p>Responsible Party: Program Director, Area Director, Quality Assurance Specialist</p>				

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	<p>evidence to support that it is likely that (AP) did play a part in the incident with the clients eating the hermit crab food and likely gave them money to try it. There is no evidence that (AP) did so with malicious intent or to cause harm."</p> <p>In an interview with the Facility Administrator (FA) #1 on 12/15/14 at 12:05 PM, FA #1 was asked if the investigation determined whether any ingredients in the food pellets were harmful to human consumption. FA #1 acknowledged that aspect had not been investigated. When FA #1 was asked if any nursing exam had been included as part of the investigation to verify if any harm was caused, FA #1 explained that also had not been considered.</p> <p>An internet search of the product "Tetra fauna hermit crab food pellets" conducted by the surveyor on 12/16/14 at 4:26 PM indicated the following: "Feeding Directions: Keep out of reach of children" with the additional explicit statement, "For animal use only."</p> <p>2. On 11/18/14 the facility completed a</p>				

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	<p>medication error report for Client #8. The report identified: Metoprolol - 25 milligrams (for hypertension); a stool softener - 100 milligrams; Amitriptyline - 25 milligrams (anti-depressive); Metformin - 50 milligrams (for diabetes) and Atorvastin - 10 milligrams (for cholesterol) were scheduled to be administered at 8:00 PM on 11/17/14 and it was discovered by a night shift employee at 9:00 PM they had not been given.</p> <p>Per interview with the Licensed Practical Nurse (LPN) #1 on 12/16/14 at 10:20 AM it was verified those medications had not been dispensed as ordered by Client #8's physician. The incident report indicated the error was discovered the night before at 9:00 PM. But the error was not actually discovered until the next morning when the night shift employee found the medications.</p> <p>Per follow-up interview with the Home Manager (HM) #3 and Qualified Intellectual Disabilities Professional (QIDP) #4 on 12/17/14 at 8:30 AM, HM #3 indicated the night shift employee</p>			

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W000159	<p>checked the medication administration records (MARs) and discovered the MAR for Client #8 had been initialed by the previous shift employee indicating 8:00 PM medications were administered. The QIDP acknowledged there may have been some miscommunication regarding the actual time of discovery and what she had documented on the incident report.</p> <p>The medication error incident report was absent of any clarification regarding the verbal explanations provided on 12/15/14 and 12/16/14 and the report was also absent of any impact that may have occurred when Client #8 failed to receive his evening dose medications.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3, and</p>	W000159	The Program Director was retrained	01/30/2015			

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	<p>#4), the QIDP/Qualified Intellectual Disabilities Professional failed to coordinate each client's active treatment program in regards to client assessments (vocational), revising Individual Support Plan (ISP) training objectives, coordinating with the behavior specialist in regards to behavior medications and their withdrawal criteria being a part of the clients' behavior support plans (BSP).</p> <p>Findings include:</p> <p>1. During record review for Client #3 on 12/16/14 at 8:30 AM, the record indicated Client #3 had a training objective to learn how to flush the toilet. The objective was established at Client #3's ISP/Individual Support Plan on 9/18/14. The associated monthly progress reports completed by Qualified Intellectual Disabilities Professional/QIDP #4 for September through November 2014 were reviewed and it was indicated Client #3 achieved 90% criterion for three consecutive months.</p> <p>In an interview with QIDP #4 on 12/16/14 at 10:00 AM to ascertain whether the criterion for success had</p>		<p>on 1/28/15 on updating and revising client program plans due to lack of progress or criteria being met to ensure client programming needs are met.</p> <p>The Program Director and Area Director will meet weekly, and at least monthly, will review Client Monthly Summaries to ensure progress or lack of progress is address and changes to plans are made as needed.</p> <p>Responsible Party: Program Director, Area Director</p>				

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	<p>been achieved, the QIDP stated she usually makes changes when clients attain a "75%" success rate. QIDP #4 indicated no revisions to the ISP had been made.</p> <p>2. On 12/16/14 at 7:45 AM, Client #4 was brought to the medication area and was prompted by a facility Direct Support Professional (DSP) to sanitize his hands prior to medication administration.</p> <p>During record review for Client #4 on 12/16/14 at 10:40 AM, it was indicated Client #4 had the following training objective established at an ISP meeting conducted on 9/17/14, "[Client #4] will rub hands together with sanitizer before med pass for three consecutive months." The associated monthly progress reports completed by the Qualified Intellectual Disabilities Professional (QIDP) #4 for September through November 2014 were reviewed and it was indicated Client #4 achieved 100% criterion for three consecutive months.</p> <p>In an interview with QIDP #4 on 12/16/14 at 2:30 PM to ascertain whether</p>			

