

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G266	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/19/2013
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2840 JOHN ST NEW HARMONY, IN 47631
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 12/9, 12/10, 12/11 and 12/19/13</p> <p>Facility Number: 000786 Provider Number: 15G266 AIMS Number: 100248990</p> <p>Surveyor: Paula Chika, QIDP-TC</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/27/13 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on interview and record review for 1 of 3 sampled clients (#1), the facility's governing body failed to exercise general policy and operating direction over the facility to develop a policy and procedure/system on when an internal incident report, of any type, would be utilized/filled out.</p> <p>Findings include:</p>	W000104	<p>Following an incident, direct care staff are to take immediate action or protective measures to assure client health and safety and/or contacts "911" for medical assistance. Staff immediately contact and report incident to Supervisor or On-Call Supervisor. Staff document incident occurrence and who it was reported to in Daily Support Records. Supervisor or On-Call Supervisor determines category</p>	01/18/2014

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

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

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	Client #1's record was reviewed on 12/11/13 at 11:15 AM. Client #1's March 2013 Behavioral Supports Monthly Service Notes indicated on 3/25/13, indicated client #1 had "severe" behavior. The note indicated "...Fellow peer went to bed and slammed door, waking [client #1] who decided to slam door multiple times and came upstairs to staff.' Incident: [Client #1] came to staff stating peer woke her up by slamming the door. Staff told her peer probably did not mean to and she knows that. [Client #1] stated if she can slam the door then I can too! Staff asked [client #1] to calm down. Staff continued to pass meds (sic) to other peer. When staff asked [client #1] to take her meds she said, 'No!' Staff ignored behavior. [Client #1] went down to her room and put on her shoes and jacket. She then continued to walk out the front door and stand (sic) in front of the tree. Staff asked her to come back in as it was cold and rainy. [Client #1] called both staff b...and refused to come in. [Client #1] continued to walk off property and down the road. Staff kept [client #1] in line of sight and followed [client #1] with the van. [Client #1] stopped at the end of the road and stood there calling staff You b...Staff asked [client #1] to get back into van. [Client #1] said she would get back in van but		of incident and type of incident report that will be completed. Supervisor or On-Call Supervisor determines if additional protective measures are necessary. Supervisor or On-Call Supervisor obtains necessary information about the Incident from the supervisor and/or witness. Supervisor or On-Call Supervisor completes an internal incident report and BDDS report OR completes an internal incident report only if BDDS report is not required and an internal incident report is needed. Supervisor or On-Call Supervisor completes required incident notifications and documents such, as applicable. Supervisory staff will ensure that direct care staff document as required in the Daily Support Record and other internal report forms as applicable, such as Behavior Problem Record Narrative Note, Immediate Investigation of Injury form, etc... that an incident has occurred. If an investigation is required, supervisory staff will ensure that all staff and clients who witness/observe an incident are interviewed for the incident report. Home Manager will review documentation on a weekly basis and Program Director will review documentation at least monthly to ensure reportable incidents are being reported accurately and timely. Addendum 1/29/2014: The Program Director will meet with	

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	<p>wasn't going to talk to b...staff. Staff brought [client #1] back to group home and [client #1] proceeded to sit in van while shtaff (sic) stood in front doorway. [Client #1] refused to get out of van and made a scene in van which caught the neighbor's attention. She screamed and cussed, calling both staff stupid b... and she hated everyone. 30 minutes later, [client #1] came inside and sat at kitchen table. While other peer were asleep [client #1] started to kick the table really loud. Staff asked her to stop. [Client #1] continued to knock all the chairs onto the ground. She threw everything off the table and threw the lunch boxes across the kitchen. [Client #1] proceeded (sic) over to the sink/stock area and threw dishes everywhere. Staff asked her multiple times to stop and was returned with 'No! F...you b...!' [Client #1] threw dishes at staff, dumped mop bucket onto floor and threw broom and mop at staff. Staff removed bigger, breakable objects out of path of destruction. It took [client #1] 30 minutes of destroying the kitchen till she wore herself [out]..."</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 12/10/13 at 11:57 AM. The facility's reportable incident reports and/or investigations did not indicate an</p>		<p>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, timeliness and thoroughness by the Area Director and/or Quality Assurance Specialist or other designee. Responsible parties: Quality Assurance Specialist, Area Director and Program Director</p>				

