

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/09/2013
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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
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W000000	<p>This visit was for a pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00132706.</p> <p>Complaint #IN00132706: Substantiated. Federal and state deficiencies related to the allegations are cited at W102, W104, W122, W125, W149, W153, W154, W156, W159, W209, W210, W218, W227, W249, W250, W252, W259, W312, W318, W322, W323, W331, W368, W436, W440, W454, W460, W473, W480 and W9999.</p> <p>Dates of Survey: July 30, 31, August 1, 2 and 9, 2013.</p> <p>Facility Number: 001194 Provider Number: 15G628 AIMS Number: 100245710</p> <p>Surveyors: Claudia Ramirez, RN - Team Leader Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/16/13 by Ruth Shackelford, QIDP.</p>	W000000		

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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W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H). The governing body failed: To ensure the staff immediately reported abuse, neglect and mistreatment to the administrator; to develop a system/policy and procedure which ensured the facility conducted complete and thorough investigations of all allegations of abuse/neglect/mistreatment/exploitation for clients A, B, C, D, E, F, G and H; to implement its policy and procedures to prevent potential neglect and/or abuse of clients to ensure a staff person, who had allegations of abuse/neglect and/or concerns in regard to resident care against them, was monitored to ensure clients A, B, C, D, E, F, G and H were protected from further incidents of neglect, abuse and/or mistreatment; to ensure clients A, B, C, D, E, F, G and H received health care services timely for their medical needs; to implement policies and procedures which prohibited client neglect, abuse, mistreatment and exploitation; to ensure the clients' home</p>	W000102	In regard to W0102, An updated policy for Reporting Abuse, Neglect and Exploitation has been completed. Updated procedures to ensure that staff are trained to identify, report and document incidents of abuse, neglect or exploitation is being written. Updated procedures on completing thorough investigations is being written. A policy for Clients providing medical care to other clients has been written and is in place. Monthly site checklists are in place to ensure that any repairs needed in the home are being done, they are reviewed in safety committee bi-monthly meeting. Action plan and responsible person is assigned. Safety Committee chair is responsible for follow up. Current repairs needed will be completed. An updated policy for Medication Administration is being written. Procedures for this policy will include scheduling of health care services for all clients and guidelines for completion of assessments. To correct the specific consumer health care and medical needs deficits, the Director of Programming and Nurse will implement a weekly chart audit process. This will ensure that all medical	09/06/2013			

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	<p>was maintained and in good repair and to ensure clients were not providing medical care for their housemates.</p> <p>Findings include:</p> <p>1. Please refer to W122 the Condition of Participation: Client Protections for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), for the Governing Body's failure: ___ To ensure the staff immediately reported abuse, neglect and mistreatment to the administrator. ___ To develop a system/policy and procedure which ensured the facility conducted complete and thorough investigations of all allegations of abuse/neglect/mistreatment/exploitation for clients A, B, C, D, E, F, G and H. ___ To implement its policy and procedures to prevent potential neglect and/or abuse of clients to ensure a staff person, who had allegations of abuse/neglect and/or concerns in regard to resident care against them, was monitored to ensure clients A, B, C, D, E, F, G and H were protected from further incidents of neglect, abuse and/or mistreatment.</p> <p>2. Please see W318. The governing body failed to meet the Condition of Participation: Health Care Services for 4 of 4 sampled clients (clients A, B, C and</p>		<p>appointments, documentation and follow-ups and documentation are in place. Any appointments that are missed will result in disciplinary action for staff if prior approval has not been received from the Director of Programming. The nurse is implementing new nursing protocols to ensure assessments and tracking of needed information based on assessments is completed. Weekly chart audits will be completed on tracking sheets. All staff who work with these consumers will be trained and the nurse will implement in-service trainings at monthly staff meetings. All of these systemic changes will be monitored by the Leadership Team and it is the Executive's Director's responsibility to ensure that all pieces of the plan is maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. It is the responsibility of the Director of Programming to directly supervise the staff to ensure they are maintaining their jobs within this system. This will occur in individual supervision as well as Group Home staff meetings; each of which will take place monthly and will be documented. In regard to a letter dated 9/10, ASI did have policies and procedures in place to prevent and investigate allegations of abuse/neglect/exploitation. The</p>		

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	<p>D) and 4 additional clients (clients E, F, G and H). The governing body failed to ensure the clients received health care services for their medical needs: by failing to obtain a yearly physical for client C; by failing to obtain physician ordered laboratory tests for clients C and D; by failing to ensure client C had a plan for when she was to be out of the wheelchair and when she was to use her walker; by failing to obtain an updated PT (Physical Therapy) reassessment for client C; by failing to obtain a wheelchair reassessment for client C; by failing to monitor and document the skin integrity of clients C and D; by failing to obtain an ophthalmic appointment for client D; by failing to ensure client B and D's prescribed diets were followed and menu portion size addressed; by failing to obtain a PT evaluation for client D's unsteady gait; by failing to have a fall risk plan for client D; by failing to have completed a fall risk assessment for client H and by failing to have a fall risk plan for client H.</p> <p>3. Please refer to W104 for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H) for the Governing Body's failure to exercise general operating direction over the facility by failing: __ To implement policies and procedures</p>		<p>agency also had a process in place for investigating injuries of unknown origin and consumer to consumer abuse. The system failed in the instances cited in this W for a few reasons: 1. Incident Reports were not being submitted to the appropriate staff in a timely manner; and 2. Due to the delay in reporting, the QIDP/Director were not able to conduct a timely and thorough investigations. To address these issues, ASI has revamped its Incident Reporting process for all Group Homes. Any time an Incident Report is written, the DSP must call the Programming Coordinator, QIDP, and Nurse to report the incident. This begins the notification process for them in case a BDDS report is required or an investigation must be initiated. These individuals are on-call 24-7. The Incident Report is then electronically scanned to these same persons so that the paperwork process follows their actions. There is no opportunity for delay in an investigation process with this notification system. If it is an investigation of unknown injury or consumer to consumer abuse, the QIDP and Nurse conduct the investigation. ASI has up-dated the report format of this document to ensure it is more complete. If the allegation involves staff abuse, the Director is notified and she/he initiates the investigation. Staff are immediately suspended in</p>				

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	<p>which prohibited client neglect, abuse, mistreatment and exploitation. ___To ensure the clients' home was maintained and in good repair. ___To ensure clients were not providing medical care for their housemates.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-1(a)</p>		<p>these instances. The policy, procedure, and form for investigating allegations of abuse/neglect/exploitation have been up-dated to address the timeliness and thoroughness of the investigation. When a Director initiates an investigation, she will email the Executive Director with the staff's name and brief description of the allegation. When the investigation is complete, a second email will be send to the ED for him to ensure it is completed in a timely manner. This also ensures that he has been informed and is up-to-date on any allegations. In addition, the Quality Assurance Committee is tracking all staff investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. In regard to allegations of unknown injury or consumer to consumer abuse, the investigating QIDP will send an email to the ED upon the initiation of an investigation as well as at the conclusion of the investigation so that he is able to monitor the timeliness of these events.ASI created a new policy called "Consumers providing medical treatment" which clarifies that consumers are not ever to be put in a position to deliver care to other consumers. This had not been explicitly stated to staff creating an opportunity for them</p>		

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			to use their own discretion. This has been added to the new employee orientation training. ASI has up-dated its frequency of the Site Checks to be done weekly rather than monthly as was the prior procedure. This will ensure that concerns are identified and addressed in a more timely manner. These are given to the Programming Coordinator to address emergency issues. These are then reviewed at the bi-monthly Safety Committee meetings to ensure that the issues identified have been addressed.		

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), the facility's governing body failed to exercise general policy and operating direction over the facility:</p> <p>___ To ensure the facility implemented/developed its written policy and procedures to ensure the facility immediately reported all allegations of abuse/neglect/mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) and APS (Adult Protective Services) in accordance with state law. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse/neglect/mistreatment/exploitation were thoroughly investigated.</p> <p>___ To ensure a staff person, who had previous allegations of abuse/neglect/exploitation/mistreatment was monitored to ensure clients A, B, C, D, E, F, G and H were protected from further incidents of abuse, neglect, exploitation and/or mistreatment.</p> <p>___ To ensure clients were not providing</p>	W000104	<p>In regard to W0104, An updated policy for Reporting Abuse, Neglect and Exploitation has been completed. Updated procedures to ensure that staff are trained to identify, report and document incidents of abuse, neglect or exploitation is being written. Updated procedures on completing thorough investigations is being written and includes immediate staff suspension upon any allegation of abuse, neglect or exploitation. A policy for Clients providing medical care to other clients has been written and is in place. Monthly site checklists are in place to ensure that any repairs needed in the home are being done, they are reviewed in safety committee bi-monthly meeting. Action plan and responsible person is assigned. Safety Committee chair is responsible for follow up. Current repairs needed will be completed. Sharp objects are available to consumers. An updated policy for Medication Administration is being written. Procedures for this policy will include scheduling of health care services for all clients and guidelines for completion of assessments. To correct the specific consumer health care</p>	09/06/2013

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	<p>medical care.</p> <p>__ To ensure the clients' home was maintained and in good repair.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 7/30/13 between 3:15 PM and 5:30 PM. During a walk through of the home with staff #1, the following was observed:</p> <p>__ The fluorescent light in the shower bath was burned out, leaving no other light for clients A, B, C, D, E, F, G and H to use in the shower/bathroom.</p> <p>__ The seat of the shower chair was cracked and peeling.</p> <p>__ The pad of the pull down shower seat/shelf that was attached to the shower wall was cracked and broken. The pad was beige in color with streaks of brown and black. On 07/30/13 at 4:00 PM, an interview with staff #1 was conducted. Staff #1 stated, "I think it's mold. It's dirty and disgusting." Staff #1 stated, "I think it's dangerous and just needs to be removed. I don't think anyone uses it."</p> <p>__ Thirteen large tiles were missing on the floor in the laundry room.</p> <p>__ A strip of metal below the stove was broken and rusted. Staff #1 was interviewed on 07/30/13 at 4:45 PM and stated the stove "sometimes overheats and smokes everything up. We have had to</p>		<p>and medical needs deficits, the Director of Programming and Nurse will implement a weekly chart audit process. This will ensure that all medical appointments, documentation and follow-ups and documentation are in place. Any appointments that are missed will result in disciplinary action for staff if prior approval has not been received from the Director of Programming. The nurse is implementing new nursing protocols to ensure assessments and tracking of needed information based on assessments is completed. Weekly chart audits will be completed on tracking sheets. All staff who work with these consumers will be trained and the nurse will implement in-service trainings at monthly staff meetings. All of these systemic changes will be monitored by the Leadership Team and it is the Executive's Director's responsibility to ensure that all pieces of the plan is maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. It is the responsibility of the Director of Programming to directly supervise the staff to ensure they are maintaining their jobs within this system. This will occur in individual supervision as well as Group Home staff meetings; each of which will take place monthly and will be documented. In regard</p>		

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	<p>evacuate before because the stove overheated."</p> <p>__ Client G had a sheet draped across his window. Staff #1 was interviewed on 07/30/13 at 3:30 PM and indicated client G did not have drapes for his window.</p> <p>__ Client B was missing a door knob on her closet door. Staff #1 was interviewed on 07/30/13 at 3:50 PM and indicated she was not sure why client B did not have a door knob on her closet door.</p> <p>On 07/30/13 at 4:50 PM an interview with staff #1 indicated all repairs were reported to the TL (Team Leader) and the HM (manager). Staff #1 stated the laundry tiles, the broken shower chair, the shower seat and the stove had been in need of repair "for a long time." Staff #1 indicated the TL was aware of the needed repairs in the group home.</p> <p>2. The facility's reportable records and investigative records for July 2012 through July 2013 were reviewed on 7/30/13 at 1:30 PM and again on 7/31/13 at 11 AM. A BDDS (Bureau of Developmental Disabilities Services) report of 12/9/12 at 11:55 PM indicated client E was using scissors to cut the tape off the end of a baseball bat. The report indicated the scissors slipped and "the end of the scissors went through [client E's] left ring finger, when going completely</p>		<p>to a letter dated 9/10, ASI did have policies and procedures in place to prevent and investigate allegations of abuse/neglect/exploitation. The agency also had a process in place for investigating injuries of unknown origin and consumer to consumer abuse. The system failed in the instances cited in this W for a few reasons: 1. Incident Reports were not being submitted to the appropriate staff in a timely manner; and 2. Due to the delay in reporting, the QIDP/Director were not able to conduct a timely and thorough investigations. To address these issues, ASI has revamped its Incident Reporting process for all Group Homes. Any time an Incident Report is written, the DSP must call the Programming Coordinator, QIDP, and Nurse to report the incident. This begins the notification process for them in case a BDDS report is required or an investigation must be initiated. These individuals are on-call 24-7. The Incident Report is then electronically scanned to these same persons so that the paperwork process follows their actions. There is no opportunity for delay in an investigation process with this notification system. If it is an investigation of unknown injury or consumer to consumer abuse, the QIDP and Nurse conduct the investigation. ASI has up-dated the report format of this document to ensure</p>				

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	<p>through that fingertip, the tip of the scissors punctured the base of the left thumb." The report indicated client E went to the staff and asked for a band-aid when the staff noticed the amount of blood and severity of the wounds, "she asked housemate [client A] who is CPR/First Aid certified, to assist in applying pressure" while the staff called the manager. The manager instructed the staff to call 911.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/1/13 at 11 AM indicated the facility did not have a policy in regard to clients providing health care to other clients. The QIDP indicated client A was CPR certified upon the client's request and it was not meant to provide health care for his housemates. The QIDP indicated the staff should have applied the pressure and called 911 or had client A call 911. The QIDP indicated the clients were not to be providing medical care for other clients unless it is a life or death situation.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility: __To ensure all allegations of abuse/neglect/exploitation were reported immediately to the administrator, to the Bureau of Developmental Disabilities</p>		<p>it is more complete. If the allegation involves staff abuse, the Director is notified and she/he initiates the investigation. Staff are immediately suspended in these instances. The policy, procedure, and form for investigating allegations of abuse/neglect/exploitation have been up-dated to address the timeliness and thoroughness of the investigation. When a Director initiates an investigation, she will email the Executive Director with the staff's name and brief description of the allegation. When the investigation is complete, a second email will be send to the ED for him to ensure it is completed in a timely manner. This also ensures that he has been informed and is up-to-date on any allegations. In addition, the Quality Assurance Committee is tracking all staff investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. In regard to allegations of unknown injury or consumer to consumer abuse, the investigating QIDP will send an email to the ED upon the initiation of an investigation as well as at the conclusion of the investigation so that he is able to monitor the timeliness of these events. ASI created a new policy called "Consumers providing medical treatment" which clarifies</p>				

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	<p>Services (BDDS) per 460 IAC 9(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 in accordance with state law, were thoroughly investigated for clients A, B, C, D, E, F, G and H and to ensure the results of all investigations were reported to the administrator within 5 working days from the date of knowledge of the abuse/neglect/exploitation for client A.</p> <p>___ To ensure a staff person, who had previous allegations of abuse/neglect/exploitation/mistreatment, was monitored to ensure clients A, B, C, D, E, F, G and H were protected from further incidents of abuse/neglect/exploitation/mistreatment for clients A, B, C, D, E, F, G and H. Please see W149.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure all incidents of abuse, neglect and/or mistreatment were reported immediately to the administrator and to BDDS and APS for clients A, B, C, D, E, F, G and H. Please see W153.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure all incidents of abuse/neglect/mistreatment/exploitation were thoroughly investigated for clients A, B, C, D, E, F, G and H. Please see</p>		<p>that consumers are not ever to be put in a position to deliver care to other consumers. This had not been explicitly stated to staff creating an opportunity for them to use their own discretion. This has been added to the new employee orientation training. ASI has up-dated its frequency of the Site Checks to be done weekly rather than monthly as was the prior procedure. This will ensure that concerns are identified and addressed in a more timely manner. These are given to the Programming Coordinator to address emergency issues. These are then reviewed at the bi-monthly Safety Committee meetings to ensure that the issues identified have been addressed.</p>		

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	<p>W154.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-1(a)</p>				

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H). The facility failed to implement its written policies and procedures:</p> <p>__ To prevent neglect/abuse/mistreatment/exploitation of clients A, B, C, D, E, F, G and H.</p> <p>__ To ensure all allegations of abuse/neglect/mistreatment/exploitation were thoroughly investigated.</p> <p>__ To ensure a staff person, who had previous allegations of abuse/neglect/exploitation/mistreatment, was monitored to ensure clients A, B, C, D, E, F, G and H were protected from further incidents of abuse/neglect/exploitation/mistreatment.</p> <p>__ To ensure all allegations of abuse were reported immediately to the administrator in accordance with state law.</p> <p>__ To ensure the results of all investigations were reported to the administrator within 5 working days from the date of incident or allegation.</p> <p>__ To ensure the clients in the group home had freedom to access the knives/sharps.</p>	W000122	<p>In regard to W-0122, an updated policy for Reporting Abuse, Neglect and Exploitation has been completed. Updated procedures to ensure that staff are trained to identify, report and document incidents of abuse, neglect or exploitation is being written. Updated procedures on completing thorough investigations is being written and includes immediate staff suspension upon any allegation of abuse, neglect or exploitation. In regard to W-125 Sharp objects are available to consumers. All Abuse, Neglect and Exploitation procedures will be monitored by the Leadership Team and it is the Executive's Director's responsibility to ensure that all pieces of the plan is maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. In regard to a letter dated 9/10, ASI did have policies and procedures in place to prevent and investigate allegations of abuse/neglect/exploitation. The agency also had a process in place for investigating injuries of unknown origin and consumer to consumer abuse. The system failed in the instances cited in this W for a few reasons: 1. Incident Reports were not being submitted to the appropriate staff in a timely</p>	09/06/2013			

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure client A's, B's, C's, D's, E's, F's and G's rights in regard to restricting the clients from access to the sharps. Please see W125. 2. The facility neglected to implement its policy and procedures to ensure the facility staff immediately reported all allegations of abuse/neglect to the administrator and neglected to implement its policy and procedures to conduct thorough investigations in regard to allegations of neglect, abuse, mistreatment and/or exploitation for clients A, B, C, D, E, F, G and H. The facility neglected to implement its policy and procedures to ensure results of investigations were reported to the administrator with 5 working days for client A. Please see W149. 3. The facility failed to ensure all allegations of abuse/neglect/mistreatment were reported immediately to the administrator in accordance with state law for clients A, B, C, D, E, F, G and H. Please see W153. 4. The facility failed to provide evidence of an investigation and/or evidence of a thorough investigation in regard to 		<p>manner; and 2. Due to the delay in reporting, the QIDP/Director were not able to conduct a timely and thorough investigations. To address these issues, ASI has revamped its Incident Reporting process for all Group Homes. Any time an Incident Report is written, the DSP must call the Programming Coordinator, QIDP, and Nurse to report the incident. This begins the notification process for them in case a BDDS report is required or an investigation must be initiated. These individuals are on-call 24-7. The Incident Report is then electronically scanned to these same persons so that the paperwork process follows their actions. There is no opportunity for delay in an investigation process with this notification system. If it is an investigation of unknown injury or consumer to consumer abuse, the QIDP and Nurse conduct the investigation. ASI has up-dated the report format of this document to ensure it is more complete. If the allegation involves staff abuse, the Director is notified and she/he initiates the investigation. Staff are immediately suspended in these instances. The policy, procedure, and form for investigating allegations of abuse/neglect/exploitation have been up-dated to address the timeliness and thoroughness of the investigation. When a Director initiates an investigation, she will</p>				

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	<p>allegations of abuse, neglect, mistreatment and exploitation for clients A, B, C, D, E, F, G and H. Please see W154.</p> <p>5. The facility failed to report the results of the investigations to the administrator within 5 working days from the date of incident of client to client abuse for client A. Please see W156.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-2(a)</p>		<p>email the Executive Director with the staff's name and brief description of the allegation. When the investigation is complete, a second email will be send to the ED for him to ensure it is completed in a timely manner. This also ensures that he has been informed and is up-to-date on any allegations. In addition, the Quality Assurance Committee is tracking all staff investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. In regard to allegations of unknown injury or consumer to consumer abuse, the investigating QIDP will send an email to the ED upon the initiation of an investigation as well as at the conclusion of the investigation so that he is able to monitor the timeliness of these events.</p>				