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	<p>the criterion for success had been achieved, QIDP #4 indicated the criterion was met and no revisions had been made to the ISP.</p> <p>3. During record review for Client #3 on 12/16/14 at 8:30 AM, it was indicated Client #3 had a training objective for "facial hygiene desensitization" established at an ISP meeting conducted on 9/18/14. The associated monthly progress reports completed by the Qualified Intellectual Disabilities Professional (QIDP) #4 for September through November 2014 were reviewed and it was documented Client #3 achieved: 26% in September; 26% in October; 0% in November. In an interview with QIDP #4 on 12/16/14 at 10:00 AM, QIDP #4 indicated the regression in the objective and indicated no revisions had been made to the ISP.</p> <p>Record review for Client #3 on 12/16/14 at 8:30 AM indicated Client #3 had a training objective established at an ISP meeting conducted on 9/18/14 to have regular community integration in order to "increase money management skills."</p>				

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	<p>The associated monthly progress reports completed by Qualified Intellectual Disability Professional (QIDP) #4 for September through November 2014 were reviewed and it was documented Client #3 achieved: 0% in September; 0% in October; N/A (not applicable) was recorded for November. In an interview with the Qualified Intellectual Disabilities Professional (QIDP) #4 on 12/16/14 at 10:00 AM, QIDP #4 indicated the lack of progress in the objective and indicated no revisions had been made to the ISP.</p> <p>4. Please refer to W154 for 3 of 8 reportable incidents reviewed, (clients #3 and #4), for the QIDP's failure to ensure all allegations were thoroughly investigated.</p> <p>5. Please refer to W225 for 2 of 4 sampled clients (#1 and #2), for the QIDP's failure to ensure clients' vocational needs were assessed.</p> <p>6. Please refer to W249 for 2 of 4 sampled clients (#3 and #4), for the QIDP's failure to ensure the clients' training programs were implemented at the facility operated day program.</p>						

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W000225	<p>7. Please refer to W436 for 1 of 4 clients who used adaptive equipment, (client #4), for the QIDP's failure to ensure he used his AFOs (ankle/leg braces).</p> <p>9-3-3(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on observation, record review and interview for 2 of 4 sampled clients (#1 and #2), the facility failed to ensure an indepth assessment of functional vocational skills was completed.</p> <p>Findings include:</p> <p>Clients #1 and #2 were observed at the facility's operated habilitation program on 12/15/14 from 1:35 PM until 3:00 PM. Both clients participated in unpaid work of cooking, doing puzzles, listening to music and playing board games.</p> <p>Client #1's record was reviewed on</p>	W000225	<p>The Vocational Assessment has been revised to include more comprehensive information. These will be completed at least annually for all clients. The updated assessment will be completed for all clients in the home.</p> <p>Responsible Party: Home Manager, Program Director</p>	01/30/2015

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W000249	<p>12/15/14 at 1:17 PM. Her 8/1/14 Vocational Profile Summary assessment indicated no indepth assessment of functional vocational skills.</p> <p>Client #2's record was reviewed on 12/15/14 at 10:00 AM. Her 11/02/14 Vocational Profile Summary assessment indicated no indepth assessment of functional vocational skills.</p> <p>Workshop supervisory staff (WS) #1 was interviewed on 12/15/14 at 1:30 PM. WS staff #1 and #2 were asked if they had done a vocational assessment of clients #1 and #2's vocational abilities. WS staff #1 indicated no assessment had been done by day program staff.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in</p>				