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	<p>internal incident report and/or a Bureau of Developmental Disabilities Services (BDDS) reportable incident report was filled out in regard to the above mentioned 3/25/13 behavioral incident.</p> <p>Interview with administrative staff #1 on 12/9/13 at 2:40 PM indicated she did not have any internal incident reports for the New Harmony Group Home.</p> <p>Interview with administrative staff #1 and administrative staff #2 on 12/11/13 at 2:20 PM, by phone, indicated the facility did have any internal incident reports for the group home but did have BDDS reportable incident reports. When asked if the facility had a reportable incident report for the 3/25/13 incident with client #1, administrative staff #1 stated "No, it was not reportable." Administrative staff #1 stated the facility did internal incident reports but no internal incident report needed to be filled out for "level one incidents." Administrative staff #1 stated "If there is a medical incident, there is a form they fill out and fax to office called Immediate Investigation of Injury forms."</p> <p>The facility's policy and procedures were reviewed on 12/9/13 at 2:40 PM. The facility's April 2011 policy indicated</p>				

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W000125	<p>"...Indiana MENTOR follows the BDDS Incident Reporting policy as outlined in the Provider Standards. An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS. 1. Alleged, suspected, or actual abuse, neglect, or exploitation of an individual. An incident in this category shall also be reported to Adult Protective Services or Child Protective Services as applicable...." The facility's policy also indicated "...1. All incidents that require a report to the Bureau of Developmental Disabilities Services, or internal incident reports will be entered into a database maintained by The Mentor Network..." The facility's April 2011 policy indicated the facility failed to develop a specific policy and procedure which specifically indicated when the facility would fill out an internal incident report if no BDDS reportable incident report was required.</p> <p>9-3-1(a)</p> <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 citizens of the United States, including the right to file complaints, and the right to due process.</p>			

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	<p>Based on interview and record review for 1 of 3 sampled clients (#3), the facility failed to ensure the client's right to due process in regard to limiting/restricting the client's right to go on home visits with her mother based on the client's behavior.</p> <p>Findings include:</p> <p>Interview with client #3 on 12/10/13 at 2:30 PM indicated client #3 would not be able to go home/visit her mother unless she earned it.</p> <p>Client #3's record was reviewed on 12/11/13 at 9:49 AM. Client #3's 12/9/13 interdisciplinary team (IDT) note indicated "IDT met to discuss [client #3's] (increase) in verbal aggression and behaviors. [Client #3] wants to visit mom, knowing it is contingent on behaviors due to staff having to drive and supervise visit 4 hours to [name of city]. IDT agreed her outburst that have (sic) occurred over weekend regarding cigarettes that she would not have the privilege until behaviors decrease...."</p> <p>Client #3's 4/28/13 Behavioral Support Plan (BSP) and/or 8/1/13 Individual Support Plan (ISP) did not indicate client #3's right to visit her mother</p>	W000125	<p>IDT meeting held on 12/20/2013 for Client #3 to lift the HRC restriction that was obtained on 12/12/13. Home visits with Client #3's mother are not contingent on Client #3's behaviors. Program Directors were retrained on 1/10/2014 in regards to the Interdisciplinary Team (IDT) and Human Rights Committee (HRC). HRC will meet quarterly to review restrictions. Client's plans will be updated as changes occur and reviewed annually for revisions. Addendum 1/29/2014: Human Rights Committee will meet at least quarterly and as needed to review all HRC restrictions. No other clients were affected by the deficient practice. Responsible parties: Human Rights Committee, Area Director, Program Director and Home Manager</p>	01/18/2014			