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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 citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (A, B, C and D) and 3 additional clients (E, F and G), the facility failed to ensure the clients' rights in regard to restricting the clients from access to the sharps.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/30/13 between 3:15 PM and 5:30 PM. The sharp knives were in a container in the kitchen cabinet above the stove/microwave. The cabinet was out of reach for clients C, D and F.</p> <p>Client A's record was reviewed on 7/31/13 at 12 PM. Client A's ISP (Individual Support Plan) of 4/23/13 indicated no need to restrict client A from sharp objects.</p> <p>Client B's record was reviewed on 7/31/13 at 2 PM. Client B's ISP of 4/23/13 indicated no need to restrict client B from sharp objects.</p>	W000125	<p>All consumers are informed of their rights upon admission and annually. All staff are trained on consumers rights during orientation, annual recertification and during med core. Monthly site checks will contain a section of possible rights violations and will be reviewed by safety committee at bi-monthly meetings and oversight of any action needed will be provided by safety chairperson - Director of Programming. All sharps are available to all consumers. In response to a letter dated 9/10, the problem stemmed from staff making individual decisions to restrict access to sharps. To address this issue, staff have been re-trained on consumer rights and that any restrictions cannot be put into place without approval from the Human Rights Committee. In addition, the QIDP have started using a new Comprehensive Functional Assessment on each consumer which is more detailed. It specifically includes an assessment of consumer's safety with sharps. Based on the findings from this assessment,</p>	09/06/2013			

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	<p>The facility's Human Rights Committee (HRC) notes for 2012/2013 were reviewed on 8/1/13 at 2 PM. The HRC notes indicated no need for restriction of the knives for clients A, B, C, D, E, F and G.</p> <p>Interview with client C on 7/30/13 at 4:30 PM stated the knives were in the cupboard above the microwave and "They won't let us have them." Client C indicated she was unable to reach the knives.</p> <p>During interview with staff #1 on 7/30/13 at 4:35 PM, staff #1 stated, "She [client C] has to have help to use the knives." Staff #1 indicated all of the clients in the group home were supposed to ask for help if they wanted a knife and were not to get a sharp knife independently.</p> <p>Interview with client D on 7/30/13 at 4:40 PM indicated he was unable to reach the sharp knives and stated, "We aren't supposed to have them. They keep them out of our reach."</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/1/13 at 11 AM indicated clients A, B, C, D, E, F and G did not have a need to restrict them from the sharps in the group</p>		<p>the QIDP will follow up with HRC for any restrictions that need to be considered. Human Rights will be reviewed as a training topic at each GH's monthly staff meetings. Compliance with consumer rights will be monitored by the QIDP and Program Coordinator when they are in the homes. In response to the letter dated Sept 23rd, how often are the QIDP and PC in the home - ASI has set procedures for unannounced and announced site visits by the nurse, med records assistant, PC, Assistant PC, and QIDP. Each week, three visits to the home will be completed by any of the above. The checks will include an area identified and will rotate between the areas. Areas/Topics include but are not limited to: Medical, Quality Assurance, Dietary, Environmental, Adaptive, and Staffing. Each visit will have a site visitation form to be completed and returned to the Director of Programming. Any immediate safety/jeopardy is to be immediately reported to a Director. The Director of Programming will monitor these site visits and will review them in Quality Assurance Committee meeting that meets at least bi-weekly but mostly weekly.</p>		

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	home. This federal tag relates to complaint #IN00132706. 9-3-2(a)				

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 4 of 4 sample clients (A, B, C, and D) and 4 additional clients (E, F, G and H): The facility neglected to:</p> <p>___ Develop and implement written policies and procedures to ensure all allegations of abuse/neglect/exploitation were reported immediately to the administrator, to the Bureau of Developmental Disabilities Services (BDDS) per 460 IAC 9(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 in accordance with state law, were thoroughly investigated and to ensure the results of all investigations were reported to the administrator within 5 working days from the date of knowledge of the abuse/neglect/exploitation.</p> <p>___ Develop and implement written policies and procedures to ensure a staff person, who had previous allegations of abuse/neglect/exploitation/mistreatment, was monitored to ensure clients A, B, C, D, E, F, G and H were protected from further incidents of abuse/neglect/exploitation/mistreatment.</p> <p>Findings include:</p>	W000149	An updated policy for Reporting Abuse, Neglect and Exploitation has been completed. Updated procedures to ensure that staff are trained to identify, report and document incidents of abuse, neglect or exploitation is being written. Updated procedures on completing thorough investigations is being written and includes immediate staff suspension upon any allegation of abuse, neglect or exploitation. Monitoring of staff to ensure clients are protected from further incidents of abuse neglect or exploitation will be in procedure and will include site checks when staff is working. Monthly client meetings including a Director and Coordinator or other administrative staff that do not work at the site the consumer lives will take place. This will allow consumers to express any concerns/needs at the site, preventing them from feeling uncomfortable saying something about staff that work at their site. Documentation of meetings will be reviewed by Leadership Team at one of the monthly Leadership meetings. QIDP will investigate consumer to consumer abuse allegations and injuries of unknown origin. If the QIDP is not available the Coordinator or	09/06/2013	

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	<p>1. The facility's reportable records and investigative records for July 2012 through July 2013 were reviewed on 7/30/13 at 1:30 PM and again on 7/31/13 at 11 AM.</p> <p>__A 2/8/13 BDDS report indicated on 2/7/13 at 7:20 PM "Staff and consumers [clients A, B, C, D, F, G and H] had just left Special Olympics basketball game at 7:15 pm at the [name of school]. Staff was driving at the speed limit of 55 on state road [name] when staff saw a deer from his left run into the road. Staff put on the brakes but was unable to stop or avoid hitting the deer. Staff hit the deer on the driver's side of the van. The van was not able to be driven after hitting the deer. Staff asked if everyone was alright. Staff called 911 and the house manager [name of staff] arrived at the accident along with [names of Director, Program Coordinator and the Team Lead]. Everyone [clients A, B, C, D, F, G and H] was loaded into separate vehicles and transported home." The investigative record of 2/7/13 indicated client A reported to the Director of the group home that the staff driving the van was texting and driving. Client F reported the staff driving the van had his cell phone plugged in to charge and picked it up to read a text and the deer ran across the road a few seconds later. The investigative report indicated the staff</p>		<p>Nurse can investigate. All investigations will be brought to HRC bi-monthly meetings for oversight and implementation of an action plan. The Director of Programming oversees the HRC meetings and supervises the QIDP. It is her responsibility to monitor compliance with the above. The QIDP maintains these investigations and findings in the client specific files as well as an investigation binder. In response to a letter dated 9/10, when a staff person has been alleged to have participated in some sort of consumer abuse/neglect/exploitation, he/she is immediately suspended from work pending the outcome of the investigation. ASI has up-dated its investigation policy, procedure, and form to ensure that timelines are noted and followed. When a Director initiates an investigation, she will email the Executive Director with the staff's name and brief description of the allegation. When the investigation is complete, a second email will be send to the ED for him to ensure it is completed in a timely manner. This also ensures that he has been informed and is up-to-date on any allegations. In addition, the Quality Assurance Committee is tracking all staff investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5</p>				

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	<p>driving the van was terminated.</p> <p>Review of the TL's (Team Lead's) personnel file on 7/31/13 at 4 PM indicated:</p> <p>__A 9/5/12 verbal warning indicated, "On 09/05/12, I (Director of Community Living) gave a verbal warning to [TL] based on the following concerns: inappropriately using the consumer's products, photos taken and posted them on a co-workers [social media] (internet) page."</p> <p>__An Employee Warning Notice of 12/12/12 indicated, On 11/3/12, during a birthday party at [name of group home] for a consumer, [the TL] showed up to check in cycle meds. [The TL] was clocked in during this time. She [the TL] brought a friend in the home with her into the office and stayed in the office the entire time with the door shut. [The TL] was clocked in for 30 minutes on this day and in the office at the group home with a non staff person who would have seen vital information regarding each consumer in the home and had access to various medications."</p> <p>__An Employee Plan of Correction dated June 10, 2013 indicated the TL "brought alcohol into the home of our consumers without permission from the residence</p>		<p>days. The Executive Director is on this committee. In regard to allegations of unknown injury or consumer to consumer abuse, the investigating QIDP will send an email to the ED upon the initiation of an investigation as well as at the conclusion of the investigation so that he is able to monitor the timeliness of these events.</p>				

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	<p>(sic) and Director. Also, open alcohol was present in her vehicle when she arrived to transport a consumer to urgent care. [The TL] has put her co-workers in a tough situation by asking them to clock her in when she was running late."</p> <p>__An Employee Warning Notice of 6/25/13 indicated, "On June 25, 2013, a consumer came in complaining to [name of staff] that [the TL] was texting on her phone this morning while driving them into work. The consumer informed [name of staff] that [the TL] does this all the time when she is driving the consumers around." The 6/25/13 investigative record indicated "It was reported by consumer [client A] to [the HM (House Manager)] that [the TL] was using her cell phone in the agency van. [The TL] was suspended pending investigation. [The TL] stated that she was using her cell phone at a stop light - she checked her text. She stated that it was not while driving." The investigative report indicated recommendations "that [the TL] receive a written warning because her cell phone should not be accessible while driving or at a stop sign. Her attention needs to be on her surroundings, regardless of whether she is actually driving."</p> <p>No reportable records were provided for the allegations of neglect and exploitation</p>						

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	<p>noted in the TL's personnel file dated 9/5/12, 12/12/12, 6/10/13 and 6/25/13 in regard to clients A, B, C, D, E, F and G. No investigative records were provided for the allegations of neglect and exploitation noted in the TL's personnel file dated 9/5/12, 12/12/12 and 6/10/13 in regard to clients A, B, C, D, E, F and G. The investigative record for the allegation of 6/25/13 indicated no client and/or staff interviews and did not indicate evidence a thorough investigation was conducted.</p> <p>CI (Confidential Interview) #1 stated "Our Lead [name of TL] is rude with the clients [clients A, B, C, D, E, F and G] and she [the TL] uses the F word around them [clients A, B, C, D, E, F and G] all the time." CI #1 stated the TL "is constantly yelling, screaming and cussing at them [clients A, B, C, D, E, F and G]." CI #1 indicated the TL was called to take a client to the doctor and the TL arrived at work with an open can of alcohol in her car. The can of alcohol was disposed of and the TL took the client to the medical appointment using her own vehicle. CI #1 stated, "She [the TL] talks a lot about her divorce and her personal life around the consumers" and "You never know what kind of attitude she's going to be in." CI #1 stated clients A, B, C, D, E, F and G did not like the TL and "just try to stay out of her way." CI #1 indicated she was</p>						

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	<p>aware of an incident when the TL left the group home to go to the store and returned with a bottle of alcohol and put it in the refrigerator in the medication room. CI #1 indicated while transporting the clients, the TL drives over the speed limit, texts and drives and talks on her phone while driving. CI #1 stated clients A, B, C, D, E, F and G do not like for the TL to take them anywhere and "I think, especially [client C] is afraid of her." When asked if these allegations had been reported, CI #1 stated "We've reported to [the HM] and she just tells us that [the TL] is having a bad day and to ignore her [the TL]." CI #1 stated, "She [The HM] says everyone is just picking on her [the TL]." CI #1 indicated the staff were to report all allegations of abuse/neglect/exploitation to the HM and if the HM did nothing about the allegations the staff were to report to the PD (Program Director).</p> <p>CI #2 stated while transporting the clients the TL speeds, texts and talks on her phone while driving, "I know cause I have been in the van with her." CI #2 stated, "The whole time she [the TL] is on shift she goes out and smokes cigarettes and has her ear phones in. She is constantly listening to her music and she brings her personal life into the group home." CI #2 stated, "She [the TL] says the F word a lot</p>			

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	<p>and her music is offensive to listen to." CI #2 stated, "She [the TL] talks about taking a lot of pills that aren't hers and about smoking pot." CI #2 stated "about a week ago [the TL] left the group home around 5:30 PM" prior to the end of her shift, leaving the group home with 1 staff for the evening shift. CI #2 indicated client F had to be taken to work and picked up at 8:30 PM and client E had to be taken to ball practice and back again. CI #2 indicated all of the clients had to go back and forth on the transport trips because the TL had left early, leaving 1 staff to care for the clients and do the transports. CI #2 stated this was reported to the HM, "But nothing was ever done about it." CI #2 indicated the TL was called in on a Sunday to take client D to the doctor. CI #2 stated "She was hung over and had an almost full can of beer in her car. [Client A] and [client B] saw it." CI #2 indicated the TL left the home to buy alcohol and brought it back to the home. CI #2 stated the allegations of abuse/neglect were reported to the HM, "But I don't think anything was done about it."</p> <p>During interview with client B on 7/31/13 at 10 AM, client B stated, "She [the TL] doesn't treat us [clients A, B, C, D, E, F and G] right. She talks to us in a mean way. I don't like her." Client B stated, "She (the TL) told me she doesn't like</p>			

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	<p>me." Client B stated the TL used foul language around the clients in the group home, "often talked about her divorce" and "at times was rude" to the clients in the way she spoke with them. Client B stated, "She (the TL) uses the F word a lot and that offends me." Client B stated when the TL worked, "I just try to stay in my room and away from her because she makes me nervous." Client B indicated while transporting the clients the TL drives above the speed limit and texts and talks on her phone while driving. Client B stated, "It makes me nervous when she does that and I was shaking." When asked if she had reported her concerns to anyone, client B stated "Yes, to the staff and to [the HM]." Client B stated the HM told her to "just tolerate" the TL.</p> <p>During interview with client C on 7/31/13 at 10:50 AM, client C stated the TL was asleep in the recliner this AM and "I would have gotten in trouble if I said anything to her or woke her up. [Staff #4] was also there, sitting in the living room with her. [Staff #4] helped me get dressed. I didn't want [the TL] to help me." Client C stated, "I'm afraid of her [the TL]. She drives too fast and it scares me. I don't like her taking me anywhere and I'm scared when she puts me on the wheelchair lift. I don't trust her doing the wheelchair lift." Client C indicated she</p>				

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	<p>had never been dropped or injured while on the lift, but did not feel secure while the TL was operating the lift. Client C stated, "I don't trust her. I honestly don't. She (the TL) still talks about her divorce all the time and that makes me uncomfortable." Client C stated the TL "says the F word a lot" and was "constantly on her phone or listening to her music. She (the TL) is either outside smoking or she is on her phone." Client C indicated she was in the group home the day the TL brought alcohol into the group home. Client C stated "She (the TL) is mean to us and I don't want her around there anymore. This morning I had goose bumps because she was there and I don't trust her." When asked if she had reported her concerns to anyone, client C stated, "Yes, the staff."</p> <p>During interview with client F on 7/31/13 at 11:10 AM, client F stated the TL had "good days and bad days. I'll joke with her and she goes through mood swings and she'll get short with me and I never know how to take her." Client F indicated the TL used foul language around clients A, B, C, D, E, F and G, talked about her divorce and at times was rude in the way she spoke with clients A, B, C, D, E, F and G. Client F stated, "I was told she (the TL) has had someone else clock in for her so it doesn't look like she is late for work</p>			

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	<p>and I've seen her doing her personal stuff on the computer at work in the office when she was supposed to be taking care of us." Client F indicated while transporting the clients the TL drives above the speed limit and texts and talks on her phone while driving. Client F stated, "She (the TL) told me she can text and drive as long as she doesn't get caught doing it." Client F indicated he was in the van when another staff was texting and driving and the staff hit a deer and wrecked the facility vehicle. Client F stated, "A lot of us don't feel comfortable when she (the TL) is here." When asked if he had reported his concerns to anyone, client F stated "Yes, to the staff and to [the HM]."</p> <p>Interview with client A on 8/1/13 at 3:30 PM indicated while transporting clients A, B, C, D, E, F and G, the TL drives above the speed limit and texts and talks on her phone while driving. Client A stated, "I know she scares [clients B and C] when she does this and that upsets me." Client A stated, "She [the TL] has brought alcohol into the group home, which is not right." Client A stated the TL "uses foul language around us [clients A, B, C, D, E, F and G] and she talks about her divorce which is wrong." Client A stated, "She (the TL) is rude with us sometimes in the way she talks to us."</p>						

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	<p>Client A stated, "She (the TL) spends a lot of her time listening to music, talking on her cell phone or doing personal stuff on the computer when she's supposed to be there for us." Client A stated, "We just try to stay away from her (the TL) when she's there. I just go to my room." When asked if he had reported his concerns to anyone, client A stated, "Yes, the staff and [the HM], but she just said we need to overlook her (the TL)."</p> <p>Interview with the QIDP on 7/30/13 at 1 PM indicated the HM was on vacation. The QIDP indicated the HM reported directly to the PD and she did not over see the HM in regard to the clients in the group home.</p> <p>Interview with the PD and the QIDP on 8/2/13 at 11:30 AM indicated all reportable and investigative records were provided for review. The PD indicated the events in the TL's personnel file were treated as employee disciplinary actions and were not reported/investigated. The PD stated, "I thought the disciplinary action was enough. She (the TL) admitted to her actions, so why would there need to be an investigation?" The PD indicated staff #8 was terminated due to texting and driving. The PD stated the TL was not terminated due to texting and driving while transporting the clients in the group</p>				

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	<p>home "because she was texting while at a stop light and wasn't driving." The QIDP indicated the clients were to report abuse/neglect/exploitation to the DSPs (Direct Support Professionals) and then to the TL. The PD indicated the chain of command in the home to be the DSP, the TL, the HM and then the PD. The QIDP indicated the HM reported directly to the PD and the HM was not her responsibility. When asked who was showing oversight over the group home, the PD stated, "That's a problem." The PD and the QIDP indicated they were aware of the TL texting and driving and bringing alcohol into the home, but were not aware of any further allegations of abuse/neglect/exploitation of the TL in regard to clients A, B, C, D, E, F and G. The PD and the QIDP indicated they did not go to the group home on a regular basis and the HM was to report any problems.</p> <p>2. The facility's reportable and investigative records for July 2012 through July 2013 were reviewed on 7/30/13 at 1:30 PM and again on 7/31/13 at 11 AM.</p> <p>A 9/13/12 BDDS (Bureau of Developmental Disabilities Services) report indicated on 9/12/12 at 2:05 PM client A "was coming out of the break</p>				

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	<p>room into the workshop. A female consumer was following [client A]. [Client A] stated to the female, please leave me alone. [Client A] sat down at a table and stated again to the female to please leave him alone. Staff approached both [client A] and female consumer. Staff asked female consumer to please leave [client A] alone. Female consumer yelled No and picked up [client A's] can of pop and threw it at [client A]. The can hit [client A] in the chest area on the left side.... There was no redness, bruising or cuts seen." The records did not indicate the client to client abuse was investigated.</p> <p>A 9/13/12 IR (Incident Report) indicated at 12:10 PM "This staff whitnessed (sic) female consumer approach [client A] with a can of pop. Due to previous circumstances, this staff started walking to the consumers. This staff heard female consumer say 'youre (sic) not going to look at me,' then [client A] said, 'just sit it on the table please.' Female consumer picked up pop and smashed [client A] in the face with it, then began choking him. This staff got in between consumers and pulled female consumers fingers and hands off of [client A's] neck. Supervisor was on other side of prevo [pre-vocational] when this started, but at this time she had made her way to assist with female consumer. A 3rd staff took</p>						

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	<p>female consumer and supervisor took [client A] to a different room. Female consumer stated, 'That's what you get b--- -.' before [client A] was able to leave the room. [Client A] had several marks around his neck (scratch marks and 2 scratch marks on his chin and an (sic) laceration on his chin)." The records did not indicate the client to client abuse was reported to the BDDS or to APS in accordance with state law. The undated investigative report in regard to the incident of 9/13/12 indicated no interviews and no record reviews. The investigative form indicated to ensure client A's safety while at the workshop, client A and client A's peer were to be placed at a safe distance from each other at all times. The facility records did not indicate evidence a thorough investigation was conducted. The investigative form failed to indicate when the administrator was notified of the results of the investigation.</p> <p>A 9/25/12 BDDS report indicated on 9/24/12 at 12:44 PM while at the workshop, a peer "grabbed [client A's] face scratching his neck and right facial area." The report indicated client A filed a police report on the incident and the facility had begun an investigation. The records indicated no investigative records for review.</p>			

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	<p>A 10/11/12 BDDS report indicated on 10/11/12 at 9 PM client H reported to the BS (Behavior Specialist) "...housemate [client F] had kicked him [client H] in the shin the previous night while in their bedroom." The BS checked client H for injury and found no redness or bruising. The BS asked client F if the incident had happened and client F "admitted that he had gotten frustrated with [client H] and barely kicked him in the shin." The report indicated the staff will be advised to check on clients F and H prior to their going to bed to ensure they are not having any problems. The records did not indicate the client to client abuse was investigated.</p> <p>A 11/8/12 BDDS (Bureau of Developmental Disabilities Services) report indicated on 11/7/12 at 11:15 AM while at the work shop client B made allegations client A had "touched her on the chest and was looking at her butt." The report indicated the Director of Day Services would be conducting an investigation. The investigative record indicated no interviews and/or record reviews. The facility records did not indicate evidence a thorough investigation was conducted.</p> <p>A 12/12/12 BDDS report indicated on</p>			