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	<p>the individual program plan.</p> <p>Based on observation, interview and record review the facility failed to: offer functional and meaningful activities at its day program; provide behavioral interventions as outlined in plans; reinforce dining skills in accordance with the individualized program plans. This affected two of four clients in the sample, (Clients #3 and #4).</p> <p>Findings include:</p> <p>Client #3 was observed at the facility's day program on 12/15/14 at 1:40 PM. During the initial observation, Client #3 was observed spinning in an office chair holding a plastic jump rope. As Client #3 spun about in the chair, the rope wrapped around Client #3 and the base of the chair. There were two staff members in the room, but no redirection was provided.</p> <p>At 1:50 PM, Client #3 was presented with another object to manipulate but Client #3 refused and subsequently resumed playing with the plastic rope. Client #3 removed himself from the chair and sat on the floor twirling the rope and</p>	W000249	<p>Day Program staff will be retrained by 1/30/15 on clients' plans and to continually prompt Clients 3 and 4 to participate in functional and meaningful activities in accordance with their individualized support plans while at the day program.</p> <p>Staff, at the top of every hour, will encourage Clients 3 and 4 to engage in some type of sensory activity. Staff at the day program will be trained to follow this plan by 1/30/15.</p> <p>Observations will be completed by administrative staff at least three times per week for three weeks to ensure prompting is completed and participation is being encouraged for all clients.</p> <p>Responsible Party: Home Managers, Program Directors, Area Director, Quality Assurance Specialist</p>	01/30/2015			

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	<p>was observed putting the plastic end in his mouth. The remaining length of rope was on the floor and other clients in the day program walked past Client #3 trying to avoid stepping on the rope. At 1:51 PM Client #3 laid sideways on the floor and an instructor moved the rope with her foot towards Client #3's back so no one would trip on it.</p> <p>At 2:00 PM, the Day Program Director (DPD) #5 attempted to convince Client #3 to get up from the floor, but the attempt was unsuccessful. Client #3 resumed playing with the rope, twirling about including placing the end of the rope in his mouth. Again, no intervention was provided to redirect Client #3 to another activity or to get him to stop placing the rope in his mouth.</p> <p>Record review was done at the day program on 12/15/14 at 2:35 PM and indicated Client #3 had a training objective to sit in a designated area. The objective indicated "[Client #3] will sit in a designated area as opposed to anywhere on the floor, attempting a new activity daily with 3 or less physical prompts</p>						

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	<p>10/20 days per month for 3 consecutive months." Review of the December 2014 data sheet for this objective indicated a check had been placed under the dates in the month Client #3 attended, but there was no indication how many prompts were needed. There was a section for duration that could have been entered to identify the interval of time, but that was blank. Interview on 12/15/14 at 2:35 PM with DPD #5 indicated the duration data should have been entered and he was trying to find other activities Client #3 might be interested in.</p> <p>Client #4 was observed at the facility's day program 12/15/14 at 1:40 PM. Client #4 stood in the center of the day room holding handkerchiefs that were knotted together. When Client #4 flicked his wrist the handkerchiefs would move through the air or across his torso. When Client #4 was not engaged in flicking the handkerchiefs he circled the floor in one spot over and over; occasionally spitting. No staff intervention or redirection was provided to Client #4 to stop spitting. At 2:02 PM, a snack was offered and throughout the snack, the instructor fed</p>						

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	<p>Client #4 with a spoon. Client #4 was never prompted to feed himself.</p> <p>Record review for Client #4 at the day program was done on 12/15/14 at 2:52 PM and indicated Client #4 had a Behavior Support Plan (BSP) dated 11/18/13. The target behavior for spitting was identified and instructions to staff were, "When [Client #4] spits outside his room or designated area - tell him to stop and redirect him to an activity." When DPD #5 was informed there was no intervention provided when spitting occurred, DPD #5 responded by stating the BSP was written for the residence and it was "outdated." A copy of Client #4's Individualized Support Plan (ISP) dated 9/17/14 was at the day program. It identified a formal goal, "[Client #4] will attempt to feed himself approximately 5-10 bites during meal times. If it fails, staff will assist him in eating daily with no more than 3 verbal prompts."</p> <p>In a follow-up dinner observation at the residence at 4:45 PM on 12/15/14, Client #4 was observed sitting at a table. Client #4's meal was presented to him within a</p>				

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W000312	<p>high-sided dish and when given a spoon by his Direct Support Professional (DSP) #6, Client #4 began to feed himself.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 3 sampled clients who received medications to manage behaviors (#2), the facility failed to ensure the client's program plans contained withdrawal criteria for the behavior medications.</p> <p>Findings include:</p> <p>Record review for client #2 was done on 12/16/14 at 1:00 PM. Client #2's record contained a Behavior Support Plan/BSP dated 11/11/14. The BSP indicated client #2 took Prozac 10mg/milligrams daily, Prazosin 1 mg. daily and Vyvanse 50 mg. daily for behavior management. The behaviors for which the medications were used were not specifically written into the</p>	W000312	<p>The Behavior Support Plan for Client 2 has been revised to include all current medications and a plan of reduction for the current prescribed medications. Other clients plans in the home that have a Behavior Support Plan and prescribed medications, have had their plans reviewed and updated/revised if needed to include medication reduction plans.</p> <p>The Program Director will meet with the Area Director weekly and will review client plans, including Behavior Support Plans and medication reduction plans to ensure they are in place and up to date.</p> <p>Responsible Party: Program Director,</p>	01/30/2015			