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W000126	<p>should be restricted contingent up on her behaviors. The ISP, BSP and/or 12/9/13 IDT note did not include a plan which specifically indicated what client #3 had to do to get the right back to visit her mother. Client #3's 12/9/13 IDT note, 4/28/13 BSP and/or 8/1/13 ISP also did not indicate the facility's Human Rights Committee (HRC) reviewed and/or approved the client's basic right restriction.</p> <p>Interview with Qualified Intellectual Disabilities Professional (QIDP) #1 on 12/11/13 at 1:00 PM indicated client #3's IDT had met and decided that client #3 could not go visit her mother due to the client's behavior. QIDP #1 indicated she did not realize it was rights restriction as the client would be able to go at a later date as the client's behavior improved. QIDP #1 indicated the facility's HRC had not reviewed and/or approved the right's restriction.</p> <p>9-3-2(a) 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 interview and record review</p>	W000126	IDT met on 12/20/2013 for Client # 2 to implement a money	01/18/2014			

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	<p>for 1 of 3 sampled clients (#2), the facility failed to address the client's money management needs.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 12/11/13 at 8:40 AM. Client #2's 1/1/13 Risk Management Plan indicated client #2 was not independent in finances and/or required assistance in completing money transactions.</p> <p>Client #2's 1/1/13 Individual Support Plan (ISP) indicated client #2 was to have a formal training objective in regard to "money."</p> <p>Client #2's December 2013 program/goal sheets indicated the client did not have a formal money management objective.</p> <p>Interview with QIDP #1 on 12/11/13 at 1:00 PM indicated she had recently started as the QIDP for the group home. QIDP #1 indicated client #2 was to have a money objective to identify coins. QIDP #1 stated "I am still developing the objective."</p> <p>9-3-2(a)</p>		<p>management goal. Staff were trained on 1/8/2014 and the goal for Client #2 was implemented on 1/9/2014. Program Director will review goals on a monthly basis and monitor for success or make necessary revisions to ensure the appropriate training goals are being tracked or monitored. Addendum 1/29/2014: No other clients were affected by the deficient practice. Responsible parties: Program Director and Home Manager</p>	

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W000137	<p>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.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (#1), the facility failed to ensure the client had the right and was taught to keep her eyeglasses in a safe place which did not involve the facility locking the items.</p> <p>Findings include:</p> <p>During the 12/11/13 observation period between 6:00 AM and 7:55 AM, at the group home client #1's eyeglasses were in the locked medication cabinet of the office area. Staff #2 handed client #1 her eyeglasses for the day.</p> <p>Client #1's record was reviewed on 12/11/13 at 11:15 AM. Client #1's 1/1/13 Individual Support Plan (ISP) did not indicate client #1 had a need to have her eyeglasses locked. Client #1's ISP and/or 6/24/13 Behavioral Support Plan did not indicate the facility's Human Right Committee (HRC) reviewed and/or approved the locking of client #1's eyeglasses.</p>	W000137	<p>A lock box was purchased on 12/20/2013 for Client #1 to maintain her personal belongings, including eye glasses, and she keeps her own personal key to the lock box. Staff will assist Client #1 as needed to ensure she has access to her personal belongings. Addendum 1/29/2014: No other clients were affected by the deficient practice. Responsible parties: Program Director and Home Manager</p>	01/18/2014			