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	<p>12/11/12 at 9:20 PM client D "had several incidents of bowel movements of not making it to the bathroom in time throughout the evening. [Client B] advised staff [name of staff #1] that [client D] had wet his pants again and appeared angry. [Name of staff #1] asked [client D] to come to the office to show her his pants. [Client D] walked towards the office and stated to [name of staff #1] that he had not wet his pants. [Client B] grabbed [client D] by the arm and pulled him towards the office and pushed him down." The records did not indicate the client to client abuse was investigated.</p> <p>A 1/10/13 Investigative report indicated "Reported by staff that [name of staff] was throwing tissues at consumer [client H] while he was sleeping in the recliner. It was reported by consumer that [name of staff] was driving too fast in the van on the way to special olympics. Consumer reported that [name of staff] cussed at her while he was walking with her." The records did not indicate the allegations of abuse were reported to the BDDS or to APS in accordance with state law.</p> <p>A 1/22/13 IR indicated at 8:30 AM while at the workshop client B reported to one of the workshop staff that client B and client A were "an item now." The report indicated client B stated she was breaking</p>						

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	<p>up with another consumer and the other consumer stated to client B "he was going to bring a gun and shoot her." The report indicated client B reported the threat was made on 1/21/13. The records did not indicate the client to client abuse was reported to the BDDS or to APS in accordance with state law. The records did not indicate the threat of harm was investigated.</p> <p>A 1/23/13 IR indicated at 1:10 PM while at the workshop another consumer got "agitated with [client B] and started hollering. [Client B] was asked to step away from [initials of other consumer]. She [client B] ignored staff and stepped up to [initials of other consumer]. [Initials of other consumer] then smacked [client B] at her left side of her chest before staff had gotten to them." The records did not indicate the client to client abuse was reported to the BDDS or to APS in accordance with state law. The records did not indicate the client to client abuse was investigated.</p> <p>A 3/5/13 BDDS report indicated on 3/4/13 at 9:15 PM, "[Client B] became upset and smacked [client D] on the left arm, she [client B] then threw a roll of toilet paper towards him [client D]." The staff noted "redness on his [client D's] left arm but no bruising or swelling." The</p>			

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	<p>records did not indicate the client to client abuse was investigated.</p> <p>A 3/13/13 BDDS report indicated on 3/12/13 at 11:45 PM client A and client B were sitting in client B's bed room "discussing an argument they had earlier in the day. [Client A] was asking [client B] to talk to him and instead of sitting there in silence (sic). [Client B] grabbed [client A's] upper arm and tried to pull him up. [Client A] asked her to let go and just talk to him. [Client A] asked twice more. [Client B] let go and [client A] left [client B's] room." The records did not indicate the client to client abuse was investigated.</p> <p>A 4/26/13 BDDS report indicated on 4/25/13 at 5 PM "[Client F] came to staff [name of staff] and told her [client H] was in his room crying. [Name of staff] went to [client H's] room and asked him [client H] what was wrong. [Client H] told [name of staff] that [client B] had hit him on the arm and he did not know why. [Name of staff] checked [client H's] arm and noticed a red mark on it. [Name of staff] gave [client H] an ice pack and went to talk to [client B]. [Client B] said that she hit [client H] because he was being a butt...." The records did not indicate the client to client abuse was investigated.</p>			

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	<p>A 6/5/13 BDDS report indicated on 6/4/13 at 8:15 PM "[Name of staff] was in [client H's] room with [client H]. [Client H] opened up his closet door. [Name of staff] noticed [client H] had [client B's] undergarments. [Name of staff] informed [client H] he would have to return them to [client B]. [Client B] heard her name and came down to [client H's] room. Upon seeing her undergarments she smacked [client H] in the chest and stormed off to her room. Staff [name of staff] accessed (sic) [client H] for injuries. He [client H] did have a red hand print on his chest."</p> <p>A 6/13/13 BDDS report indicated on 6/12/13 at 4:30 PM "[Client B] felt that this was not appropriate of [client H] to steal her belongings. She requested with the help of staff for the cops to be called so that she could file a complaint. [Name of staff] called the [name of police department]. [Client B] requested staff be present when she gave her statement to the sheriff.... [Client H] fessed up to stealing." The records did not indicate the client to client abuse and/or the allegation of theft were investigated.</p> <p>Interview with the PD and the QIDP on 8/2/13 at 11:30 AM indicated all reportable and investigative records were provided for review. The PD stated client</p>			

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	<p>to client abuse was not investigated "unless there was a serious injury." The PD indicated their policy and procedures needed to be revised.</p> <p>Review of the revised facility policy Abuse, Neglect and Exploitation of 11/09 on 7/30/13 at 1 PM indicated:</p> <p>___ "Verbal abuse: Any yelling, cursing, screaming, threatening, etc., language directed toward any consumer."</p> <p>___ "Physical abuse: Any hitting, slapping, kicking, biting, throwing at, etc., or attempting to do so, toward a consumer, toward a consumer emotional anguish (sic)."</p> <p>___ "Emotional Abuse: Any action toward a consumer with the intent or possible intent of causing the consumer emotional anguish."</p> <p>___ "Neglect: Any action that places or potentially places a consumer in a position/situation that results in injury. Is also defined as the intentional withholding of the basic necessities of life."</p> <p>___ "Exploitation: Intentionally taking advantage of a consumer of one's own or another's gain without regard to the welfare or well being of the consumer."</p> <p>___ "Humiliation: Any attempt to embarrass, shame, disgrace, or dishonor the consumer."</p> <p>___ "Retaliation: any revenge, vengeance,</p>			

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	<p>or retribution toward the consumer."</p> <p>The policy indicated "Abilities Services also sets forth procedures for staff to report all incidents or suspected incidents of abuse, neglect, exploitation, and violation of rights in accordance with all applicable rules, regulations, and laws. All staff of Abilities Services, Inc. are MANDATORY REPORTERS of observed or suspected abuse, neglect, and exploitation in accordance with Acts of 1979, P.L. 276, Section 55 which states: Any member of the staff of a medial or other public institution, school, or facility, or agency shall report any suspect case of abuse, neglect, or exploitation to the Adult Protective Services to the Child Protective Services. In addition a report will be filed with BDDS. Abilities Services further mandates that all consumers should be free from humiliation and retaliation."</p> <p>Review of the Investigation Protocol dated "December 2011, May 2013" on 8/2/13 at 11:30 AM indicated __ "All staff has the responsibility to report concerns. These concerns should be reported to the Director of Programming, or any Director. In the event staff does not know the appropriate Director, he/she can report to their supervisor or daily administrative staff</p>						

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	<p>and be forwarded to the appropriate person. Reports should be made immediately, and in no more than 24 hours to ensure consumer safety. All allegations should be documented on an Incident Report."</p> <p>__ "The investigating Director or designee is also responsible for completing the BDDS report within 24 hours."</p> <p>__ The investigating Director, or designee, is expected to interview all relevant staff and consumers (either parties to or possible witnesses of) the alleged mistreatment...."</p> <p>__ "Allegations of Consumer to Consumer abuse/Neglect/Exploitation: All staff has the responsibility to report concerns via the incident Report system and referred to the appropriate supervisor. Investigations of consumer to consumer mistreatment can be investigated by any of the following: Groups Home Manager, Programming Coordinator, QDDP, or nurse...The investigating staff are also responsible for completing the BDDS report in a timely manner...."</p> <p>The facility Investigative Protocol failed to indicate the results of all investigations must be reported to the administrator or designated representative in accordance with State law within five working days of the discovery of the abuse/neglect/injury of unknown origin.</p>			

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	<p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-2(a)</p>			

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on interview and record review for 11 of 11 allegations of abuse/neglect/exploitation for clients A, B, C, D, E, F, G and H and for 3 of 13 incidents of client to client abuse for clients A and B, the facility failed to ensure all allegations of abuse and threats of harm were reported immediately to the administrator in accordance with state law.</p> <p>Findings include:</p> <p>The facility's reportable records and investigative records for July 2012 through July 2013 were reviewed on 7/30/13 at 1:30 PM and again on 7/31/13 at 11 AM.</p> <p>__A 9/13/12 IR (Incident Report) indicated at 12:10 PM "This staff whitnessed (sic) female consumer approach [client A] with a can of pop. Due to previous circumstances, this staff started walking to the consumers. This staff heard female consumer say 'youre</p>	W000153	<p>An updated policy for Reporting Abuse, Neglect and Exploitation has been completed. Updated procedures to ensure that staff are trained to identify, report and document incidents of abuse, neglect or exploitation is being written. Updated procedures on completing thorough investigations is being written and includes immediate staff suspension upon any allegation of abuse, neglect or exploitation. Monitoring of staff to ensure clients are protected from further incidents of abuse neglect or exploitation will be in procedure and will include site checks when staff is working. Monthly client meetings including a Director and Coordinator or other administrative staff that do not work at the site the consumer lives will take place. This will allow consumers to express any concerns/needs at the site, preventing them from feeling uncomfortable saying something about staff that work at their site. Documentation of meetings will be reviewed by Leadership Team at one of the monthly Leadership meetings. QIDP will investigate consumer to consumer abuse</p>	09/06/2013			

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	<p>(sic) not going to look at me,' then [client A] said, 'just sit it on the table please.' Female consumer picked up pop and smashed [client A] in the face with it, then began choking him. This staff got in between consumers and pulled female consumers fingers and hands off of [client A's] neck. Supervisor was on other side of prevo [pre-vocational] when this started, but at this time she had made her way to assist with female consumer. A 3rd staff took female consumer and supervisor took [client A] to a different room. Female consumer stated, 'That's what you get b----.' before [client A] was able to leave the room. [Client A] had several marks around his neck (scratch marks and 2 scratch marks on his chin and an (sic) laceration on his chin)."</p> <p>__A 1/10/13 Investigative report indicated "Reported by staff that [name of staff] was throwing tissues at consumer [client H] while he was sleeping in the recliner. It was reported by consumer that [name of staff] was driving too fast in the van on the way to special olympics. Consumer reported that [name of staff] cussed at her while he was walking with her."</p> <p>__A 1/22/13 IR indicated at 8:30 AM while at the workshop client B reported to one of the workshop staff that client B and client A were "an item now." The report indicated client B stated she was</p>		<p>allegations and injuries of unknown origin. If the QIDP is not available the Coordinator or Nurse can investigate. All investigations will be brought to HRC bi-monthly meetings for oversight and implementation of an action plan. The Director of Programming oversees the HRC meetings and supervises the QIDP. It is her responsibility to monitor compliance with the above. The QIDP maintains these investigations and findings in the client specific files as well as an investigation binder.</p>				

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	<p>breaking up with another consumer and the other consumer stated to client B "he was going to bring a gun and shoot her." The report indicated client B reported the threat was made on 1/21/13.</p> <p>__A 1/23/13 IR indicated at 1:10 PM while at the workshop another consumer got "agitated with [client B] and started hollering. [Client B] was asked to step away from [initials of other consumer]. She [client B] ignored staff and stepped up to [initials of other consumer]. [Initials of other consumer] then smacked [client B] at her left side of her chest before staff had gotten to them."</p> <p>__The facility records did not indicate the client to client abuse, the threat of harm and/or the staff to client abuse was reported to the BDDS and/or to APS in accordance with state law.</p> <p>Review of the TL's (Team Lead's) personnel file on 7/31/13 at 4 PM indicated:</p> <p>__A 9/5/12 verbal warning indicated, "On 09/05/12, I (Director of Community Living) gave a verbal warning to [TL] based on the following concerns: inappropriately using the consumer's products, photos taken and posted them on a co-workers [social media] (internet) page."</p> <p>__An Employee Warning Notice of 12/12/12 indicated, "On 11/3/12, during a</p>			

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	<p>birthday party at [name of group home] for a consumer, [the TL] showed up to check in cycle meds. [The TL] was clocked in during this time. She [the TL] brought a friend in the home with her into the office and stayed in the office the entire time with the door shut. [The TL] was clocked in for 30 minutes on this day and in the office at the group home with a non staff person who would have seen vital information regarding each consumer in the home and had access to various medications."</p> <p>__An Employee Plan of Correction dated June 10, 2013 indicated the TL "brought alcohol into the home of our consumers without permission from the residence (sic) and Director. Also, open alcohol was present in her vehicle when she arrived to transport a consumer to urgent care. [The TL] has put her co-workers in a tough situation by asking them to clock her in when she was running late."</p> <p>__An Employee Warning Notice of 6/25/13 indicated "On June 25, 2013, a consumer came in complaining to [name of staff] that [the TL] was texting on her phone this morning while driving them into work. The consumer informed [name of staff] that [the TL] does this all the time when she is driving the consumers around." A 6/25/13 investigative record indicated "It was reported by consumer [client A] to [the HM] that [staff #3] was</p>			

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	<p>using her cell phone in the agency van. [Staff #3] was suspended pending investigation. [Staff #3] stated that she was using her cell phone at a stop light - she checked her text. She stated that it was not while driving." The investigative report indicated recommendations "that [staff #3] receive a written warning because her cell phone should not be accessible while driving or at a stop sign. Her attention needs to be on her surroundings, regardless of whether she is actually driving."</p> <p>No reportable records were provided for the allegations of neglect and exploitation noted in the TL's personnel file dated 9/5/12, 12/12/12, 6/10/13 and 6/25/13 in regard to clients A, B, C, D, E, F and G. The facility records indicated no reports to the PD (Program Director/Administrator) in regard to client abuse/neglect/exploitation for clients A, B, C, D, E, F, G and H in regard to the TL.</p> <p>CI (Confidential Interview) #1 stated "Our Lead [name of TL] is rude with the clients [clients A, B, C, D, E, F and G] and she [the TL] uses the F word around them [clients A, B, C, D, E, F and G] all the time." CI #1 stated the TL "is constantly yelling, screaming and cussing at them [clients A, B, C, D, E, F and G]."</p>			

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	<p>CI #1 indicated the TL was called to take a client to the doctor and the TL arrived at work with an open can of alcohol in her car. The can of alcohol was disposed of and the TL took the client to the medical appointment using her own vehicle. CI #1 stated, "She [the TL] talks a lot about her divorce and her personal life around the consumers" and "You never know what kind of attitude she's going to be in." CI #1 stated clients A, B, C, D, E, F and G did not like the TL and "just try to stay out of her way." CI #1 indicated she was aware of an incident when the TL left the group home to go to the store and returned with a bottle of alcohol and put it in the refrigerator in the medication room. CI #1 indicated while transporting the clients, the TL drives over the speed limit, texts and drives and talks on her phone while driving. CI #1 stated clients A, B, C, D, E, F and G do not like for the TL to take them anywhere and "I think, especially [client C] is afraid of her." When asked if these allegations had been reported, CI #1 stated "We've reported to [the HM] and she just tells us that [the TL] is having a bad day and to ignore her [the TL]." CI #1 stated, "She [The HM] says everyone is just picking on her [the TL]." CI #1 indicated the staff were to report all allegations of abuse/neglect/exploitation to the HM and if the HM did nothing about the</p>						

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	<p>allegations the staff were to report to the PD.</p> <p>CI #2 stated while transporting the clients the TL speeds, texts and talks on her phone while driving, "I know cause I have been in the van with her." CI #2 stated, "The whole time she [the TL] is on shift she goes out and smokes cigarettes and has her ear phones in. She is constantly listening to her music and she brings her personal life into the group home." CI #2 stated, "She [the TL] says the F word a lot and her music is offensive to listen to." CI #2 stated, "She [the TL] talks about taking a lot of pills that aren't hers and about smoking pot." CI #2 stated "about a week ago [the TL] left the group home around 5:30 PM" prior to the end of her shift, leaving the group home with 1 staff for the evening shift. CI #2 indicated client F had to be taken to work and picked up at 8:30 PM and client E had to be taken to ball practice and back again. CI #2 indicated all of the clients had to go back and forth on the transport trips because the TL had left early, leaving only 1 staff to care for the clients and do the transports. CI #2 stated this was reported to the HM, "But nothing was ever done about it." CI #2 indicated the TL was called in on a Sunday to take client D to the doctor. CI #2 stated "She was hung over and had an almost full can of beer in</p>				

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	<p>her car. [Client A] and [client B] saw it." CI #2 indicated the TL left the home to buy alcohol and brought it back to the home. CI #2 stated the allegations of abuse/neglect were reported to the HM, "But I don't think anything was done about it."</p> <p>During interview with client B on 7/31/13 at 10 AM, client B stated, "She [the TL] doesn't treat us [clients A, B, C, D, E, F and G] right. She talks to us in a mean way. I don't like her." Client B stated, "She [the TL] told me she doesn't like me." Client B stated the TL used foul language around the clients in the group home, "often talked about her divorce" and "at times was rude" to the clients in the way she spoke with them. Client B stated, "She [the TL] uses the F word a lot and that offends me." Client B stated when the TL worked, "I just try to stay in my room and away from her because she makes me nervous." Client B indicated while transporting the clients the TL drives above the speed limit and texts and talks on her phone while driving. Client B stated, "It makes me nervous when she does that and I was shaking." When asked if she had reported her concerns to anyone, client B stated "Yes, to the staff and to [the HM]." Client B stated the HM told her to "just tolerate" the TL.</p>			

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	<p>During interview with client C on 7/31/13 at 10:50 AM, client C stated the TL was asleep in the recliner this AM and "I would have gotten in trouble if I said anything to her or woke her up. [Staff #4] was also there, sitting in the living room with her. Staff #4 helped me get dressed. I didn't want [the TL] to help me." Client C stated, "I'm afraid of her [the TL]. She drives too fast and it scares me. I don't like her taking me anywhere and I'm scared when she puts me on the wheelchair lift. I don't trust her doing the wheelchair lift." Client C indicated she had never been dropped or injured while on the lift, but did not feel secure while the TL was operating the lift. Client C stated, "I don't trust her. I honestly don't. She [the TL] still talks about her divorce all the time and that makes me uncomfortable." Client C stated the TL "says the F word a lot" and was "constantly on her phone or listening to her music. She [the TL] is either outside smoking or she is on her phone." Client C indicated she was in the group home the day the TL brought alcohol into the group home. Client C stated "She [the TL] is mean to us and I don't want her around there anymore. This morning I had goose bumps because she was there and I don't trust her." When asked if she had reported her concerns to anyone, client C stated, "Yes, to the staff."</p>			

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	<p>During interview with client F on 7/31/13 at 11:10 AM, client F stated the TL had "good days and bad days. I'll joke with her and she goes through mood swings and she'll get short with me and I never know how to take her." Client F indicated the TL used foul language around clients A, B, C, D, E, F and G, talked about her divorce and at times was rude in the way she spoke with clients A, B, C, D, E, F and G. Client F stated, "I was told she [the TL] has had someone else clock in for her so it doesn't look like she is late for work and I've seen her doing her personal stuff on the computer at work in the office when she was supposed to be taking care of us." Client F indicated while transporting the clients the TL drives above the speed limit and texts and talks on her phone while driving. Client F stated, "She [the TL] told me she can text and drive as long as she doesn't get caught doing it." Client F indicated he was in the van when another staff was texting and driving and the staff hit a deer and wrecked the facility vehicle. Client F stated, "A lot of us don't feel comfortable when she [the TL] is here." When asked if he had reported his concerns to anyone, client F stated "Yes, to the staff and to [the HM]."</p> <p>Interview with client A on 8/1/13 at 3:30</p>						

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	<p>PM indicated while transporting clients A, B, C, D, E, F and G, the TL drives above the speed limit and texts and talks on her phone while driving. Client A stated, "I know she scares [clients B and C] when she does this and that upsets me." Client A stated, "She [the TL] has brought alcohol into the group home, which is not right." Client A stated the TL "uses foul language around us [clients A, B, C, D, E, F and G] and she talks about her divorce which is wrong." Client A stated, "She [the TL] is rude with us sometimes in the way she talks to us." Client A stated, "She [the TL] spends a lot of her time listening to music, talking on her cell phone or doing personal stuff on the computer when she's supposed to be there for us." Client A stated, "We just try to stay away from her [the TL] when she's there. I just go to my room." When asked if he had reported his concerns to anyone, client A stated, "Yes, the staff and [the HM], but she just said we need to overlook her [the TL]."</p> <p>Interview with the PD and the QIDP (Qualified Intellectual Disabilities Professional) on 8/2/13 at 11:30 AM indicated all reportable and investigative records were provided for review. The PD indicated the events in the TL's personnel file were treated as employee disciplinary actions and were not reported to BDDS.</p>						

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	<p>The PD indicated no knowledge of allegations of abuse/neglect for clients A, B, C, D, E, F and G in regard to the TL.</p> <p>The PD indicated all allegations of abuse/neglect were to be reported immediately to the PD and then to BDDS within 24 hours within knowledge of the abuse and/or neglect.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-2(a)</p>			