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W000368	<p>BSP. The plan of reduction component in the BSP for the drugs indicated: "Medication reduction Plan: (drug) will be reduced per psychiatrist's evaluation of his behavior." There was no specific criteria for drug withdrawal for Prozac, Vyvanse or Prazosin in the BSP.</p> <p>QIDP/Qualified Developmental Disabilities Professional #1 was interviewed on 12/17/14 at 12:30 PM. The interview indicated QIDP #1 had not written the BSP and could not explain the absence of drug withdrawal criteria.</p> <p>9-3-5(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on interview and record review, the facility failed to ensure five medications were administered in accordance with physician orders for one additional client, (Client #8).</p> <p>Findings include:</p>	W000368	<p>Area Director</p> <p>Staff in the home were retrained on 1/27/15 on administering client medications according to the prescriptions listed on Physicians Orders and appropriate completion of buddy checks to prevent errors. Further incidents of medication errors will result in corrective action</p>	01/30/2015

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	<p>On 12/15/14 at 11:38 AM, review of incidents/allegations reported by the facility from 12/2013 through 12/14/14 indicated the facility completed a medication error report for Client #8.</p> <p>The report indicated: Metoprolol - 25 milligrams (anti[hypertensive); a stool softener - 100 milligrams; Amitriptyline - 25 milligrams (anti-depressant); Metformin - 50 milligrams (for diabetes) and Atorvastin - 10 milligrams (for cholesterol) were scheduled to be administered at 8:00 PM and it was discovered by a night shift employee they had not been given.</p> <p>Interview with the Licensed Practical Nurse (LPN) #1 on 12/16/14 at 10:20 AM, the LPN indicated the medications had not been dispensed as ordered by Client #8's physician.</p> <p>9-3-6(a)</p>		<p>for staff.</p> <p>The Program Director, Home Manager and/or Nurse will complete observations twice monthly on an on-going basis to ensure that all medications are administered properly.</p> <p>Responsible Party: Home Manager, Program Director, Nurse</p>		

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review, the facility failed to ensure ankle foot orthotics were provided in accordance with the individualized support plan for one sampled client, (Client #3), for whom the devices were prescribed.</p> <p>Findings include:</p> <p>During observations of Client #3 at the facility's day program on 12/15/14 at 1:40 PM, Client #3 did not wear any shoes and he moved about the day program in his socks until the time of departure at 3:30 PM.</p> <p>During observations of Client #3 at the facility residence on 12/15/14 at 4:45 PM, Client #3 did not wear any shoes while in the home as he walked from room to room.</p>	W000436	<p>Day Program staff will be retrained by 1/30/15 to continually prompt Client 3 to reapply his prescribed ankle foot orthotics in accordance with his individualized support plan.</p> <p>Observations will be completed by administrative staff at least three times per week to ensure prompting is completed for Client 3.</p> <p>Responsible Party: Home Managers, Program Directors</p>	01/30/2015	

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	<p>On 12/16/14 at 7:25 AM, Client #3 was prompted by Direct Support Professional (DSP) #7 to put on his shoes. DSP #7 placed an ankle foot orthotic (AFO) on Client #3's left leg. DSP #7 covered Client #3's AFO with a sock and then placed Client #3's shoe on his left foot. Client #3 attempted to take his shoe off, DSP #7 intervened and Client #3 kept his shoe and the AFO on as he was taken via wheelchair to the facility van.</p> <p>Record review for Client #3 on 12/16/14 at 8:30 AM indicated an Individualized Support Plan (ISP) dated 9/18/14. A reference under "Podiatry - 2/18/14 (indicated) AFOs - wear as needed."</p> <p>Interview was conducted with the facility's Licensed Practical Nurse (LPN) #1 on 12/16/14 at 10:12 AM. LPN #1 reviewed Client #3's physician's orders and then stated, "[Client #3] should wear AFOs on both legs all the time."</p> <p>9-3-7(a)</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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