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W000227	<p>Interview with Qualified Intellectual Disabilities Professional (QIDP) #1 on 12/11/13 at 1:00 PM indicated client #1's eyeglasses were kept locked in the medication cabinet. QIDP #1 indicated client #1 wanted her glasses to be kept in the cabinet. QIDP #1 indicated the facility did not teach client #1 how to keep/maintain her eyeglasses herself. QIDP #1 indicated the locking of client #1's eyeglasses had not been reviewed and/or approved by the facility's HRC.</p> <p>9-3-2(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 2 of 3 sampled clients (#1 and #2), the clients' Individual Support Plans (ISPs) failed to address the clients' identified training and/or behavioral needs.</p> <p>Findings include:</p> <p>1. During the 12/11/13 observation period between 6:00 AM and 7:55 AM, at the group home, client #2 would kick the door frame and/or wall when</p>	W000227	<p>IDT met on 12/20/2013 to update Client #2's Behavior plan to include target behaviors of physical aggression and property destruction, how staff are to respond to each target behavior and which Physical Intervention Alternative (PIA) techniques can be used by staff. Staff trained on 1/8/2014 on new behavior plan. IDT met on 12/20/2013 to update Client #2's ISP, RMAP and goals and to put new goals in place. Client #2's goals, ISP and RMAP revised, staff trained on 1/8/2014 and new ISP and RMAP implemented on 1/9/2014. IDT</p>	01/18/2014

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	<p>prompted by staff to participate in a task or redirection. Client #2 also hit staff #3 in the shoulder area 2 different times and threw herself on staff #3 while the staff person was sitting on the couch.</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 12/10/13 at 11:57 AM. The facility's 12/6/13 reportable incident report indicated client #2 "initiated a physical altercation with [client 5]..." The reportable incident report indicated client #2 hit client #5 with "...closed fists at [client #5's] head..." as client #5 was sitting down. The reportable incident report indicated client #5 blocked her blows.</p> <p>Client #2's record was reviewed on 12/11/13 at 8:40 AM. Client #2's Behavioral Narrative Notes indicated the following (not all inclusive):</p> <p>-12/8/13 Client #2 threw her Boost (dietary supplement) and medications at the wall in the medication room.</p> <p>-12/7/13 "[Client #2] in living room w/ (with) peers, talking. Then [client #2] kicked table door that's below TV. [Client #2] kicked the table door for no apparent reason (other than attention)..." The narrative indicated staff redirected</p>		<p>met on 12/20/2013 to update Client #1's Behavior plan to include needed target behavior of physical aggression, how staff are to respond to each target behavior and which Physical Intervention Alternative (PIA) techniques can be used by staff. Staff trained on 1/8/2014 on new behavior plan. Addendum 1/29/2014: Program Director and Behavior Specialist will review plans at least quarterly and make necessary revisions as needed. No other clients were affected by the deficient practice. Responsible parties: Behavior Specialist and Program Director</p>				

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	<p>client #2 to her room but client #2 refused to go. The note indicated client #2 hit the wall and knocked down decorations off the wall.</p> <p>-12/6/13 "[Client #2] was walking by another peer to go over to the table to color.. [Client #2] as walking over said to a peer I'll hit you and started hitting with her fist. He put up his hands to block her. Staff separated [client #2] from other peer by getting between her and he (sic) who was sitting on a chair...."</p> <p>-12/4/13 "[Client #2] told staff earlier in the evening she was going to hit her peer (client #5). Client #5 walked into living room where peer was watching TV and she started hitting him. He put his hands up to block his face. I heard [client #2] saying I'll hit you and started swinging at his face...."</p> <p>-12/3/13 Client #2 hit walls and file cabinets when she became upset.</p> <p>Client #2's 11/16/12 interdisciplinary team (IDT) meeting note indicated "IDT agrees that [client #2's] targeted behaviors will be as follows and will be addressed in the following ways: -Verbal Aggression: Redirect client to another activity.</p>			

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	<p>-Physical Aggression, Property Destruction, SIB (self-injurious behavior): Verbal redirect if possible; Physical Intervention Alternatives (PIA-physical restraint techniques) if client is at risk of harming self or others."</p> <p>Client #2's 6/10/13 Behavioral Support Plan (BSP) indicated client #2's targeted behavior was "Questioning/Echolalia." Client #2's 6/10/13 BSP did not include and/or address physical aggression and/or property destruction. Client #2's BSP did not include any reactive and/or proactive strategies for the client's identified behavior with specific behavioral objectives.</p> <p>Interview with Qualified Intellectual Disabilities Professional #1 on 12/11/13 at 1:00 PM indicated facility staff should redirect and block using PIA interventions when client #2 demonstrated physical aggression and/or property destruction. QIDP #1 indicated client #2's BSP did not address the client's identified behavioral needs in regard to including proactive and reactive strategies/behavioral objectives.</p> <p>2. Client #2's record was reviewed on 12/11/13 at 8:40 AM. Client #2's December 2013 program/goal sheets</p>			