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 11 of 12 allegations of client to client abuse for clients A, B, D, F and H and for 5 allegations of abuse/neglect/mistreatment/harm for clients A, B, C, D, E, F, G and H, the facility failed to provide evidence of an investigation and/or evidence a thorough investigation was conducted.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records for July 2012 through July 2013 were reviewed on 7/30/13 at 1:30 PM and again on 7/31/13 at 11 AM.</p> <p>A 9/13/12 BDDS (Bureau of Developmental Disabilities Services) report indicated on 9/12/12 at 2:05 PM client A "was coming out of the break room into the workshop. A female consumer was following [client A]. [Client A] stated to the female, please leave me alone. [Client A] sat down at a table and stated again to the female to please leave him alone. Staff approached both [client A] and female consumer. Staff asked female consumer to please</p>	W000154	An updated policy for Reporting Abuse, Neglect and Exploitation has been completed. Updated procedures to ensure that staff are trained to identify, report and document incidents of abuse, neglect or exploitation is being written. Updated procedures on completing thorough investigations is being written and includes immediate staff suspension upon any allegation of abuse, neglect or exploitation. A new form for investigating will be implemented. This will allow for prompting of all questions that need to be asked and paperwork reviewed to complete a thorough investigation. Monitoring of staff to ensure clients are protected from further incidents of abuse neglect or exploitation will be in procedure and will include site checks when staff is working. Monthly client meetings including a Director and Coordinator or other administrative staff that do not work at the site the consumer lives will take place. This will allow consumers to express any concerns/needs at the site, preventing them from feeling uncomfortable saying something about staff that work at their site. Documentation of meetings will be reviewed by Leadership Team	09/06/2013			

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	<p>leave [client A] alone. Female consumer yelled No and picked up [client A's] can of pop and threw it at [client A]. The can hit [client A] in the chest area on the left side.... There was no redness, bruising or cuts seen." The records did not indicate the client to client abuse was investigated.</p> <p>A 9/13/12 IR (Incident Report) indicated at 12:10 PM "This staff whitnessed (sic) female consumer approach [client A] with a can of pop. Due to previous circumstances, this staff started walking to the consumers. This staff heard female consumer say 'youre (sic) not going to look at me,' then [client A] said, 'just sit it on the table please.' Female consumer picked up pop and smashed [client A] in the face with it, then began choking him. This staff got in between consumers and pulled female consumers fingers and hands off of [client A's] neck. Supervisor was on other side of prevo [pre-vocational] when this started, but at this time she had made her way to assist with female consumer. A 3rd staff took female consumer and supervisor took [client A] to a different room. Female consumer stated, 'That's what you get b--- -.' before [client A] was able to leave the room. [Client A] had several marks around his neck (scratch marks and 2 scratch marks on his chin and an (sic) laceration on his chin)."</p>		<p>at one of the monthly Leadership meetings. QIDP will investigate consumer to consumer abuse allegations and injuries of unknown origin. If the QIDP is not available the Coordinator or Nurse can investigate. All investigations will be brought to HRC bi-monthly meetings for oversight and implementation of an action plan. The Director of Programming oversees the HRC meetings and supervises the QIDP. It is her responsibility to monitor compliance with the above. The QIDP maintains these investigations and findings in the client specific files as well as an investigation binder. It is the responsibility of the executive director to ensure that the other directors are implementing the procedure revision. This will be done monthly via the leadership meetings.. In regard to a letter dated 9/10, ASI did have policies and procedures in place to prevent and investigate allegations of abuse/neglect/exploitation. The agency also had a process in place for investigating injuries of unknown origin and consumer to consumer abuse. The system failed in the instances cited in this W for a few reasons: 1. Incident Reports were not being submitted to the appropriate staff in a timely manner; and 2. Due to the delay in reporting, the QIDP/Director were not able to conduct a timely and thorough investigations. To</p>	

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	<p>__The undated investigative report in regard to the incident of 9/13/12 indicated no interviews and no record reviews. The investigative form indicated to ensure client A's safety while at the workshop, client A and client A's peer were to be placed at a safe distance from each other at all times. The facility records did not indicate evidence a thorough investigation was conducted.</p> <p>A 9/25/12 BDDS report indicated on 9/24/12 at 12:44 PM while at the workshop, a peer "grabbed [client A's] face scratching his neck and right facial area." The report indicated client A filed a police report on the incident and the facility had begun an investigation. The records indicated no investigative records for review.</p> <p>A 10/11/12 BDDS report indicated on 10/11/12 at 9 PM client H reported to the BS (Behavior Specialist) "...housemate [client F] had kicked him [client H] in the shin the previous night while in their bedroom." The BS checked client H for injury and found no redness or bruising. The BS asked client F if the incident had happened and client F "admitted that he had gotten frustrated with [client H] and barely kicked him in the shin." The report indicated the staff will be advised to check on clients F and H prior to their</p>		<p>address these issues, ASI has revamped its Incident Reporting process for all Group Homes. Any time an Incident Report is written, the DSP must call the Programming Coordinator, QIDP, and Nurse to report the incident. This begins the notification process for them in case a BDDS report is required or an investigation must be initiated. These individuals are on-call 24-7. The Incident Report is then electronically scanned to these same persons so that the paperwork process follows their actions. There is no opportunity for delay in an investigation process with this notification system. If it is an investigation of unknown injury or consumer to consumer abuse, the QIDP and Nurse conduct the investigation. ASI has up-dated the report format of this document to ensure it is more complete. If the allegation involves staff abuse, the Director is notified and she/he initiates the investigation. Staff are immediately suspended in these instances. The policy, procedure, and form for investigating allegations of abuse/neglect/exploitation have been up-dated to address the timeliness and thoroughness of the investigation. When a Director initiates an investigation, she will email the Executive Director with the staff's name and brief description of the allegation. When the investigation is</p>				

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	<p>going to bed to ensure they are not having any problems. The records did not indicate the client to client abuse was investigated.</p> <p>A 11/8/12 BDDS (Bureau of Developmental Disabilities Services) report indicated on 11/7/12 at 11:15 AM while at the work shop client B made allegations client A had "touched her on the chest and was looking at her butt." The report indicated the Director of Day Services would be conducting an investigation. The investigative record indicated no interviews and/or record reviews. The facility records did not indicate evidence a thorough investigation was conducted.</p> <p>A 12/12/12 BDDS report indicated on 12/11/12 at 9:20 PM client D "had several incidents of bowel movements of not making it to the bathroom in time throughout the evening. [Client B] advised staff [name of staff #1] that [client D] had wet his pants again and appeared angry. [Name of staff #1] asked [client D] to come to the office to show her his pants. [Client D] walked towards the office and stated to [name of staff #1] that he had not wet his pants. [Client B] grabbed [client D] by the arm and pulled him towards the office and pushed him down." The records did not indicate the</p>		<p>complete, a second email will be send to the ED for him to ensure it is completed in a timely manner. This also ensures that he has been informed and is up-to-date on any allegations. In addition, the Quality Assurance Committee is tracking all staff investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. In regard to allegations of unknown injury or consumer to consumer abuse, the investigating QIDP will send an email to the ED upon the initiation of an investigation as well as at the conclusion of the investigation so that he is able to monitor the timeliness of these events.</p>				

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	<p>client to client abuse was investigated.</p> <p>A 1/22/13 IR indicated at 8:30 AM while at the workshop client B reported to one of the workshop staff that client B and client A were "an item now." The report indicated client B stated she was breaking up with another consumer and the other consumer stated to client B "he was going to bring a gun and shoot her." The report indicated client B reported the threat was made on 1/21/13. The records did not indicate the threat of harm was investigated.</p> <p>A 1/23/13 IR indicated at 1:10 PM while at the workshop another consumer got "agitated with [client B] and started hollering. [Client B] was asked to step away from [initials of other consumer]. She [client B] ignored staff and stepped up to [initials of other consumer]. [Initials of other consumer] then smacked [client B] at her left side of her chest before staff had gotten to them." The records did not indicate the client to client abuse was investigated.</p> <p>A 3/5/13 BDDS report indicated on 3/4/13 at 9:15 PM, "[Client B] became upset and smacked [client D] on the left arm, she [client B] then threw a roll of toilet paper towards him [client D]." The staff noted "redness on his [client D's] left</p>						

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	<p>arm but no bruising or swelling. The records did not indicate the client to client abuse was investigated.</p> <p>A 3/13/13 BDDS report indicated on 3/12/13 at 11:45 PM client A and client B were sitting in client B's bed room "discussing an argument they had earlier in the day. [Client A] was asking [client B] to talk to him and instead of sitting there in silence (sic). [Client B] grabbed [client A's] upper arm and tried to pull him up. [Client A] asked her to let go and just talk to him. [Client A] asked twice more. [Client B] let go and [client A] left [client B's] room." The records did not indicate the client to client abuse was investigated.</p> <p>A 4/26/13 BDDS report indicated on 4/25/13 at 5 PM "[Client F] came to staff [name of staff] and told her [client H] was in his room crying. [Name of staff] went to [client H's] room and asked him [client H] what was wrong. [Client H] told [name of staff] that [client B] had hit him on the arm and he did not know why. [Name of staff] checked [client H's] arm and noticed a red mark on it. [Name of staff] gave [client H] an ice pack and went to talk to [client B]. [Client B] said that she hit [client H] because he was being a butt...." The records did not indicate the client to client abuse was</p>						

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	<p>investigated.</p> <p>A 6/5/13 BDDS report indicated on 6/4/13 at 8:15 PM "[Name of staff] was in [client H's] room with [client H]. [Client H] opened up his closet door. [Name of staff] noticed [client H] had [client B's] undergarments. [Name of staff] informed [client H] he would have to return them to [client B]. [Client B] heard her name and came down to [client H's] room. Upon seeing her undergarments she smacked [client H] in the chest and stormed off to her room. Staff [name of staff] accessed (sic) [client H] for injuries. He [client H] did have a red hand print on his chest." The records did not indicate the client to client abuse was investigated.</p> <p>A 6/13/13 BDDS report indicated on 6/12/13 at 4:30 PM "[Client B] felt that this was not appropriate of [client H] to steal her belongings. She requested with the help of staff for the cops to be called so that she could file a complaint. [Name of staff] called the [name of police department]. [Client B] requested staff be present when she gave her statement to the sheriff.... [Client H] fessed up to stealing." The records did not indicate the client to client abuse and/or the allegation of theft were investigated.</p> <p>Review of the TL's (Team Lead's)</p>						

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	<p>personnel file on 7/31/13 at 4 PM indicated:</p> <p>__A 9/5/12 verbal warning indicated, "On 09/05/12, I (Director of Community Living) gave a verbal warning to [TL] based on the following concerns: inappropriately using the consumer's products, photos taken and posted them on a co-workers [social media] (internet) page."</p> <p>__An Employee Warning Notice of 12/12/12 indicated, "On 11/3/12, during a birthday party at [name of group home] for a consumer, [the TL] showed up to check in cycle meds. [The TL] was clocked in during this time. She [the TL] brought a friend in the home with her into the office and stayed in the office the entire time with the door shut. [The TL] was clocked in for 30 minutes on this day and in the office at the group home with a non staff person who would have seen vital information regarding each consumer in the home and had access to various medications."</p> <p>__An Employee Plan of Correction dated June 10, 2013 indicated the TL "brought alcohol into the home of our consumers without permission from the residence (sic) and Director. Also, open alcohol was present in her vehicle when she arrived to transport a consumer to urgent care. [The TL] has put her co-workers in a tough situation by asking them to clock her in</p>						

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	<p>when she was running late." ___An Employee Warning Notice of 6/25/13 indicated "On June 25, 2013, a consumer came in complaining to [name of staff] that [the TL] was texting on her phone this morning while driving them into work. The consumer informed [name of staff] that [the TL] does this all the time when she is driving the consumers around." The 6/25/13 investigative record indicated "It was reported by consumer [client A] to [the HM (House Manager)] that [the TL] was using her cell phone in the agency van. [The TL] was suspended pending investigation. [The TL] stated that she was using her cell phone at a stop light - she checked her text. She stated that it was not while driving." The investigative report indicated recommendations "that [the TL] receive a written warning because her cell phone should not be accessible while driving or at a stop sign. Her attention needs to be on her surroundings, regardless of whether she is actually driving."</p> <p>No investigative records were provided for the allegations of neglect and exploitation noted in the TL's personnel file dated 9/5/12, 12/12/12 and 6/10/13 in regard to clients A, B, C, D, E, F, G and H. The investigative record for the allegation of 6/25/13 indicated no client and/or staff interviews and did not</p>						

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	<p>indicate evidence a thorough investigation was conducted.</p> <p>Interview with the PD and the QIDP on 8/2/13 at 11:30 AM indicated investigative records were provided for review. The PD stated client to client abuse was not investigated "unless there was a serious injury." The PD indicated their policy and procedures needed to be revised. The PD indicated the events in the TL's personnel file were treated as employee disciplinary actions and were not investigated. The PD stated, "I thought the disciplinary action was enough. She [the TL] admitted to her actions, so why would there need to be an investigation?"</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-2(a)</p>			

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W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on interview and record review for 1 of 4 investigations reviewed, the facility failed to report the results of the investigations to the administrator within 5 working days from the date of incident of client to client abuse for client A.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records for July 2012 through July 2013 were reviewed on 7/30/13 at 1:30 PM and again on 7/31/13 at 11 AM.</p> <p>A 9/13/12 IR (Incident Report) indicated at 12:10 PM "This staff whitnessed (sic) female consumer approach [client A] with a can of pop. Due to previous circumstances, this staff started walking to the consumers. This staff heard female consumer say 'youre (sic) not going to look at me,' then [client A] said, 'just sit it on the table please.' Female consumer picked up pop and smashed [client A] in the face with it, then began choking him. This staff got in between consumers and pulled female consumers fingers and</p>	W000156	An updated policy for Reporting Abuse, Neglect and Exploitation has been completed. Updated procedures to ensure that staff are trained to identify, report and document incidents of abuse, neglect or exploitation is being written. Updated procedures on completing thorough investigations is being written and includes immediate staff suspension upon any allegation of abuse, neglect or exploitation. A new form for investigating will be implemented. This will allow for prompting of all questions that need to be asked and paperwork reviewed to complete a thorough investigation. Investigations will be completed within 5 working days and reported to Director of Administration or Executive Director within 5 working days. Monitoring of staff to ensure clients are protected from further incidents of abuse neglect or exploitation will be in procedure and will include site checks when staff is working. Monthly client meetings including a Director and Coordinator or other administrative staff that do not work at the site the consumer lives will take place. This will	09/06/2013			

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	<p>hands off of [client A's] neck. Supervisor was on other side of prevo [pre-vocational] when this started, but at this time she had made her way to assist with female consumer. A 3rd staff took female consumer and supervisor took [client A] to a different room. Female consumer stated, 'That's what you get b--- -.' before [client A] was able to leave the room. [Client A] had several marks around his neck (scratch marks and 2 scratch marks on his chin and an (sic) laceration on his chin)." The investigative report indicated recommendations to ensure client A's safety while at the workshop, client A and client A's peer were to be placed at a safe distance from each other at all times. The investigative report failed to indicate when the administrator was notified of the results of the investigation.</p> <p>Interview with the Director and the QIDP (Qualified Intellectual Disabilities Professional) on 8/2/13 at 12 PM indicated the investigative report failed to indicate when the administrator was notified of the results of the investigation. The Director and the QIDP did not know when the administrator was notified of the results of the investigation.</p> <p>This federal tag relates to complaint #IN00132706.</p>		<p>allow consumers to express any concerns/needs at the site, preventing them from feeling uncomfortable saying something about staff that work at their site. Documentation of meetings will be reviewed by Leadership Team at one of the monthly Leadership meetings. QIDP will investigate consumer to consumer abuse allegations and injuries of unknown origin. If the QIDP is not available the Coordinator or Nurse can investigate. All investigations will be brought to HRC bi-monthly meetings for oversight and implementation of an action plan. The Director of Programming oversees the HRC meetings and supervises the QIDP. It is her responsibility to monitor compliance with the above. The QIDP maintains these investigations and findings in the client specific files as well as an investigation binder. It is the responsibility of the executive director to ensure that the other directors are implementing the procedure revision. This will be done monthly via the leadership meetings. In regard to a letter dated 9/10, ASI did have policies and procedures in place to prevent and investigate allegations of abuse/neglect/exploitation. The agency also had a process in place for investigating injuries of unknown origin and consumer to consumer abuse. The system failed in the instances cited in this</p>		

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	9-3-2(a)		W for a few reasons: 1. Incident Reports were not being submitted to the appropriate staff in a timely manner; and 2. Due to the delay in reporting, the QIDP/Director were not able to conduct a timely and thorough investigations. To address these issues, ASI has revamped its Incident Reporting process for all Group Homes. Any time an Incident Report is written, the DSP must call the Programming Coordinator, QIDP, and Nurse to report the incident. This begins the notification process for them in case a BDDS report is required or an investigation must be initiated. These individuals are on-call 24-7. The Incident Report is then electronically scanned to these same persons so that the paperwork process follows their actions. There is no opportunity for delay in an investigation process with this notification system. If it is an investigation of unknown injury or consumer to consumer abuse, the QIDP and Nurse conduct the investigation. ASI has up-dated the report format of this document to ensure it is more complete. If the allegation involves staff abuse, the Director is notified and she/he initiates the investigation. Staff are immediately suspended in these instances. The policy, procedure, and form for investigating allegations of abuse/neglect/exploitation have been up-dated to address the		

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			timeliness and thoroughness of the investigation.	

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W000159	<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.</p> <p>Based on record review and interview, the QIDP (Qualified Intellectual Disabilities Professional) failed for 4 of 4 sampled clients (clients A, B, C and D) and 3 additional clients (clients E, F and G), to ensure: the individual programs were reviewed and revised for clients (clients A, B, C and D); a PT (Physical Therapy) reassessment was completed for client C; safe sex assessments/reassessments were completed for clients A and B; a Behavior Support Plan contained identified behaviors for client B; updated active treatment plans for clients A, B, C and D; staff provided program implementation at every opportunity for clients E and G; program data was documented and collected for clients A, B, C and D; Comprehensive Functional Assessments were updated annually for clients C and D; the Behavior Support Plan medications included a titration plan and fire drills were conducted at least every quarter on the night shift for clients A, B, C, D, E, F and G.</p> <p>Findings include:</p>	W000159	<p>Each clients active treatment will be integrated, coordinated and monitored by the QIDP. The QIDP will review and/or revise the clients ISP annually or if there are changes to the clients goals based on quarterly progress reviews. Any assessment or reassessments that identify a risk will have a protocol in place to address this risk. The QIDP is the chair person for the IDT to monitor that protocols are in place and appropriate staff trained. QIDP will work with behavior specialist and nurse to ensure each consumer with a psychotropic medication with a targeted behavior has a medication titration plan and tracking. Coordinators are responsible for scheduling and tracking fire drills. All completed drills are brought to safety bi-monthly meeting for review and action plan if needed. Director of Programming is responsible for supervision of Coordinator and QIDP as well as safety committee chair person. In addition to QIDP oversight for active treatment, tracking for all active treatment schedules will be monitored weekly through individual chart audits. In regard to a letter dated 9/10, ASI did</p>	09/06/2013

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	<p>1. Client A's record was reviewed on 7/31/13 at 12 PM. Client A's ISP (Individualized Support Plan) of 4/23/13 indicated the following objectives:</p> <ul style="list-style-type: none"> To choose 7 words out of the books he checked out from the library to learn to spell. To brush his teeth for 1 minute twice a day. To measure out his mouth wash to the line on the Dixie cup. To learn specific cleaning supplies for each room. To deposit his check from work. To ask if he can join in a conversation. To write down the appointments he has on his calendar. To do his daily therapy exercises. To purchase the items from the store on his list. To cook the main dish on Sunday. To complete problems from his math workbooks. <p>Client A's record indicated no Quarterly Progress Reviews from the QIDP (Qualified Intellectual Disabilities Professional) of client A's progression on his objectives since September 2012.</p> <p>Client B's record was reviewed on 7/31/13 at 2 PM. Client B's ISP of 4/23/13 indicated client B had the following objectives:</p>		<p>have policies and procedures in place to prevent and investigate allegations of abuse/neglect/exploitation. The agency also had a process in place for investigating injuries of unknown origin and consumer to consumer abuse. The system failed in the instances cited in this W for a few reasons: 1. Incident Reports were not being submitted to the appropriate staff in a timely manner; and 2. Due to the delay in reporting, the QIDP/Director were not able to conduct a timely and thorough investigations. To address these issues, ASI has revamped its Incident Reporting process for all Group Homes. Any time an Incident Report is written, the DSP must call the Programming Coordinator, QIDP, and Nurse to report the incident. This begins the notification process for them in case a BDDS report is required or an investigation must be initiated. These individuals are on-call 24-7. The Incident Report is then electronically scanned to these same persons so that the paperwork process follows their actions. There is no opportunity for delay in an investigation process with this notification system. If it is an investigation of unknown injury or consumer to consumer abuse, the QIDP and Nurse conduct the investigation. ASI has up-dated the report format of this document to ensure it is more complete. If the</p>				

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	<p>To put her activities and appointments on her calendar.</p> <p>To go over a menu of her choice and put items needed on a grocery list.</p> <p>To practice writing food items that she might be purchasing at the store.</p> <p>To write her identification information.</p> <p>To count the money to a staff member after making a purchase.</p> <p>To complete a saving account ledger when given a list of deposits and withdrawals that had been made.</p> <p>To pop out medications from the bubble pack and then crush the pills with the pill crusher. And then state why she is taking the medications.</p> <p>To read five words of her choosing from the word search book.</p> <p>Client B's record indicated no Quarterly Progress Reviews from the QIDP of client B's progression on her objectives since September 2012.</p> <p>Interview with the QIDP on 8/1/13 at 11 AM indicated the QIDPs were to review and/or revise the clients' program objectives monthly depending on the client's progress toward obtaining their objectives. After interviewing the QIDP about the lack of quarterly progress notes, the QIDP provided a review form for May, June and July with no signatures and/or no recommendations.</p>		<p>allegation involves staff abuse, the Director is notified and she/he initiates the investigation. Staff are immediately suspended in these instances. The policy, procedure, and form for investigating allegations of abuse/neglect/exploitation have been up-dated to address the timeliness and thoroughness of the investigation.</p>		

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	<p>Client C's records were reviewed on 07/31/13 at 1:43 PM. Client C's ISP was dated 04/23/13. The ISP objectives were as follows: clean her wheelchair; clean her glasses daily; keep in contact with her friends; notify staff she is going to take her shower and read aloud to staff 15 minutes. Client C's record contained a Quarterly Progress Report dated September 2012. The next Quarterly Progress Report was dated July 2013. There was no evidence of program reviews or revisions between these dates.</p> <p>Client D's records were reviewed on 07/31/13 at 11:33 AM. Client D's ISP was dated 04/23/13. The ISP objectives were as follows: identify his multivitamin; shave daily with electric razor; write or recite address, city, state, phone number; make a shopping list for one meal; wash his private areas thoroughly when showering; write a letter or send a card to brother; exercise 30-60 minutes a day; go to the local library 2 times a month to check out item; fold his laundry when he is finished washing and drying it; take his wet clothes from washer and put then into the dryer; measure out the serving size for his main dish, fruit and vegetable for each meal and sort and bring his clothes to the laundry room. Client D's record</p>			

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	<p>contained a Quarterly Progress Report dated September 2012. The next Quarterly Progress Report was dated July 2013. There was no evidence of program reviews or revisions between these dates.</p> <p>2. Please refer to W209. The QIDP failed for 3 of 4 sampled clients (clients A, C and D), to ensure actions were taken to obtain the participation of the guardians (GU) in the Interdisciplinary Team.</p> <p>3. Please refer to W210. The QIDP failed for 1 of 4 sampled clients (client C) to obtain a reassessment by Physical Therapy (PT) and failed to ensure the Interdisciplinary Team (IDT) re-assessed 2 of 4 sampled clients (clients A and B) for the understanding of safe sex and/or the need for sex education.</p> <p>4. Please refer to W218. The QIDP failed for 1 of 4 sampled clients (client D) with sensorimotor deficits to have a sensorimotor assessment.</p> <p>5. Please refer to W227. The QIDP failed for 1 of 4 sampled clients (client B) to ensure the client's BSP (Behavior Support Plan) addressed the client's identified behavioral needs.</p> <p>6. Please refer to W249. The QIDP</p>				

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	<p>failed for 2 additional clients (clients E and G) to implement written objectives during times of opportunity.</p> <p>7. Please refer to W250. The QIDP failed for 4 of 4 sampled clients (clients A, B, C and D), to update and individualize the active treatment schedules (ATS).</p> <p>8. Please refer to W252. The QIDP failed for 4 of 4 sampled clients (clients A, B, C and D), to document and/or collect data as outlined in the Individual Support Plans (ISP).</p> <p>9. Please refer to W259. The QIDP failed for 2 of 4 sampled clients (clients C and D), to ensure the comprehensive functional assessments (CFAs) were reviewed and updated annually.</p> <p>10. Please refer to W312. The QIDP failed for 2 of 4 sampled clients (clients B and C) who were on medications related to behaviors, by not ensuring the clients' Behavior Support Plans (BSP) included the medication or a titration plan for the medications in the plan.</p> <p>11. Please refer to W440. The QIDP failed for 7 of 7 clients (clients A, B, C, D, E, F and G) who resided in the home, by not ensuring an evacuation drill was</p>			

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	<p>conducted at least every quarter on the night shift.</p> <p>On 08/01/13 at 1:30 PM an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP stated there were "numerous things that should have been done that were not." She indicated the CFAs were to be updated annually and these were not completed in the appropriate time frame. She also indicated clients E and F were difficult to engage in activities but should be prompted.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-3(a)</p>			

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W000209	<p>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.</p> <p>Based on record review and interview, the facility failed to ensure actions were taken to obtain the participation of the guardians (GU) in the Interdisciplinary Team process for 3 of 4 sampled clients (clients A, C and D).</p> <p>Findings include:</p> <p>Client C's records were reviewed on 07/31/13 at 1:43 PM. Client C's ISP (Individual Support Plan) was dated 04/23/13 and indicated client C has a GU. Client C's ISP was not signed by the GU to indicate her input with the ISP.</p> <p>Client D's records were reviewed on 07/31/13 at 11:33 AM. Client D's ISP was dated 04/23/13 and indicated client D has a GU. Client D's ISP was not signed by the GU to indicate his input with the ISP.</p> <p>On 08/01/13 at 1:30 PM an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated clients C and D's ISPs had not been signed by their GUs to</p>	W000209	Each clients active treatment will be integrated, coordinated and monitored by the QIDP. The QIDP will review and/or revise the clients ISP annually or if there are changes to the clients goals based on quarterly progress reviews. Any assessment or reassessments that identify a risk will have a protocol in place to address this risk. The QIDP is the chair person for the IDT to monitor that protocols are in place and appropriate staff trained. QIDP will work with behavior specialist and nurse to ensure each consumer with a psychotropic medication with a targeted behavior has a medication titration plan and tracking. Coordinators are responsible for scheduling and tracking fire drills. All completed drills are brought to safety bi-monthly meeting for review and action plan if needed. Director of Programming is responsible for supervision of Coordinator and QIDP as well as safety committee chair person. In addition to QIDP oversight for active treatment, tracking for all active treatment schedules will be monitored weekly through individual chart audits. The QIDP will obtain participation of	09/06/2013

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	<p>indicate their input with the ISPs.</p> <p>Client A's record was reviewed on 7/31/13 at 12 PM. Client A's record indicated client A's brother served as the client's legal representative. Client A's record failed to provide evidence client A and/or client A's legal representative had participated in the review and/or revision of client A's 4/23/13 ISP. The record indicated no invitation to client A's representative to attend the meeting.</p>		<p>the guardians in the IDT meetings by notifying them of the time of the meeting and providing a call in number to discuss information pertinent to the consumer. In response to a letter dated 9/10, the issues noted were the result of the QIDP not following up with guardians who did not attend meetings. This has been addressed with the QIDP to ensure that she documents invitations and guardian responses for the file. In addition, it is the responsibility of the QIDP to follow up with guardians to ensure their approval/comments are received and noted. ASI has started a new filing audit where documents will be reviewed on a weekly basis for deficiencies. Any deficiencies are reported to the QIDP, Nurse, and Programming Coordinator for remediation. The Quality Assurance Committee will also be notified of the deficiencies and corrections to ensure they are completed.</p>		

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	<p>During interview with client A on 8/1/13 at 3:30 PM client A stated he had attended his annual ISP meeting of 4/23/13, "but I don't remember signing anything." Client A indicated his legal representative did not attend the annual ISP meeting to revise and/or update client A's ISP.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/1/13 at 11 AM indicated client A's legal representative had not attended client A's ISP meeting of 4/23/13. The QIDP stated, "I haven't gotten his signature yet."</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-4(a)</p>			
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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (client C) to obtain a reassessment by Physical Therapy (PT) and failed to ensure the Interdisciplinary Team (IDT) re-assessed 2 of 4 sampled clients (clients A and B) for the understanding of safe sex and/or the need for sex education.</p> <p>Findings include:</p> <p>1. Observations were conducted in the group home on 07/30/13 from 3:30 PM until 6:02 PM and on 07/31/13 from 6:30 AM until 7:45 AM. During both observation times client C sat in her wheelchair and was observed to move around the house by self-propelling her wheelchair. Client C was not observed to use a walker in the home.</p> <p>Client C's records were reviewed on 07/31/13 at 1:43 PM. Client C's ISP (Individual Support Plan) was dated 04/23/13 and indicated her diagnoses included but were not limited to Cerebral</p>	W000210	<p>Each clients active treatment will be integrated, coordinated and monitored by the QIDP. The QIDP will review and/or revise the clients ISP annually or if there are changes to the clients goals based on quarterly progress reviews. Any assessment or reassessments that identify a risk will have a protocol in place to address this risk. After preliminary evaluation of a new consumer, IDT will perform accurate assessments as needed to set up a plan for the client. The QIDP is the chair person for the IDT to monitor that protocols are in place and appropriate staff trained. QIDP will work with behavior specialist and nurse to ensure each consumer with a psychotropic medication with a targeted behavior has a medication titration plan and tracking. Coordinators are responsible for scheduling and tracking fire drills. All completed drills are brought to safety bi-monthly meeting for review and action plan if needed. Director of Programming is responsible for supervision of Coordinator and QIDP as well as safety committee chair person. In addition to QIDP oversight for</p>	09/06/2013	

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	<p>Palsy and Moderate Spastic Paresis (paralysis). A Continuity Of Care Form dated 08/08/12 indicated she was seen by PT for evaluation of ambulation, transfer and exercise training. The PT recommendation indicated, "Increase time out of the wheelchair with standing walking and laying (sic) bed with leg straight." A Continuity Of Care Form dated 01/31/13 indicated client C was seen by PT. The form indicated PT for, "ambulation/transfer training, stand/seating balance, (unable to read) stretches to B (bilateral) hip flexors."</p> <p>Client C's record did not contain a fall risk plan or instructions on when, how or what staff were to do to regarding ambulation instructions or an ambulation plan for client C.</p> <p>On 08/01/13 at 11:10 AM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client C did not have a fall risk plan and there was not a plan to indicate how/when client C was to ambulate. She indicated she did not know when client C had her last complete PT evaluation and she should be reassessed.</p> <p>2. During observations at the workshop on 7/31/13 between 9 AM and 10 AM, clients A and B sat across from each other</p>		<p>active treatment, tracking for all active treatment schedules will be monitored weekly through individual chart audits. In response to a letter dated 9/10, the errors identified in W210 were deficiencies from nursing services. To ensure that follow up appointments are not missed, the Assistant Programming Coordinator is now receiving all Continuity of Care forms (following a doctor appointment) to ensure that an additional appointments are scheduled. These are then reviewed by the Nurse when she reviewed the COC to make sure that appointment has already been set. The new Comprehensive Functional Assessment that the QIDP are switching to includes a section on sexual knowledge. Information from this assessment can be used to develop goals for them.</p>		

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	<p>at the same table.</p> <p>The facility's reportable and investigative records for July 2012 through July 2013 were reviewed on 7/30/13 at 1:30 PM and again on 7/31/13 at 11 AM.</p> <p>A 11/8/12 BDDS (Bureau of Developmental Disabilities Services) report indicated on 11/7/12 at 11:15 AM while at the work shop client B made allegations client A had "touched her on the chest and was looking at her butt." The 11/8/12 investigative record indicated clients A and B were to stay "at least" 3 feet from one another while working. The staff were trained to not let them work at the same table until told otherwise.</p> <p>A 1/22/13 IR indicated at 8:30 AM while at the workshop client B reported to one of the workshop staff that client B and client A were "an item now." The report indicated client B stated she was breaking up with another consumer.</p> <p>An IR (Incident Report) of 2/6/13 at 10:12 PM indicated the staff observed client B lying on top of client A. The IR indicated the staff informed clients A and B "this was not appropriate behavior. [Client B] moved off of [client A] before staff left. This is not the first time this staff has said something to them."</p>				

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	<p>Client A's record was reviewed on 7/31/13 at 12 PM. Client A's record indicated no assessment of client A's understanding of safe sex and/or the need for sex education.</p> <p>Client B's record was reviewed on 7/31/13 at 2 PM. Client B's record indicated no assessment of client B's understanding of safe sex and/or the need for sex education.</p> <p>Interview with client A on 8/1/13 at 3:30 PM indicated he and client B were not having sex because the facility would not let them. Client A indicated whenever he and client B were in a room together they had to keep their door open all the time.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/1/13 at 11 AM indicated the IDT had not assessed clients A and B in regard to their understanding of safe sex and/or their need for sex education.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-4(a)</p>						

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W000218	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 4 sampled clients (client D) with sensorimotor deficits to have a sensorimotor assessment.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 07/30/13 from 3:30 PM until 6:02 PM and on 07/31/13 from 6:30 AM until 7:45 AM. During both observation times client D was observed to ambulate slowly. During the 07/31/13 observation client D wore bilateral leg braces and walked more slowly than without the braces.</p> <p>Client D's records were reviewed on 07/31/13 at 11:33 AM. Client D's record contained a fall risk assessment dated 04/30/13 which indicated he was not at risk for falls. A Continuity of Care Form dated 05/31/13 indicated client D had seen the podiatrist. The podiatrist indicated, "Pt (patient) limping with unsteady gait, 'holds the wall' when walking. Recommended AFO (ankle-foot orthotic) B (bilaterally), because (sic) weakness...." Client D's record did not</p>	W000218	The nurse will complete upon admission and quarterly a head to toe nursing assessment that includes a neurological section (sensorimotor assessment). Fall risk assessments will be done by nurse upon admission, quarterly, and as needed. A fall protocol will be developed with IDT follow up when necessary. Tracking forms will be implemented and staff trained on any new or revised fall protocols. Weekly chart audits will ensure assessments are completed and protocols in place. Any missing information will be reported to Director of Programming. Safety Committee bi-monthly meeting will review any outstanding issues with charts. In response to a letter dated 9/10, the deficiency noted was a result of inadequate follow up by the nurse. This has been addressed as a performance issue. ASI has a contract with an RN who will be utilized to do monthly reviews of medical and nursing care for group home clients. The intent of this is to identify consumer needs that may be missed by the agency's nurse. The RN will provide a written report to the Director of Programming and Executive Director regarding her findings and recommendations to ensure that they are addressed.	09/06/2013			

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	<p>contain a PT (Physical Therapy) evaluation to evaluate the unsteady gait. Client D's record did not contain an updated fall risk assessment related to the unsteady gait.</p> <p>On 08/01/13 at 11:10 AM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client D was at risk for falls, he had not had a PT evaluation and one should be obtained. She further indicated a fall risk plan had not been completed.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-4(a)</p>			

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W000227	<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.</p> <p>Based on record review and interview for 1 of 4 sampled clients (B), the client's BSP (Behavior Support Plan) failed to address the client's identified behavioral needs.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records for July 2012 through July 2013 were reviewed on 7/30/13 at 1:30 PM and again on 7/31/13 at 11 AM.</p> <p>A 12/7/12 BDDS (Bureau of Developmental Disabilities Services) report indicated on 12/4/12 at 10:50 AM client B grabbed another consumer's wheelchair and "pushed him fast. The other consumer's wheelchair tipped over with him in it."</p> <p>A 2/12/13 BDDS report indicated on 2/12/13 at 2:50 PM "Two staff [initials of staff] were standing in the lunch room getting other consumers' coats to leave for the day. Staff stepped to the side to let a female consumer in a wheelchair through.</p>	W000227	The clients program plan has been revised to address the client's identified behavioral needs. IDT will review all BSP's and any new or revised BSP's will be reviewed in HRC. Tracking sheets will be created to track identified behaviors. Behavior Specialist will train staff on behavior plans. Human Resources will track trainings for each staff. In response to a letter dated 9/10, the Behavior Specialist met with the Director of Programming to review this particular BSP. Although the specific language of "physical aggression" is not used, the descriptions under "emotional outbursts" in the BSP do specifically include examples of stomping, slamming doors and objects, hitting, and property destruction. ASI will continue to include the Behavior Specialist in the monthly group home staff meetings to not only receive information from staff regarding consumer behavior but to continually train staff on how to implement the BSP.	08/29/2013			

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	<p>[Client B] then came thru (sic) and put her hands up and shoved staff [initials of staff] out of her way and pushed other staff [initials of staff] with her shoulder and arm with enough force that it moved staff."</p> <p>A 3/5/13 BDDS report indicated on 3/4/13 at 9:15 PM, "[Client B] became upset and smacked [client D] on the left arm, she [client B] then threw a roll of toilet paper towards him [client D].... Staff reminded [client B] that when she becomes upset it is not appropriate to hit others...."</p> <p>A 3/13/13 BDDS report indicated on 3/12/13 at 11:45 PM client A and client B were sitting in client B's bed room "discussing an argument they had earlier in the day. [Client A] was asking [client B] to talk to him and instead of sitting there in silence (sic). [Client B] grabbed [client A's] upper arm and tried to pull him up. [Client A] asked her to let go and just talk to him. [Client A] asked twice more. [Client B] let go and [client A] left [client B's] room.... [Client B] was remained (sic) by staff it is not ok to grab others but to use her words and ask [client A] to leave her room."</p> <p>A 3/15/13 BDDS report indicated on 3/14/13 at 9:30 PM client B was taking</p>						

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	<p>her 9 PM medications when client B said she was tired of client C "always being in her business. [Client B] became upset and elbowed staff [name of staff]. She [client B] then threw her pill crusher across the office nearly hitting staff. [Client B] began cursing and screaming at staff...."</p> <p>A 4/26/13 BDDS report indicated on 4/25/13 at 5 PM "[Client F] came to staff [name of staff] and told her [client H] was in his room crying. [Name of staff] went to [client H's] room and asked him [client H] what was wrong. [Client H] told [name of staff] that [client B] had hit him on the arm and he did not know why. [Name of staff] checked [client H's] arm and noticed a red mark on it. [Name of staff] gave [client H] an ice pack and went to talk to [client B]. [Client B] said that she hit [client H] because he was being a butt.... Staff reminded [client B] it is not appropriate to hit others when she is upset."</p> <p>A 6/5/13 BDDS report indicated on 6/4/13 at 8:15 PM "[Name of staff] was in [client H's] room with [client H]. [Client H] opened up his closet door. [Name of staff] noticed [client H] had [client B's] undergarments. [Name of staff] informed [client H] he would have to return them to [client B]. [Client B] heard her name and came down to [client H's] room. Upon</p>						

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	<p>seeing her undergarments she smacked [client H] in the chest and stormed off to her room. Staff [name of staff] accessed (sic) [client H] for injuries. He [client H] did have a red hand print on his chest."</p> <p>Client B's record was reviewed on 7/31/13 at 2 PM. Client B's updated BSP of 3/11/13 indicated the BS (Behavior Specialist) "removed elopement and physical aggression from targeted behaviors." Client B's BSP indicated client B had targeted behaviors of depressive characteristics and emotional outbursts. The BSP defined emotional outbursts to be "yelling, cussing, threatening, stomping, ignoring/refusing to talk to those with whom she is angry, slamming doors or other objects (including her own hand, head, etc. against something), minor hitting, and property destruction (such as throwing her own belongings)." The BSP indicated reactive strategies to client B's emotional outbursts to be: "Continue to use a calm voice and react calmly. Watch for signs of [client B] beginning to get upset... encourage her to use her coping strategies such as taking a break in a safe place, deep breathing, music, relaxation exercises, talking about it with someone appropriate, journaling, etc. to calm herself... Compliment her when she calms down using one of her coping</p>			

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	<p>strategies.... If [client B] begins to get agitated by yelling, cussing, threatening, stomping, slamming items, etc., clear the environment of people and items that would be unsafe. Redirect her to a safe place away from others where she can calm down. [Client B] usually chooses to go to her room if at home. Encourage her to use her self-calming strategies. [Client B] may come out when she is calm.... Check on [client B] after 30 minutes to make sure she is safe....Talk through the issue once she is calm." Client B's BSP did not address client B's identified behavior of physical aggression.</p> <p>During interview with client A on 8/1/13 at 3:30 PM, client A stated "Oh yeah, she [client B] gets physically aggressive all the time. I don't think she aims to, but she does." Client A stated client B "often gets mad" and would hit him and/or other clients in the group home.</p> <p>Interview with QIDP (Qualified Intellectual Disabilities Professional) on 7/31/13 at 11 AM indicated client B's BSP indicated target behaviors of depressive characteristics and emotional outbursts. The QIDP indicated client B's BSP did not address client B's identified behavior of physical aggression.</p> <p>This federal tag relates to complaint</p>				