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	<p>indicated the client had the following training objectives:</p> <ul style="list-style-type: none"> -to "appropriately" attend a community outing once a week -to complete her laundry chore once a week with 3 or fewer verbal prompts -to identify each of her medications she takes with 3 or fewer prompts. Client #2's program/goal sheets did not indicate client #2 had any additional training objectives. <p>Client #1's 1/1/13 ISP indicated client #2 was to have formal training objectives in regard to meal preparation, money hygiene, chores and laundry in addition to the above mentioned objectives.</p> <p>Interview with QIDP #1 on 12/11/13 at 1:00 PM indicated she had recently started as the QIDP for the group home. QIDP #1 indicated client #2's objectives needed to be redone to match the client's ISP.</p> <p>3. The facility's reportable incident reports and/or investigations were reviewed on 12/10/13 at 11:57 AM. The facility's 12/5/13 reportable incident report indicated client #1 got into a "physical altercation" with client #3. The reportable incident report indicated client #1 hit client #3 "...at least 4 times</p>						

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	<p>with an open hand toward her head (client #3)...."</p> <p>Client #1's record was reviewed on 12/11/13 at 11:15 AM. Client #1's 12/2/13 Daily Support Record (DSR) indicated client #1 hit a client in the van.</p> <p>Client #1's March 2013 Behavioral Supports Monthly Service Notes indicated on 3/25/13, client #1 demonstrated verbal aggression, "runs away," property destruction and threw her dishes, a broom and a mop at staff. The note indicated "...It took 30 minutes of destroying the kitchen till she wore herself [out]...."</p> <p>Client #1's 6/24/13 BSP indicated client #1 received Invega 6 milligrams daily for "agitation/aggression" and Tenex for "anger." Client #1's BSP indicated client #1's targeted behaviors were verbal aggression, elopement and non-compliance. Client #1's BSP indicated facility staff could utilize PIA techniques/physical restraints. The BSP indicated "...Physical restraints should only be used for 10 minute intervals (these should be used ONLY when physical aggression will likely result in physical harm to himself, others, or when property destruction might affect peoples' health and safety otherwise use</p>						

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W000264	<p>blocking/avoidance...." Client #1's BSP did not specifically address client #1's physical aggression.</p> <p>Interview with QIDP #1 on 12/11/13 at 1:00 PM indicated client #1 received the behavioral medication Invega for physical aggression. QIDP #1 indicated client #1 did not have a behavior plan for physical aggression.</p> <p>9-3-4(a)</p> <p>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.</p> <p>Based on observation, interview and record review for 2 of 3 sampled clients (#1 and #3), the facility failed to have its Human Rights Committee (HRC) review and/or approved the facility's practice of restricting a client's right to see her mother and a client's right to keep/maintain her eyeglasses.</p> <p>Findings include:</p> <p>1. Interview with client #3 on 12/10/13</p>	W000264	<p>IDT meeting held on 12/20/2013 for Client #3 to lift the HRC restriction that was obtained on 12/12/13. Home visits with Client #3's mother are not contingent on Client #3's behaviors. A lock box was purchased on 12/20/2013 for Client #1 to maintain her personal belongings, including eye glasses, and she keeps her own personal key to the lock box. Staff will assist Client #1 as needed to ensure she has access to her personal belongings. Program Directors</p>	01/18/2014