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview, the facility failed to implement written objectives during times of opportunity for 2 additional clients (clients E and G).</p> <p>Findings include:</p> <p>1. Observations were conducted in the group home on 07/30/13 from 3:30 PM until 6:02 PM. Staff #1 and #2 were on duty. Client E was in his bedroom at 3:30 PM and stayed in his room until 5:11 PM when he came to the dining room table and ate his supper. Client E did not communicate with his roommates and wore earphones at the table and had a CD player with him. Client E returned to his bedroom at 5:23 PM and remained in his room until the end of the observation at 6:02 PM. Staff #1 or #2 did not prompt him every 15 minutes to engage in an activity.</p> <p>An interview was conducted with staff #1 and #2 on 07/30/13 at 4:40 PM and they</p>	W000249	<p>Each clients active treatment will be integrated, coordinated and monitored by the QIDP. The QIDP will review and/or revise the clients ISP annually or if there are changes to the clients goals based on quarterly progress reviews. Active Treatment Schedules will be updated annually and dated. In addition to QIDP oversight for active treatment, tracking for all active treatment schedules will be monitored weekly through individual chart audits. Any missing information in chart audits will be sent to QIDP and Director of Programming for follow up. In response to a letter dated 9/10, all group home staff have been retrained on consumer specific plans to ensure compliance. In addition, the QIDP and Programming Coordinator are expected to be in the homes at least once per week to observe staff interactions with consumers. This will be an opportunity to retrain staff in the moment. These visits will be tracked using a Site Observation form. These will be reviewed by the Quality</p>	09/06/2013
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	<p>both indicated client E liked to stay in his room and lay on his bed listening to music. They indicated he "rarely" participated in anything.</p> <p>Observations were conducted in the group home on 07/31/13 from 6:30 AM until 7:45 AM. The TL (Team Lead) and staff #4 were on duty. Client E was in his bedroom at 6:30 AM and stayed in his room until 7:29 AM when he received his medications and then boarded the van to leave for day placement. The TL or staff #4 did not prompt him every 15 minutes to engage in an activity.</p> <p>An interview was conducted with the TL and staff #4 on 07/31/13 at 7:40 AM and they both indicated client E liked to stay in his room and lay on his bed listening to music. They stated he "rarely" participated in anything.</p> <p>Observations were conducted in the group home on 07/31/13 from 4:30 PM until 5:45 PM. Staff #5 and #6 were on duty. Client E remained in his room during the entire observation. Staff #5 or #6 did not prompt him every 15 minutes to engage in an activity.</p> <p>An interview was conducted with staff #5 and #6 on 07/31/13 at 5:30 PM and they both indicated client E liked to stay in his</p>		<p>Assurance Committee at each meeting to identify areas for improvement and to ensure that changes that are made are maintained. In response to the letter dated Sept 23, - ASI has set procedures for unannounced and announced site visits by the nurse, med records assistant, PC, Assistant PC, and QIDP. Each week, three visits to the home will be completed by any of the above. The checks will include an area identified and will rotate between the areas. Areas/Topics include but are not limited to: Medical, Quality Assurance, Dietary, Environmental, Adaptive, and Staffing. Each visit will have a site visitation form to be completed and returned to the Director of Programming. Any immediate safety/jeopardy is to be immediately reported to a Director. The Director of Programming will monitor these site visits and will review them in Quality Assurance Committee meeting that meets at least bi-weekly but mostly weekly.</p>		

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	<p>room and lay on his bed listening to music. They indicated it was difficult to get him to participate.</p> <p>Client E's records were reviewed on 08/01/13 at 10:00 AM and contained the following dated documents:</p> <p>04/23/13: ISP (Individual Support Plan) indicated client E had the following goals: use a towel to dry his body; fold his own clothes; pay for an item on an outing; assist to make dinner; take an appropriately long shower 10 minutes approximately; take his dirty clothes to the laundry room putting them in the washer and transferring them to the dryer; make a list on a board in his room when he starts running low on personal items; go to the library and check out two books and take his shampoo and soap into the shower with him.</p> <p>An undated Active Treatment Schedule indicated client E had the following schedule: 5:00 AM - 7:40 AM: Wake up, make bed, dress, medications, breakfast and leave for workshop. 3:30 PM - 8:00 PM: Arrive home from work, check chore chart, supper, dishes to sink and clean-up and goals.</p> <p>On 08/01/13 at 11:24 AM an interview</p>						

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	<p>with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client E should be following his Active Treatment Schedule and he should be engaged in activity and staff should prompt him every 15 minutes to engage in an activity.</p> <p>2. Observations were conducted at the group home on 7/30/13 between 3:15 PM and 5:30 PM. At 3:30 PM client G was in his bed, covered up with his blankets. From 3:30 PM until time for the evening meal at 5 PM, client G paced the hallway and/or was in his room, not involved in any activity. The staff did not provide client G with any choices of leisure activities and/or training objectives during this time. Staff did not prompt him every 15 minutes to engage in an activity.</p> <p>Observations were conducted at the workshop on 7/31/13 between 9:15 AM and 11:45 AM. From 9:15 AM until 10:20 AM client G sat in the workshop on the floor next to the exercise bike. The staff did not provide client G with any choices of leisure activities and/or training objectives during this time. Staff did not prompt him every 15 minutes to engage in an activity.</p> <p>Client G's record was reviewed on 8/2/13 at 10 AM. Client G's ISP of 4/23/13</p>				

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	<p>indicated client G had objectives: To write 4 foods that he wants to put on the grocery list. To put his clothes away. To match 5 words with the same word (cat for cat, dog for dog). To make the powdered drink for the evening meal. To write the days of the week.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 7/31/13 at 11 AM indicated training objectives were to be offered at every available opportunity. The QIDP indicated leisure activities were to be offered when time allotted.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-4(a)</p>				

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W000250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>Based on record review and interview, the facility failed for 4 of 4 sampled clients (clients A, B, C and D), to update and individualize the active treatment schedules (ATS).</p> <p>Findings include:</p> <p>Client C's records were reviewed on 07/31/13 at 1:43 PM. The ATS in the record was not dated.</p> <p>Client D's records were reviewed on 07/31/13 at 11:33 AM. The ATS in the record was not dated.</p> <p>On 07/31/13 at 3:30 PM an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the ATS was to be updated along with the ISP (Individual Support Plan). She indicated the ATS in the record were not dated and she could not tell if they had been updated at the time of the ISP.</p>	W000250	<p>Each clients active treatment will be integrated, coordinated and monitored by the QIDP. The QIDP will review and/or revise the clients ISP annually or if there are changes to the clients goals based on quarterly progress reviews. Active Treatment Schedules will be updated annually and dated. Staff will be trained on the schedules and they will be readily available in the home for staff and clients. In addition to QIDP oversight for active treatment, tracking for all active treatment schedules will be monitored weekly through individual chart audits. Any missing information in chart audits will be sent to QIDP and Director of Programming for follow up. In response to the letter dated Sept 23rd, ASI has set procedures for unannounced and announced site visits by the nurse, med records assistant, PC, Assistant PC, and QIDP. Each week, three visits to the home will be completed by any of the above. The checks will include an area identified and will rotate between the areas. Areas/Topics include but are not limited to: Medical, Quality Assurance, Dietary, Environmental, Adaptive, and</p>	09/06/2013	

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	<p>Client A's record was reviewed on 7/31/13 at 12 PM. Client A's record indicated an undated Active Treatment Schedule (ATS). The ATS did not include client A's job in the community.</p> <p>Client B's record was reviewed on 7/31/13 at 2 PM. Client B's record indicated an undated Active Treatment Schedule.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/1/13 at 11 AM indicated client A's and client B's ATSs were undated. The QIDP indicated she did not know the last time client A's and client B's ATSs were updated. The QIDP indicated all clients' ATSs were to be updated along with their</p>		<p>Staffing. Each visit will have a site visitation form to be completed and returned to the Director of Programming. Any immediate safety/jeopardy is to be immediately reported to a Director. The Director of Programming will monitor these site visits and will review them in Quality Assurance Committee meeting that meets at least bi-weekly but mostly weekly. The QIDP has been retrained to make sure she reviews and updates active treatment schedules and dates them. Failure to complete will result in disciplinary action.</p>		

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	<p>Individualized Support Plans.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-4(a)</p>				

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W000252	<p>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.</p> <p>Based on record review and interview for 4 of 4 sampled clients (clients A, B, C and D), the facility failed to document and/or collect data outlined in the Individual Support Plans (ISP).</p> <p>Findings include:</p> <p>1. Client C's records were reviewed on 07/31/13 at 1:43 PM. Client C's ISP was dated 04/23/13 and contained the following goals which lacked documentation indicating the goals had been implemented:</p> <p>May 2013: - clean her wheelchair - 4 times a week (4 x week x 4 weeks = 16 times) - the tracking sheet contained recorded documentation of the goal implementation 8 times. -clean her glasses daily - the tracking sheet contained recorded documentation of the goal implementation 20 times. -keep in contact with her friends - twice a month - the tracking sheet contained recorded documentation of the goal implementation 1 time.</p>	W000252	<p>Each clients active treatment will be integrated, coordinated and monitored by the QIDP. The QIDP will review and/or revise the clients ISP annually or if there are changes to the clients goals based on quarterly progress reviews. Active Treatment Schedules will be updated annually and dated. Staff will be trained on the schedules and they will be readily available in the home for staff and clients. In addition to QIDP oversight for active treatment, tracking for all active treatment schedules will be monitored weekly through individual chart audits. Any missing information in chart audits will be sent to QIDP and Director of Programming for follow up. Site checks will also ensure that Coordinators are available to answer any questions in regard to filing out tracking sheets. In response to the letter dated Sept 23rd, ASI has set procedures for unannounced and announced site visits by the nurse, med records assistant, PC, Assistant PC, and QIDP. Each week, three visits to the home will be completed by any of the above. The checks will include an area identified and will rotate between the</p>	09/06/2013			

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	<p>- notify staff she is going to take her shower - daily - the tracking sheet contained recorded documentation of the goal implementation 24 times.</p> <p>-read aloud to staff 15 minutes twice a week (2x week x 4 weeks = 8 times) - the tracking sheet contained recorded documentation of the goal implementation 8 times.</p> <p>June 2013:</p> <p>-state the names of each medication in the medication cup - daily - the tracking sheet contained recorded documentation of the goal implementation 22 times.</p> <p>- clean her wheelchair - 4 times a week (4 x week x 4 weeks = 16 times) - the tracking sheet contained recorded documentation of the goal implementation 7 times.</p> <p>-clean her glasses daily - the tracking sheet contained recorded documentation of the goal implementation 20 times.</p> <p>-keep in contact with her friends - twice a month - the tracking sheet contained recorded documentation of the goal implementation 0 times.</p> <p>- notify staff she is going to take her shower - daily - the tracking sheet contained recorded documentation of the goal implementation 23 times.</p> <p>-read aloud to staff 15 minutes twice a week (2x week x 4 weeks = 8 times) - the tracking sheet contained recorded</p>		<p>areas. Areas/Topics include but are not limited to: Medical, Quality Assurance, Dietary, Environmental, Adaptive, and Staffing. Each visit will have a site visitation form to be completed and returned to the Director of Programming. Any immediate safety/jeopardy is to be immediately reported to a Director. The Director of Programming will monitor these site visits and will review them in Quality Assurance Committee meeting that meets at least bi-weekly but mostly weekly. Data collection will be monitored at the site visits and in each weekly chart audit. Staff not completing paperwork correctly will receive disciplinary action that will include individual retraining on the tracking of goals.</p>				

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	<p>documentation of the goal implementation 5 times.</p> <p>-read menu and make grocery list - twice a month - the tracking sheet contained recorded documentation of the goal implementation 0 times.</p> <p>July 2013:</p> <p>-state the names of each medication in the medication cup - daily - the tracking sheet contained recorded documentation of the goal implementation 24 times.</p> <p>- clean her wheelchair - 4 times a week (4 x week x 4 weeks = 16 times) - the tracking sheet contained recorded documentation of the goal implementation 8 times.</p> <p>-clean her glasses daily - the tracking sheet contained recorded documentation of the goal implementation 21 times.</p> <p>-keep in contact with her friends - twice a month - the tracking sheet contained recorded documentation of the goal implementation 0 times.</p> <p>- notify staff she is going to take her shower - daily - the tracking sheet contained recorded documentation of the goal implementation 23 times.</p> <p>-read aloud to staff 15 minutes twice a week (2x week x 4 weeks = 8 times) - the tracking sheet contained recorded documentation of the goal implementation 6 times.</p> <p>-read menu and make grocery list - twice</p>						

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	<p>a month - the tracking sheet contained recorded documentation of the goal implementation 0 times.</p> <p>2. Client D's records were reviewed on 07/31/13 at 11:33 AM. Client D's ISP was dated 04/23/13 and contained the following goals which lacked documentation indicating the goals had been implemented:</p> <p>May 2013:</p> <ul style="list-style-type: none"> -identify his multivitamin - twice a day - the tracking sheet contained recorded documentation of the goal implementation 52 times. - shave daily with electric razor - daily - the tracking sheet contained recorded documentation of the goal implementation 26 times. -write or recite address, city, state, phone number - 3 times a week - the tracking sheet contained recorded documentation of the goal implementation 10 times. -make a shopping list for one meal - weekly - the tracking sheet contained recorded documentation of the goal implementation 0 times. - wash his private areas thoroughly when showering - daily - the tracking sheet contained recorded documentation of the goal implementation 27 times. -write a letter or send a card to brother - once a month - the tracking sheet 			

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	<p>contained recorded documentation of the goal implementation 0 times.</p> <p>-exercise 30-60 minutes a day - daily - the tracking sheet contained recorded documentation of the goal implementation 5 times.</p> <p>-go to the local library 2 times a month to check out item - twice a month - the tracking sheet contained recorded documentation of the goal implementation 1 time.</p> <p>-fold his laundry when he is finished washing and drying it - 2 times a week - the tracking sheet contained recorded documentation of the goal implementation 5 times.</p> <p>-take his wet clothes from washer and put them into the dryer - 2 times a week - the tracking sheet contained recorded documentation of the goal implementation 3 times.</p> <p>-measure out the serving size for his main dish, fruit and vegetable for each meal - up to 3 times a day - the tracking sheet contained recorded documentation of the goal implementation 65 times.</p> <p>-sort and bring his clothes to the laundry room - 2 times a week - the tracking sheet contained recorded documentation of the goal implementation 3 times.</p> <p>June 2013:</p> <p>-identify his multivitamin - twice a day - the tracking sheet contained recorded</p>						

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	<p>documentation of the goal implementation 46 times.</p> <p>- shave daily with electric razor - daily - the tracking sheet contained recorded documentation of the goal implementation 22 times.</p> <p>-write or recite address, city, state, phone number - 3 times a week - the tracking sheet contained recorded documentation of the goal implementation 6 times.</p> <p>-make a shopping list for one meal - weekly - the tracking sheet contained recorded documentation of the goal implementation 0 times.</p> <p>- wash his private areas thoroughly when showering - daily - the tracking sheet contained recorded documentation of the goal implementation 22 times.</p> <p>-write a letter or send a card to brother - once a month - the tracking sheet contained recorded documentation of the goal implementation 0 times.</p> <p>-exercise 30-60 minutes a day - daily - the tracking sheet contained recorded documentation of the goal implementation 5 times.</p> <p>-go to the local library 2 times a month to check out item - twice a month - the tracking sheet contained recorded documentation of the goal implementation 0 times.</p> <p>-fold his laundry when he is finished washing and drying it - 2 times a week - the tracking sheet contained recorded</p>				

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	<p>documentation of the goal implementation 4 times.</p> <p>-take his wet clothes from washer and put them into the dryer - 2 times a week - the tracking sheet contained recorded documentation of the goal implementation 3 times.</p> <p>-measure out the serving size for his main dish, fruit and vegetable for each meal - up to 3 times a day - the tracking sheet contained recorded documentation of the goal implementation 71 times.</p> <p>-sort and bring his clothes to the laundry room - 2 times a week - the tracking sheet contained recorded documentation of the goal implementation 3 times.</p> <p>July 2013:</p> <p>-identify his multivitamin - twice a day - the tracking sheet contained recorded documentation of the goal implementation 42 times.</p> <p>-shave daily with electric razor - daily - the tracking sheet contained recorded documentation of the goal implementation 12 times.</p> <p>-write or recite address, city, state, phone number - 3 times a week - the tracking sheet contained recorded documentation of the goal implementation 7 times.</p> <p>-make a shopping list for one meal - weekly - the tracking sheet contained recorded documentation of the goal implementation 0 times.</p>						

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	<p>- wash his private areas thoroughly when showering - daily - the tracking sheet contained recorded documentation of the goal implementation 23 times.</p> <p>-write a letter or send a card to brother - once a month - the tracking sheet contained recorded documentation of the goal implementation 0 times.</p> <p>-exercise 30-60 minutes a day - daily - the tracking sheet contained recorded documentation of the goal implementation 4 times.</p> <p>-go to the local library 2 times a month to check out item - twice a month - the tracking sheet contained recorded documentation of the goal implementation 0 times.</p> <p>-fold his laundry when he is finished washing and drying it - 2 times a week - the tracking sheet contained recorded documentation of the goal implementation 3 times.</p> <p>-take his wet clothes from washer and put them into the dryer - 2 times a week - the tracking sheet contained recorded documentation of the goal implementation 2 times.</p> <p>-measure out the serving size for his main dish, fruit and vegetable for each meal - up to 3 times a day - the tracking sheet contained recorded documentation of the goal implementation 58 times.</p> <p>-sort and bring his clothes to the laundry room - 2 times a week - the tracking sheet</p>						

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	<p>contained recorded documentation of the goal implementation 2 times.</p> <p>On 08/01/13 at 11:24 AM an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the goal sheets were not properly documented and had many blanks in them. She indicated it was her responsibility to ensure the documentation was completed on the goal sheets.</p> <p>3. Client A's record was reviewed on 7/31/13 at 12 PM. Client A's Data Tracking Sheet (DTS) for May, June, July 2013 indicated the following objectives and data:</p> <p>__ Twice a day client A will brush his teeth for 1 minute. The DTS indicated the staff failed to document this objective 13 out of 31 days in June and July and 10 out of 31 days in May.</p> <p>__ Weekly client A will deposit his check from work into his checking account. The DTS indicated no documentation for July and 1 out of 4 weeks in June and 2 out of 4 weeks in May.</p> <p>__ Daily client A will read from a book. The DTS indicated no documentation for July and June and only twice in May.</p> <p>__ Daily client A will practice spelling words. The DTS indicated no documentation for July and no</p>						

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	<p>documentation for 17 days out of 30 in June and 10 days out of 31 in May.</p> <p>__ Weekly client A will learn specific cleaning supplies for each room. The DTS indicated no documentation for 1 out of 4 weeks in July and June and 2 out of 4 weeks in May.</p> <p>__ Twice a day client A will measure out his mouth wash to the line on the Dixie cup. The DTS indicated no documentation for 15 out of 31 days in July and 12 out of 31 days in June and 10 out of 31 days in May.</p> <p>__ Daily client A will do his daily therapy exercises. The DTS indicated this was not documented 27 out of 31 days and 18 out of 30 days in June and 12 out of 31 days in May.</p> <p>__ Three nights a week client A will work problems from his math work books. The DTS indicated this was not documented 29 out of 31 days and 20 out of 30 days in June and 18 out of 31 days in May.</p> <p>4. Client B's record was reviewed on 7/31/13 at 2 PM. Client B's DTS for May, June, July 2013 indicated the following objectives and data:</p> <p>__ Whenever client B makes a purchase she will count the money out to a staff member. The DTS indicated documentation of 1 time for the month of July and no documentation for June and/or May</p>			

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	<p>__ Once a week client B will sit down with staff and go over a popular menu item. The DTS indicated this was not documented 3 out of 4 weeks in July</p> <p>__ Three times a week client B will practice writing food items she might purchase at the store. The DTS indicated this was not documented 3 out of 4 weeks in July, 3 out of 4 weeks in June and 1 out of 4 weeks in May.</p> <p>__ Three times a week client B will write down her identification information. The DTS indicated this was not documented 3 out of 4 weeks in July, 3 out of 4 weeks in June and 1 out of 4 weeks in May.</p> <p>__ Twice a day client B will pop out her medications. The DTS indicated this was not documented 9 out of 31 days in July, 9 out of 30 days in June and 6 out of 31 days in May.</p> <p>__ With each new word search client B will read 5 words. The DTS indicated this was documented only once in July, 3 times in June and 10 out of 31 days in May.</p> <p>__ To complete a saving account ledger when given a list of deposits and withdrawals. The DTS indicated this was documented only once in July, once in June and no documentation for May.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 7/31/13 at 11 AM indicated the staff were</p>						

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	<p>to document the clients' data as indicated on the DTS.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-4(a)</p>				

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W000259	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p> <p>Based on interview and record review for 2 of 4 sampled clients (clients C and D), the facility failed to ensure the comprehensive functional assessments (CFAs) were reviewed and updated annually.</p> <p>Findings include:</p> <p>Client C's records were reviewed on 07/31/13 at 1:43 PM. The CFA was dated 09/21/11 and the next one was dated October 2012.</p> <p>Client D's records were reviewed on 07/31/13 at 11:33 AM. The CFA was dated 09/20/11 and the next one was dated November 2012.</p> <p>On 08/01/13 at 1:30 PM an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the CFAs were to be updated annually and these were not completed in the annual time frame.</p> <p>This federal tag relates to complaint #IN00132706.</p>	W000259	<p>Annually the QIDP will update the FBA. IDT will review the assessment relevancy and will update as needed. Any additional assessments needed will be assigned to IDT and overseen by QIDP to ensure they are completed. Director of Programming supervises QIDP and will receive chart audit report weekly to ensure assessments are completed. In response to the letter dated Sept 23rd, a new functional assessemnt has been implemented to ensure that every needed area is being assessed. The QIDP has been retrained to make sure she remembers to date the assessment to show the review has been completed annually. The new assessment has a line for the date to be entered. The QIDP has been retrained that the assessments must be reviewed annually. Failure to complete will result in disciplinary action.</p>	09/06/2013	