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	<p>at 2:30 PM indicated client #3 would not be able to go home/visit her mother unless she earned it.</p> <p>Client #3's record was reviewed on 12/11/13 at 9:49 AM. Client #3's 12/9/13 interdisciplinary team (IDT) note indicated "IDT met to discuss [client #3's] (increase) in verbal aggression and behaviors. [Client #3] wants to visit mom, knowing it is contingent on behaviors due to staff having to drive and supervise visit 4 hours to [name of city]. IDT agreed her outburst that have (sic) occurred over weekend regarding cigarettes that she would not have the privilege until behaviors decrease...."</p> <p>Client #3's 4/28/13 Behavioral Support Plan (BSP) and/or 8/1/13 Individual Support Plan (ISP) did not indicate client #3's right to visit her mother should be restricted contingent up on her behaviors. Client #3's 12/9/13 IDT note, 4/28/13 BSP and/or 8/1/13 ISP did not indicate the facility's HRC reviewed and/or approved the client's basic right restriction.</p> <p>Interview with Qualified Intellectual Disabilities Professional (QIDP) #1 on 12/11/13 at 1:00 PM indicated client #3's IDT had met and decided that client</p>		<p>were retrained on 1/10/2014 in regards to the Interdisciplinary Team (IDT) and Human Rights Committee (HRC). Client's plans will be updated as changes occur and reviewed annually for revisions. HRC will meet quarterly to review restrictions. Addendum 1/29/2014: Program Director will review plans at least quarterly and make necessary revisions as needed. No other clients were affected by the deficient practice. Human Rights Committee will meet at least quarterly and as needed to review all HRC restrictions. Responsible parties: Human Rights Committee, Area Director and Program Director</p>				

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	<p>#3 could not go visit her mother due to the client's behavior. QIDP #1 indicated she did not realize it was rights restriction as the client would be able to go at a later date as the client's behavior improved. QIDP #1 indicated the facility's HRC had not reviewed and/or approved the right's restriction.</p> <p>2. During the 12/11/13 observation period between 6:00 AM and 7:55 AM, at the group home client #1's eyeglasses were in the locked medication cabinet of the office area. Staff #2 handed client #1 her eyeglasses for the day.</p> <p>Client #1's record was reviewed on 12/11/13 at 11:15 AM. Client #1's 1/1/13 Individual Support Plan (ISP) did not indicate client #1 had a need to have her eyeglasses locked. Client #1's ISP and/or 6/24/13 Behavioral Support Plan did not indicate the facility's HRC reviewed and/or approved the locking of client #1's eyeglasses.</p> <p>Interview with Qualified Intellectual Disabilities Professional (QIDP) #1 on 12/11/13 at 1:00 PM indicated client #1's eyeglasses were kept locked in the medication cabinet. QIDP #1 indicated the locking of client #1's eyeglasses had not been reviewed and/or approved by the facility's HRC.</p>			

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W000312	<p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 3 of 3 sampled clients (#1, #2 and #3) on behavioral medications, the facility failed to ensure drugs used to address clients' behaviors were incorporated into the clients' behavior plans and/or included active treatment programs which addressed the behaviors for which the medications were prescribed.</p> <p>Findings include:</p> <p>1. Client #3's record was reviewed on 12/11/13 at 9:59 AM. Client #3's 10/29/13 physician's orders indicated client #3 received Sertraline HCL 100 milligrams 2 tablets at bed time and Trazodone 150 milligrams at bed time for Depression.</p> <p>Client #3's 4/28/13 Behavioral Support Plan (BSP) indicated client #3 demonstrated "Resistance to Instruction," "Emotional Outbursts" and</p>	W000312	<p>IDT meetings were held for Clients #1, #2 and #3 on 12/20/2013 to review the behavior plans for necessary changes. Behavior plans have been updated to ensure the medication list, target behaviors, staff response and staff tracking forms are accurate. Staff were trained on the new plans for Clients #1, #2 and #3 on 1/8/2014. Addendum 1/29/2014: Program Director and Behavior Specialist will review plans at least quarterly and make necessary revisions as needed. No other clients were affected by the deficient practice. Responsible parties: Behavior Specialist and Program Director</p>	01/18/2014			