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W000312	<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.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (clients B and C) who were on medications related to behaviors, by not ensuring the clients' Behavior Support Plan (BSP) included the medication or a titration plan for the medications in the plan.</p> <p>Findings include:</p> <p>1. Client C's records were reviewed on 07/31/13 at 1:43 PM. Client C's BSP (Behavior Support Plan) dated 02/05/13 indicated client C's diagnosis included anxiety and her behaviors included communicating inaccurate information, refusals and urinating in a non-toilet location. The BSP indicated client C was on Zolofit for anxiety. The BSP indicated, "...Should [client C] demonstrate marked improvement in her anxiety as evidenced by having 6 months free of anxiety, the team may consider making an appointment with her MD to consider a titration plan." The BSP did not include a</p>	W000312	<p>Psychotropic drugs to control inappropriate targeted behaviors must be used only as an integral part of the clients individual program plan. The behavior specialist will collaborate with the psychiatrist and nurse to develop an individual medication reduction and eventual elimination of the behaviors of which the drugs are prescribed for plan. The behavioral specialist will develop the BSP to include making an appointment with a medical doctor to consider a titration plan of measurable and reasonable goals of reduction. Psychotropic medication is monitored by the psychiatrist and the IDT maintain responsibility for all changes in the medication. Behavioral data is collected to monitor changes in behaviors. This data is to provide information to the medical doctor to consider a medication reduction plan at each 90 day medication review. Behavioral tracking will demonstrate a marked, measureable improvement in targeted behavior. The team will consider making the appointment with the medical doctor to have a reduction in the medication. This</p>	09/06/2013	

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	<p>titration plan.</p> <p>On 07/31/13 at 3:30 PM an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client C's BSP should contain a titration plan.</p> <p>2. Client B's record was reviewed on 7/31/13 at 2 PM. Client B's 7/1/13 physician's orders indicated client B took Lexapro 10 mg (milligrams) a day and Klonopin 0.5 mg twice a day for behavior modification. Client B's updated BSP (Behavior Support Plan) of 3/11/13 indicated client B had targeted behaviors of depressive characteristics and emotional outbursts. Client B's BSP indicated a "Medication reduction statement: [Client B's] current psychotropic medication is monitored by psychiatrist [name of psychiatrist] with [name of physician's network] in [name of city]. [Client B] and her IDT (Interdisciplinary Team) maintain responsibility for all changes in medication. Behavior data is collected to monitor changes in behavior. This data is to provide information to [client B's] MD (medical doctor) to consider a medication reduction plan at each 90 day medication review. [Client B's] team has expressed that the medications currently prescribed are necessary and appropriate for [client</p>		document will be reviewed by HRC upon each change in psychotropic medication. The QIDP is responsible for presenting information to HRC and leading IDT meeting discussion.				

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	<p>B] at this time. Should [client B] demonstrate marked improvement in her depression, anxiety, and irritability as evidenced by having 6 months free of one of these behaviors, the team may consider making an appointment with her MD to consider a titration plan. This document will be reviewed by the Human Rights Committee upon each change in psychotropic medication."</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/1/13 at 11 AM indicated client B's medication reduction plan was not specific to the client B's behaviors for which each psychoactive medication was to target.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-5(a)</p>				

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W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on record review and interview, the Condition of Participation of Health Care Services is not met as the facility failed for 4 of 4 sampled clients (clients A, B, C and D) and 4 additional clients (clients E, F, G and H) to ensure they received health care services for their medical needs.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Please refer to W322. The facility nursing services failed for 2 of 4 sampled clients (clients B and C) to have an annual physical. Please refer to W323. The facility nursing services failed for 2 of 4 sampled clients (clients B and D) to have an annual vision screening examination. Please refer to W331. The facility nursing services failed for 4 of 4 sampled clients (clients A, B, C and D) and 1 additional client (client H) to ensure they received health care services for their medical needs: by failing to obtain a yearly physical for client C; by failing to obtain physician ordered laboratory tests for clients C and D; by failing to ensure client C had a plan for when she was to be 	W000318	<p>Procedures for nursing administration which include protocols, assessments, scheduling of medical appointments, medication administration, and follow ups are being revised. A master list of all appointments needed will be maintained by the nursing assistant with oversight from the nurse. All appointments scheduled will be put in a master calendar with alerts sent to all relevant staffs calendar. Alerts for appointments are received on the smart phones carried by all Coordinators, QIDP's and Nurse. All medical files will be reviewed weekly by administrative assistant. Any missing items will be summarized and sent to Nurse, Nursing Assistant and Programming Director to oversee an action plan to get missing items. All staff working with consumer will be trained on all high risk care plans and protocols upon hire and as changes plans and protocols occur. Adaptive equipment checklists specific to each client are being created. The current adaptive equipment checklists are completed weekly and turned in to Programming Coordinator to review for any repairs needed. All adaptive equipment checklists are presented to Safety Committee</p>	09/06/2013			

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	<p>out of the wheelchair and when she was to use her walker; by failing to obtain an updated PT (Physical Therapy) reassessment for client C; by failing to obtain a wheelchair reassessment for client C; by failing to monitor and document the skin integrity of clients C and D; by failing to obtain an ophthalmic appointment for client D; by failing to ensure client B and D's prescribed diets were followed and menu portion size addressed; by failing to obtain a PT evaluation for client D's unsteady gait; by failing to have a fall risk plan for client D; by failing to have completed a fall risk assessment for client H and by failing to have a fall risk plan for client H.</p> <p>4. Please refer to W368. The facility nursing services failed for 3 of 4 sampled clients (clients A, B and C) and 2 additional clients (clients F and G), who take medications prescribed by the physician, to administer medications as ordered.</p> <p>5. Please refer to W436. The facility nursing services failed for 1 of 4 sampled clients (client C), to ensure client C's wheelchair was maintained in good repair.</p> <p>6. Please refer to W460. The facility nursing services failed for 2 of 4 sample</p>		<p>bi-monthly to review and create action plan for needs. The Director of Programming is the safety committee chairperson and oversees the coordinators. ASI is contracting with a new nutritionist beginning Sept 16th. Portion sizes of individual diets will be listed and staff will be trained on dining plan. Dietary intake will be tracked in home and at Day Services. Weekly review of charts will be done to ensure tracking is completed. All the systematic changes will be monitored by the leadership team. It is the executive directors responsibility to ensure that all pieces of the plan are maintained on an on going basis. This will occur in the monthly leadership meeting. It is the responsibility of the Director of Programming to directly supervise the group home staff and nurse to ensure they are maintaining their jobs within the system. This will occur in individual supervision as well as group home staff meetings. Each will take place monthly and be documented. In response to a letter dated 9/10, the deficiency noted was a result of inadequate follow up by the nurse. This has been addressed as a performance issue. ASI has a contract with an RN who will be utilized to do monthly reviews of medical and nursing care for group home clients. The intent of this is to identify consumer needs that may be missed by the</p>		

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	<p>clients (clients B and D) who were on a modified diet to ensure diet orders were followed.</p> <p>7. Please refer to W480. The facility nursing services failed for 4 of 4 sampled clients (clients A, B, C and D) and 3 additional clients (clients E, F and G) to ensure the facility menu included the serving size for menu items.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-6(a)</p>		<p>agency's nurse. The RN will provide a written report to the Director of Programming and Executive Director regarding her findings and recommendations to ensure that they are addressed.</p>		

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W000322	<p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (clients B and C) to have an annual physical examination.</p> <p>Findings include:</p> <p>Client B's record was reviewed on 7/31/13 at 2 PM. Client B's last recorded annual physical was conducted in 1/2012.</p> <p>Client C's records were reviewed on 07/31/13 at 1:43 PM. Client C's record did not contain a physical examination after 01/19/12.</p> <p>On 08/01/13 at 11:10 AM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated clients B and C had not had physical examinations since 01/2012.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-6(a)</p>	W000322	<p>A master list of all appointments needed, including history and physical, paps for women and psa for men will be maintained by the nursing assistant with oversight from the nurse. All appointments scheduled will be put in a master calendar with alerts sent to all relevant staffs calendar. Alerts for appointments are received on the smart phones carried by all Coordinators, QIDP's and Nurse. All medical files will be reviewed weekly by administrative assistant. Any missing items will be summarized and sent to Nurse, Nursing Assistant and Programming Director to oversee an action plan to get missing items. In response to a letter dated 9/10, the deficiency noted was a result of inadequate follow up by the nurse. This has been addressed as a performance issue. ASI has a contract with an RN who will be utilized to do monthly reviews of medical and nursing care for group home clients. The intent of this is to identify consumer needs that may be missed by the agency's nurse. The RN will provide a written report to the Director of Programming and Executive Director regarding her findings and recommendations to ensure that they are addressed.</p>	09/06/2013	

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W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (clients B and D) to have an annual vision screening examination.</p> <p>Findings include:</p> <p>Client B's record was reviewed on 7/31/13 at 2 PM. Client B's last recorded vision evaluation was conducted on 7/31/12.</p> <p>Client D's records were reviewed on 07/31/13 at 11:33 AM. Client D's record did not contain any documentation of an annual vision screening examination.</p> <p>On 08/01/13 at 11:10 AM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated clients B and C did not have a current annual vision screening examination.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-6(a)</p>	W000323	<p>A master list of all appointments, including annual vision screening needed will be maintained by the nursing assistant with oversight from the nurse. All appointments scheduled will be put in a master calendar with alerts sent to all relevant staffs calendar. Alerts for appointments are received on the smart phones carried by all Coordinators, QIDP's and Nurse. All medical files will be reviewed weekly by administrative assistant. Any missing items will be summarized and sent to Nurse, Nursing Assistant and Programming Director to oversee an action plan to get missing items. In response to a letter dated 9/10, the deficiency noted was a result of inadequate follow up by the nurse. This has been addressed as a performance issue. ASI has a contract with an RN who will be utilized to do monthly reviews of medical and nursing care for group home clients. The intent of this is to identify consumer needs that may be missed by the agency's nurse. The RN will provide a written report to the Director of Programming and Executive Director regarding her findings and recommendations to ensure</p>	09/06/2013	

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			that they are addressed.		

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed for 4 of 4 sampled clients (clients A, B, C and D), and 1 additional client (client H), by not ensuring clients received nursing services according to their medical needs: by failing to obtain a yearly physical for client C; by failing to obtain physician ordered laboratory tests for clients C and D; by failing to ensure client C had a plan for when she was to be out of the wheelchair and when she was to use her walker; by failing to obtain an updated PT (Physical Therapy) reassessment for client C; by failing to obtain a wheelchair reassessment for client C; by failing to monitor and document the skin integrity of clients C and D; by failing to obtain an ophthalmic appointment for client D; by failing to ensure client B and D's prescribed diets were followed and menu portion size addressed; by failing to obtain a PT evaluation for client D's unsteady gait; by failing to have a fall risk plan for client D; by failing to have completed a fall risk assessment for client H and by failing to have a fall risk plan for client H.</p> <p>Findings include:</p>	W000331	<p>Procedures for nursing administration which include protocols, assessments, scheduling of medical appointments, medication administration, and follow ups are being revised. A master list of all appointments needed will be maintained by the nursing assistant with oversight from the nurse. All appointments scheduled will be put in a master calendar with alerts sent to all relevant staffs calendar. Alerts for appointments are received on the smart phones carried by all Coordinators, QIDP's and Nurse. All medical files will be reviewed weekly by administrative assistant. Any missing items will be summarized and sent to Nurse, Nursing Assistant and Programming Director to oversee an action plan to get missing items. All staff working with consumer will be trained on all high risk care plans and protocols upon hire and as changes plans and protocols occur. Adaptive equipment checklists specific to each client are being created. The current adaptive equipment checklists are completed weekly and turned in to Programming Coordinator to review for any repairs needed. All adaptive equipment checklists are presented to Safety Committee</p>	09/06/2013			

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	<p>1. Client C's records were reviewed on 07/31/13 at 1:43 PM. Client C's 04/23/13 ISP (Individual Support Plan) indicated client C used a wheelchair and her diagnoses included but were not limited to Cerebral Palsy and Moderate Spastic Paresis (paralysis). Client C's record review included review of the following dated documents:</p> <p>01/19/12: Annual Physical.</p> <p>08/08/12: A Continuity Of Care Form indicated she was seen by PT for evaluation of ambulation, transfer and exercise training. The PT recommendation indicated, "Increase time out of the wheelchair with standing walking and laying (sic) bed with leg straight."</p> <p>01/31/13: A Continuity Of Care Form indicated client C was seen by PT. The form indicated PT for, "ambulation/transfer training, stand/seating balance, (unable to read) stretches to B (bilateral) hip flexors."</p> <p>Client C's record did not contain an annual physical after 01/19/12, a fall risk plan or instructions on when, how or what staff were to do to regarding ambulation instructions or an ambulation plan for client C. Client C's record did not</p>		<p>bi-monthly to review and create action plan for needs. The Director of Programming is the safety committee chairperson and oversees the coordinators. ASI is contracting with a new nutritionist beginning Sept 16th. Portion sizes of individual diets will be listed and staff will be trained on dining plan. Dietary intake will be tracked in home and at Day Services. Weekly review of charts will be done to ensure tracking is completed. All the systematic changes will be monitored by the leadership team. It is the executive directors responsibility to ensure that all pieces of the plan are maintained on an on going basis. This will occur in the monthly leadership meeting. It is the responsibility of the Director of Programming to directly supervise the group home staff and nurse to ensure they are maintaining their jobs within the system. This will occur in individual supervision as well as group home staff meetings. Each will take place monthly and be documented. In response to a letter dated 9/10, the deficiency noted was a result of inadequate follow up by the nurse. This has been addressed as a performance issue. ASI has a contract with an RN who will be utilized to do monthly reviews of medical and nursing care for group home clients. The intent of this is to identify consumer needs that may be missed by the</p>				

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	<p>indicate the last time she had been fitted in that wheelchair or when she had originally received that chair. Client C's record did not contain skin integrity monitoring or a scheduled when she should be in or out of her wheelchair.</p> <p>On 08/01/13 at 11:10 AM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client C did not have an annual physical after the 01/19/12 physical. She also indicated client C should have a PT reassessment and plan for when to be out of the wheelchair and when to ambulate with her walker. She indicated client C did not have skin integrity monitoring documentation in place and she was at risk for skin breakdown and therefore her skin should be monitored daily. She also indicated client C was at risk for falls and did not have a fall risk plan. The LPN indicated client C's wheelchair was in need of repair and she should be refitted as she did not know when client C had obtained the wheelchair.</p> <p>2. Client D's records were reviewed on 07/31/13 at 11:33 AM. Client D's 04/23/13 ISP (Individual Support Plan) indicated client D's diagnosis included but were not limited to Gout. Client D's record review included review of the following dated documents:</p>		agency's nurse. The RN will provide a written report to the Director of Programming and Executive Director regarding her findings and recommendations to ensure that they are addressed.				

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	<p>04/19/13: Annual Physical indicated client D was to obtain laboratory tests the following week and to obtain an optometry examination.</p> <p>04/30/13: A fall risk assessment indicated he was not at risk for falls.</p> <p>05/31/13: A Continuity of Care Form indicated client D had seen the podiatrist. The podiatrist indicated, "Pt (patient) limping with unsteady gait, 'holds the wall' when walking. Recommended AFO (ankle-foot orthotic) B (bilaterally), because (sic) weakness...."</p> <p>Client D's record did not contain the ordered laboratory tests or the ordered optometry examination. Client D's record did not contain a PT (Physical Therapy) evaluation to evaluate the unsteady gait. Client D's record did not contain an updated fall risk assessment or plan related to the unsteady gait. Client D's record did not contain daily skin integrity monitoring and documentation related to his Gout.</p> <p>On 08/01/13 at 11:10 AM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client D did not have the laboratory tests or optometry examination as ordered. She</p>				

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	<p>indicated client D was at risk for falls, he had not had a PT evaluation and one should be obtained. She further indicated a fall risk plan had not been completed. She indicated client D did not have skin integrity monitoring documentation in place and he was at risk for skin breakdown due to his gout and therefore his skin should be monitored and documented on daily.</p> <p>3. Client H's records were reviewed on 07/30/13 at 1:10 PM. Client H's 04/23/13 ISP indicated client H's diagnoses included but were not limited to High Cholesterol and Aortic Stenosis (aortic valve is narrowed resulting in decreased blood flow from the heart). The ISP indicated client H had a systolic murmur and needed to avoid extreme temperature changes and strenuous activity. Client H's record review included review of the following dated documents:</p> <p>01/10/13: Echocardiogram test indicated client H had an aortic valve disorder.</p> <p>04/30/13: Fall Risk Assessment indicated client H was not at risk for falls.</p> <p>07/08/13: An Incident Report indicated client H had fallen at 8:15 PM in the group home. The report indicated no one saw him fall and he reported he tripped</p>						

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	<p>over his own feet while laughing, standing and watching TV.</p> <p>07/09/13: An Incident Report indicated client H had fallen at 2:30 PM at the day service site while loading on the van. It was reported there was only 1 group home staff loading and she was busy with client C and did not see him fall but she saw him on the ground. The incident report indicated he said he was ok and his blood pressure was taken and it was documented to be fine.</p> <p>07/10/13: A BDDS (Bureau of Developmental Disabilities Services) report for an incident at 1:45 PM indicated, "[Client H] was complaining of a headache at the workshop most of the day. The headache began after two falls resulting in no injuries on two prior days. The agency nurse contacted staff to transport [client H] to his family Doctor, (sic) he was not in the office at the time and it was decided to take him to the Emergency room (ER). [Client H] was checked out at [hospital] ER by Dr. [name] who stated that no cat scan was needed due to him not losing consciousness. The Dr. stated that (sic) pupils were reacting appropriately and all other vitals signs were good. Temperature was 98.3 and blood pressure was 118/74. He had a small contusion on</p>			

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	<p>the back of his head. They gave him two Tylenol and some antibiotic cream as well as a band aid. Dr. stated he could take Tylenol or Advil for pain as needed. No other action was required by the ER Doctor at the time."</p> <p>07/10/13: A BDDS report for an incident at 10:45 PM indicated, "Staff [staff #7], was on shift, went to check on [client H] at 9:45 PM. He spoke to her and told her he was okay, didn't complain of a headache. She asked him if he needed anything, [client H] responded, 'No.' Staff [staff #7], went back to check on [client H] at 10:45 PM, and [client H] was unresponsive. He had foam coming from his mouth and nose. When staff, [staff #7] noted [client H] unresponsive, [staff #7] immediately called for help. [Clients A, B and F] (housemates) as well as [staff #7] moved [client H] from the bed to the floor. 911 notified by housemate. CPR/AED (Cardiopulmonary resuscitation/Automated External Defibrillator), immediately started by [client A] (who is CPR certified) and staff [staff #7]. Paramedics arrived and transported (sic) to [hospital] in [city], Indiana. [House manager], and [LPN] was (sic) notified by housemates."</p> <p>07/17/13: A BDDS Follow-up indicated, "[client H] passed away on 07/10/13 due</p>						

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	<p>to cardiac arrest, he had a previous heart condition."</p> <p>Client H's record did not contain a nursing evaluation after either of the falls. The record did not contain any fall risk assessments or a fall risk plan after either of the falls and there was no documentation of monitoring client H after either of the falls.</p> <p>On 08/01/13 at 11:10 AM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated she did not examine client H after the 07/08/13 fall or after the 07/10/13 fall. She indicated a licensed medical person did not examine client H until he went to the ER on 07/10/13 at 1:45 pm. She indicated she had not done a fall risk assessment or completed a fall risk plan after either one of the falls. She also indicated she had not instructed the staff when or how to monitor client H after the falls.</p> <p>4. Observations were conducted at the group home on 7/30/13 between 3:15 PM and 5:30 PM. Client B ate a baked potato with butter and sour cream, a thick cut pork chop, a large portion of green beans, a slice of bread with margarine and kool-aid for her evening meal. Client B was not offered or prompted milk to</p>						