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	<p>false reporting. Client #3's 4/28/13 BSP and/or 8/1/13 Individual Support Plan (ISP) did not indicate client #3 had an active treatment program for Depression and/or a plan of reduction based on the client's behavior for which the client received the medication.</p> <p>Interview with Qualified Intellectual Disabilities Professional (QIDP) #1 on 12/11/13 at 1:00 PM indicated client #3 did not have an active treatment program for Depression. QIDP #1 stated "Nothing except for what is in the behavior plan."</p> <p>2. Client #2's record was reviewed on 12/11/13 at 8:40 AM. Client #2's 12/1/13 physician's orders indicated client #2 received Seroquel 25 milligrams at bed time for "mood/sleep" and Klonopin 0.5 milligrams three times a day for anxiety.</p> <p>Client #2's 6/10/13 BSP indicated client #2 did not have an active treatment program which addressed client #2's mood/sleep. Client #2's BSP indicated client #2 was not on any behavioral medications. Client #2's BSP did not include the use of the Klonopin and/or Seroquel and/or include a plan of reduction based on the behaviors for which the client received the</p>			

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	<p>medications.</p> <p>Interview with QIDP #1 on 12/11/13 at 1:00 PM indicated the facility tracked client #2's sleep pattern at night. QIDP indicated client #2's sleeping at night had improved. QIDP #1 indicated the medications were not part of the client's BSP with a plan of reduction based on the behaviors for which the medications were prescribed. QIDP #1 indicated client #1's BSP did not include an active treatment program which addressed the client's mood and/or sleep.</p> <p>3. Client #1's record was reviewed on 12/11/13 at 11:15 AM. Client #1's 6/24/13 BSP indicated client #1 received Invega 6 milligrams daily for "agitation/aggression" and Tenex for "anger." Client #1's BSP indicated client #1's targeted behaviors were verbal aggression, elopement and non-compliance. Client #1's BSP did not include an active treatment program for physical aggression.</p> <p>Interview with QIDP #1 on 12/11/13 at 1:00 PM indicated client #1 received the behavioral medication Invega for physical aggression. QIDP #1 indicated client #1 did not have a behavior plan/active treatment program for physical aggression.</p>			

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W000488	<p>9-3-5(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation, interview and record review for 3 of 3 sampled clients (#1, #2, and #3) and for 2 additional clients (#4 and #6), the facility failed to ensure each participated in the meal preparation and/or served themselves accordingly.</p> <p>Findings include:</p> <p>During the 12/11/13 observation period between 6:00 AM and 6:01 AM, at the group home, staff #3 placed english muffins and bread in a toaster without encouraging clients #1, #2, #3 and #6 to make their own english muffin and/or toast for the breakfast meal. Staff #3 poured clients #1, #2, #3, #4 and #6's milk without allowing the clients to pour their own milk. Staff #3 carried the milk to the table and placed it at each client's setting.</p> <p>Client #1's record was reviewed on 12/11/13 at 11:15 AM. Client #1's 1/1/13 Individual Support Plan (ISP) indicated client #1 had an objective to</p>	W000488	<p>Staff were retrained on 12/17/2013 regarding family style dining and meal preparation. Management staff will do documented mealtime observations twice a week for four weeks to ensure clients are participating in the meal preparation and/ or serving themselves accordingly. Addendum 1/29/2014:The Home Manager is in the home several times a week and will ensure that clients are participating in the meal preparation and/ or serving themselves accordingly on a regular basis. The Program Director is in the home several times a month and will ensure that clients are participating in the meal preparation and/ or serving themselves accordingly on a regular basis. Responsible parties: Home Manager and Program Director</p>	01/18/2014

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	<p>increase meal preparation.</p> <p>Interview with Qualified Intellectual Disabilities Professional (QIDP) #1 on 12/11/13 at 1:00 PM indicated clients #1, #2, #3, #4, and #6 were capable of preparing their own english muffin or toast and could pour their own milk.</p> <p>9-3-8(a)</p>			