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	<p>drink. Staff #1 and #2 did not offer or prompt client B to drink milk with her evening meal. Staff #1 and #2 did not prompt or guide client B in portion sizes.</p> <p>Observations were conducted at the workshop on 7/31/13 between 9:15 AM and 11:45 AM. At 10 AM the clients took a break. Client B got out a gallon of tea from the refrigerator. Client B indicated she did not want and/or bring a snack for the 10 o'clock break. At 11:30 AM client B prepared her lunch of a cup of chicken flavored instant noodles in the microwave. Client B also had a small baggie with animal crackers, a sugar free snack pudding cup and tea.</p> <p>Review of the undated facility menu labeled ASI Rossville - Summer 2013 on 7/30/13 at 4:30 PM indicated the following was to be served in the group home for the evening meal of 7/30/13: baked potato, sour cream, green beans, wheat bread, margarine, skim milk. The menu indicated client B was to have the following for her lunch meal for 7/31/13: cold meat with cheese sandwich, broccoli salad, tomato slices, animal crackers, skim milk.</p> <p>No portion sizes were indicated on the menu. The menu indicated no specific diet. The menu indicated only 1 snack per</p>						

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	<p>day and milk 3 times a day.</p> <p>Client B's record was reviewed on 7/31/13 at 2 PM. Client B's record indicated a diagnosis of, but not limited to, MCAD (Medium Chain acyl CoA Dehydrogenase - a disorder of fatty acid oxidation that impairs the body's ability to break down fatty acids), Impaired Nutrition and Epilepsy.</p> <p>Client B's Seizure Protocol dated 11/21/11 indicated client B had a history of seizure activity since birth caused from "a diagnosis of MCAD." "Her seizures have a wide range of symptoms. These can be staring off into space, not being aware that someone is talking to her, appearing to not be listening or unaware of her surroundings, grinding of her teeth and loss of awareness. Her body may also shake. She, at times, is able to tell staff that a seizure is about to come on by having an 'aura' (feeling) like she gets real tired real fast, weak and dizzy. Her seizures usually only last about a minute." The protocol indicated if a seizure lasts more than 3 - 5 minutes, staff are to call 911 and the nurse. "Staff are to BE PREPARED to do CPR because of the MCAD diagnosis can lead to cardiac arrest."</p> <p>Client B's undated dining plan indicated</p>				

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	<p>"MCAD can develop health problems such as: seizures, lethargy (extreme tiredness), breathing difficulties and heart failure if she has lack of eating or vigorous exercise." The plan indicated client B is on a special diet of 2000 calorie, 44 grams of fat per day over 3 meals and 3 snacks with 2 servings of skim milk per day. "Her MCAD physician is very Adamant that this diet is followed as it is prescribed. [Client B's] intakes are good to fair. She feeds herself. [Client B] can be somewhat selective and manipulative regarding eating habits. Staff must remind her she is on a specific type of diet, and explain that she needs to go by what the menu serving sizes and types of food to eat in order to stay healthy. She likes to drink [name of soda] out of a 2 liter bottle. Staff must remind and redirect her to have skim milk or water with her meals because of the [name of soda] not good for her diet."</p> <p>Client B's Care Plans dated 11/21/11 indicated client B was at risk of "Impaired nutrition related to MCAD disease." The plan indicated client B was on a low fat/low cholesterol diet. Client B was not to fast longer than 8 hours. The plan indicated client B was at risk for Hypoglycemia related to MCAD disease and if client B had any of the following: confusion, increased fatigue, moist and</p>						

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	<p>clammy skin, the staff were to check her blood sugar. "If blood sugar is below 90, staff is to give consumer orange juice, honey, soda, or sugar water to elevate blood sugar. Staff is to call nurse." There were no blood sugar results documented in the client's record for review. The plan did not indicate a regular testing of client B's blood glucose.</p> <p>Client B's Nutritional Services Progress Note of 12/17/12 from the facility dietician indicated client B was to have a 2200 calorie, 44 gram fat diet with 2 glasses of milk over 3 meals and 3 snacks per day.</p> <p>Client B's [name] Clinic Visit record of 1/9/13 from the client's metabolic physician treating her MCAD indicated client B's diet was to be decreased to 1800 calorie 40 gram fat diet divided over 3 meals and 3 snacks per day. "May use Carnation Instant Breakfast with skim milk for breakfast." The form indicated client B was to return in 1 year (1/15/14) for a return visit.</p> <p>Client B's ISP (Individualized Support Plan) of 4/23/13 indicated client B was on a low fat diet and "must eat frequently." The ISP indicated client B would use not eating as a way to manipulate others.</p>			

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	<p>Client B's 7/1/13 physician's orders indicated client B was to have a 2200 Calorie 44 gram fat diet in 3 meals and 3 snacks per day and 2 servings of skim milk. The physician's orders indicated client B was to have a "glucose containing fluids immediately after seizure activity - may include soda, sugar water, orange juice, etc."</p> <p>Review of client B's Dietary Intake Records for May, June and July failed to include client B's intake while at the day program. The records indicated only percentage of food eaten and not actual calories and/or fat intake. The client's Dietary Intake Records failed to document the client's snack intake.</p> <p>Interview with staff #1 on 7/30/13 at 4:30 PM indicated the menu has never included size of food portions to be served. When asked how the staff knew how much to give client B, the staff stated, "We were told to just follow whatever is on the box of food." Staff #1 indicated all clients were on the same diet and followed the same menus.</p> <p>During interview with DP staff #1 on 7/31/13 at 11:35 AM indicated client B was not on any special diet that she was aware of. DP staff #1 indicated the staff had to watch her for not eating.</p>				

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	<p>Interview with the LPN (Licensed Practical Nurse) on 7/31/13 at 2:30 PM stated client B's diet orders were "conflicting" and she did not know for sure the exact diet client B was supposed to be on. The LPN stated, "[Name of client B's metabolic physician] is the one ordering her diet." The LPN indicated she would have to call both of client B's physicians to get the order clarified. The LPN indicated the dietary change by client B's metabolic physician made in January 2013 was never addressed. The LPN indicated client B's dining plan and client B's health plans had been updated, but still included the 2000 calorie diet. When asked how the staff were to know the correct portion sizes, the LPN indicated the dietician refused to include portion sizes on the menu and that was one of the reasons the current dietician was being let go as of 9/15/13. The LPN indicated a new company would be taking over the clients' dietary reviews. The LPN indicated the staff did not have a specific menu to follow in regard to client B's dietary requirements and was not providing client B with the modified diet ordered by client B's metabolic specialist. The LPN indicated the dining plan had been updated but had not been placed in the group home and/or the workshop. The LPN stated the HM (Home Manager) was</p>			
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	<p>supposed to put the new plans in the home, "But apparently never did." The LPN indicated client B's blood glucose was not being monitored on a routine basis. When asked when her last testing was, the LPN indicated she didn't know. The LPN stated she remembered the doctor saying "about a year ago, we didn't have to do it anymore." The LPN indicated client B's dietary intake records monitored percentage of food eaten, but not actual calories and/or fat content or what foods were eaten by the client.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-6(a)</p>				

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W000368	<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.</p> <p>Based on record review and interview, the facility failed for 3 of 4 sampled clients (clients A, B and C) and 2 additional clients (clients F and G), who take medications prescribed by the physician, to administer medications as ordered.</p> <p>Findings include:</p> <p>On 07/31/13 at 1:43 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports and internal incident/accident reports was completed and included the following medication errors:</p> <p>08/23/12: "[Client F] informed staff [staff #8] that he was out of his Clotrim/Beta Cre (cream) Diprop lotion for his ankles to be applied topically twice daily. [Staff #8] checked the tube and it was empty and asked if he had gotten any of it to apply and [client F] advised no. [Staff #8] faxed refill to pharmacy...All staff informed that consumers are to apply topicals in front of staff to ensure proper amount is being used and to ensure noting if running low prior to running out of medication...to check the medications</p>	W000368	<p>Procedures for nursing administration which include protocols, assessments, scheduling of medical appointments, medication administration, and follow ups are being revised. Staff will be trained to administer medication (creams) to ensure proper dosage. When consumers leave, staff will stress to guardians the importance of administering the correct dose of medications at prescribed times. A form titled LOA is used for medications leaving the home. The Programming Coordinator will oversee the forms being used and filled out. Weekly audits will be performed to ensure proper forms have been completed. In response to a letter dated 9/10, the Nurse is working with the pharmacy to get "take home" bubble packs for when the consumers are away from the Group Home. Staff has been retrained on how to administer the correct dose of creams to consumers to reduce overuse which results in running out. ASI has rewritten its Medication Administration and Monitoring policy and procedure to be group home-specific.</p>	09/06/2013			

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	<p>weekly to ensure refill requests (sic) being sent prior to running out also."</p> <p>10/18/12: "[Client A] was taking an antibiotic, Sulfamethoxazole 1 tablet twice daily for 7 days for (sic) Urinary Tract Infection. Original prescription was sent to [pharmacy #1] on a weekend, who then called a short fill to a local [pharmacy #2]. Staff [staff #9] was administering PM medications on the 18th and assumed since the [pharmacy #2] bottle was empty that [client A] had finished the medication...10/19/12 [staff #1] was doing evening medications and noted bubble packs in [client A's] medication basket for the antibiotic. Due to [client A] leaving earlier that day to go on a home visit with family, [staff #1] notified the agency nurse [name] who advised staff to check if the family could come by the home...Family was notified and were not able to come pick up the medication. [Client A] returned home on 10/21/12 and [nurse] advised staff to resume the antibiotic...."</p> <p>Follow-up BDDS report dated 12/19/12 indicated, "[Client A] did not receive antibiotic as prescribed for 10/18/12, 10/19/12, 10/20/12 and (sic) morning of 10/21/12...."</p> <p>10/27/12: "[Client B] went on a home visit with her family. Upon returning</p>						

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	<p>[staff #1] was counting [client B's] medication back in and noted that Carbamazepine (seizures)...had not been taken during the 2:30 PM dosages for either 10/27/12 or 10/28/12...[Staff #1] asked [client B] if she had taken the medication at 2:30 PM, [client B] cursed at staff and slammed the door, with out answering...discussed with [client B] the importance of remembering to take her medications at each time when she goes on home visits. [Client B] expressed understanding of this."</p> <p>12/12/12: "On 12/12/12 [staff #1] did not give [client B] her Certavite tab[let] (vitamin) during morning med[ication]."</p> <p>01/10/13: "[Staff #10] and [staff #11] arrived at the workshop on 01/10/13 at 3:00 PM to transport consumers home. [Client C] stated that she had not received her 2:00 PM med due to being gone for doctor's appointment during that time with [Team Lead]. [Client C's] 2:00 PM medication is Baclofen (spasticity)...."</p> <p>02/03/13: "[Client B] went home 02/01/13 for a weekend visit with family...[client B] had not received her 2:30 PM dose of Carbamazepine Chewable (seizures)...on 02/03/13...Staff reminded to stress to guardians the importance of administering the correct</p>				

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	<p>dose of medications at he prescribed times."</p> <p>02/23/13: "[Client B] left for the day on 02/23/13. Staff [staff #12] prepared her meds to go. [Client B's] Levocarnitin (for lack of carnitine)...was not sent with her...."</p> <p>04/21/13: "[Client B] returned to the group home from a weekend at her parents...[client B] did not receive her evening dose of Clonazepam (seizures)...on Saturday 04/20/13...Staff reminded to stress to guardians the importance of administering the correct dose of medications at he prescribed times."</p> <p>05/19/13: "[Client G] returned home on 5/19/13 from a week-end visit with his parents. [Staff #13] was counting in meds and noted that [client G] did not receive his Folic Acid in the am or pm on Saturday 5/18/12...Staff reminded to stress to guardians the importance of administering the correct dose of medications at the prescribed times."</p> <p>On 08/01/13 at 11:10 AM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated medications that are not given as prescribed are considered medication</p>			

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	<p>errors as staff are not following the physician's orders. She further indicated client B self-administered her meds but staff needed to ensure she received her medications when she went on home visits.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-6(a)</p>			

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview, for 1 of 4 sampled clients (client C), the facility failed to ensure client C's wheelchair was maintained in good repair.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 07/30/13 from 3:30 PM until 6:02 PM and staff #1 and #2 were on duty. Client C was observed to sit in a wheelchair during the observation from 3:30 PM until 4:15 PM when she was assisted to move from her wheelchair into a chair. Staff #1 assisted client C to wipe off her wheelchair arms, wheels and seat pad. Client C's arm rests on the wheel chair were taped in blue tape and a quarter size hole was in the black arm rest covering. Client C was asked why the arms were taped with the blue tape and she indicated the black covering had come off and staff had taped the arm rests. When asked how long it had been since client C had been measured or fitted</p>	W000436	<p>Adaptive equipment checklists specific to each client are being created. The current adaptive equipment checklists are completed weekly and turned in to Programming Coordinator to review for any repairs needed. All adaptive equipment checklists are presented to Safety Committee bi-monthly to review and create action plan for needs. The Director of Programming is the safety committee chairperson and oversees the coordinators. Procedures for nursing administration which include protocols, assessments, scheduling of medical appointments, medication administration, and follow ups are being revised. A master list of all appointments needed including annual wheelchair evaluations will be maintained by the nursing assistant with oversight from the nurse. All appointments scheduled will be put in a master calendar with alerts sent to all relevant staffs calendar. Alerts for appointments are received on the smart phones carried by all Coordinators, QIDP's and Nurse. All medical files will be reviewed</p>	09/06/2013			

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	<p>in her wheelchair she indicated she did not know. Client C also indicated she had no idea how long of a time she'd had this wheelchair, but knew it was a long time.</p> <p>Client C's records were reviewed on 07/31/13 at 1:43 PM. Client C's ISP (Individual Support Plan) dated 04/23/13 indicated client C used a wheelchair. Client C's record did not indicate the last time she had been fitted in that wheelchair or when she had originally received that chair.</p> <p>On 08/01/13 at 11:10 AM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated she did not know when client C had received that wheelchair. She further indicated client C should be evaluated to ensure the chair was still appropriate for her, the chair needed to be kept in good repair and the arms should not be taped.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-7(a)</p>		<p>weekly by administrative assistant. Any missing items will be summarized and sent to Nurse, Nursing Assistant and Programming Director to oversee an action plan to get missing items. In response to a letter dated 9/10, ASI has a system in place with weekly Adaptive Checklists to identify and address this kind of problem. The system broke down due to staff failure to follow. All staff have been re-trained on the process which primarily involves the Programming Coordinator, Nurse, and Nursing Assistant. These will now be turned into the receptionist at the Frankfort office each week to do a secondary check that all adaptive equipment was checked. These will be monitored by the Safety Committee to ensure items are followed up on.</p>		

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W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based on record review and interview, the facility failed for 7 of 7 clients (clients A, B, C, D, E, F and G) who resided in the home, by not ensuring an evacuation drill was conducted at least every quarter on the night shift.</p> <p>Findings include:</p> <p>On 07/31/13 at 11:00 AM, record reviews were completed of the facility's evacuation drills for the period of 07/01/12 through 07/30/13. The review of the evacuation drill records included evacuation drills which were conducted for personnel and clients A, B, C, D, E, F and G.</p> <p>There was a night shift drill conducted on 11/02/12 at 3:30 AM. The next night drill was conducted on 05/15/13 at 4:00 AM.</p> <p>On 07/31/13 at 3:30 PM an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the drills were to be conducted every quarter and there were no additional evacuation drills for review.</p> <p>This federal tag relates to complaint</p>	W000440	<p>Coordinators are responsible for scheduling and tracking fire drills. A yearly calendar is in place so that staff know what days and times drills are to be performed. All completed drills are brought to safety bi-monthly meeting for review and action plan if needed. Director of Programming is responsible for supervision of Coordinator as safety committee chair person. Tracking for all drills is kept for safety committee. In response to a letter dated 9/10, ASI has a tracking mechanism in place to ensure that fire drills are done on a regular basis. This system failed when the Programming Coordinator did not monitor it. ASI restructured the PC position so that each PC only has one GH to monitor. The goal of this change is to ensure that systems such as this are not missed. The Safety Committee will monitor at it's monthly meetings.</p>	09/06/2013			

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W000454	<p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation and interview for 3 of 4 sampled clients (B, C and D) and 3 additional clients who attend the facility owned day program, the facility failed to ensure a clean area for the clients to eat their meals.</p> <p>Findings include:</p> <p>Observations were conducted at the facility owned day program on 7/31/13 between 9:15 AM and 11:45 AM. Clients B, C, D, E, F and G ate their afternoon snack at 10 AM. After eating, the staff and/or clients did not wash the dining room tables. At 11:30 AM clients B, C, D, E, F and G returned to the lunch room to eat their afternoon meal. Client D took a lunch meat sandwich and potato chips out of his lunch box and laid them on the table. Client D was not prompted to use a plate or a napkin to place his food on.</p> <p>Interview with DP (Day Program) staff #1 on 7/31/13 at 12 PM indicated the tables were not cleaned until after the clients finished their afternoon meal. DP staff #1 stated client D "always takes his food out of his bag and lays it on the table."</p>	W000454	Day Services staff have a cleaning schedule in place to ensure proper cleaning of facility during day service programming. Universal precautions are followed to ensure proper cleaning. Consumers with goals to clean are trained and prompted by staff to ensure cleanliness. Day Services completed cleaning schedule in turned in to the Day Service Coordinator to ensure completion daily.	09/06/2013			

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	<p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-7(a)</p>			

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W000460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 4 sample clients (clients B and D) who were on a modified diet to ensure diet orders were followed.</p> <p>Findings include:</p> <p>1. Observations were conducted in the group home on 07/30/13 from 3:30 PM until 6:02 PM and staff #1 and #2 were on duty. Clients B and D went to the supper table at 5:15 PM, passed dishes around the table and placed food on their plates. Supper included pork chops, green beans and baked potatoes. Staff #1 or #2 did not indicate to the clients how much a serving of the item was and the posted menu did not include serving sizes. Client D's food was not weighed or measured for portion.</p> <p>Client D's records were reviewed on 07/31/13 at 11:33 AM. Client D's July 2013 Physician's Orders indicated client D was on a 2000 calorie ADA (American Diabetic Association) diet.</p> <p>On 08/01/13 at 11:10 AM an interview</p>	W000460	<p>ASI is contracting with a new nutritionist beginning Sept 16th. Portion sizes of individual diets will be listed and staff will be trained on dining plan. Each client will received a nourishing and well balanced diet including modified and specially prescribed diets. Food will be weighed and measured to ensure portions size, according to menu. The menu will be followed for packed lunches for Day Services. Dietary intake will be tracked in home and at Day Services. Weekly review of charts will be done to ensure tracking is completed. Nurse will work closely with dietician providing updated diet orders, monthly weights, and BMI's. Nutritionist will assess clients upon admission and quarterly and give recommendations for clients diets. A dehydration protocol will be monitored through dietary intake and a dysphasia protocol will be in place for clients assessed to need this. Staff will be trained on all protocols. Oversight of Nutritionist Services will be done by Programming Director. All contracted services will be evaluated annually by the leadership team in a monthly meeting. Programming</p>	09/06/2013	

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	<p>with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated the agency was having problems with the current dietitian and a new one was starting in September 2013. She indicated one of the problems with the current dietitian was the serving size for menued items was not defined on the client menus. She further indicated that was a problem especially for clients B and D who were not on regular diets. She indicated client D's diet could only be monitored to ensure he was getting a 2000 calorie ADA diet if the portions were weighed and measured for accuracy.</p> <p>2. Observations were conducted at the group home on 7/30/13 between 3:15 PM and 5:30 PM. Client B ate a baked potato with butter and sour cream, a thick cut pork chop, a large portion of green beans, a slice of bread with margarine and kool-aid for her evening meal. Client B was not offered or prompted milk to drink. Staff #1 and #2 did not offer or prompt client B to drink milk with her evening meal. Staff #1 and #2 did not prompt or guide client B in portion sizes.</p> <p>Observations were conducted at the</p>		<p>Coordinator and Nurse will review monthly dietary information in the home to ensure items needed are available. Safety Committee will review Nutritionist reports in bi-monthly meeting. In response to a letter dated 9/10, the deficiency noted was a result of inadequate follow up by the nurse. This has been addressed as a performance issue. ASI has a contract with an RN who will be utilized to do monthly reviews of medical and nursing care for group home clients. The intent of this is to identify consumer needs that may be missed by the agency's nurse. The RN will provide a written report to the Director of Programming and Executive Director regarding her findings and recommendations to ensure that they are addressed.</p>		

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	<p>workshop on 7/31/13 between 9:15 AM and 11:45 AM. At 10 AM the clients took a break. Client B got out a gallon of tea from the refrigerator. Client B indicated she did not want and/or bring a snack for the 10 o'clock break. At 11:30 AM client B prepared her lunch of a cup of chicken flavored instant noodles in the microwave. Client B also had a small baggie with animal crackers, a sugar free snack pudding cup and tea.</p> <p>Review of the undated facility menu labeled ASI Rossville - Summer 2013 on 7/30/13 at 4:30 PM indicated the following was to be served in the group home for the evening meal of 7/30/13: baked potato, sour cream, green beans, wheat bread, margarine, skim milk. The menu indicated the following for the lunch meal of 7/31/13: cold meat with cheese sandwich, broccoli salad, tomato slices, animal crackers, skim milk. No portion sizes were indicated on the menu. The menu indicated no specific diet and only 1 snack per day with milk 3 times a day.</p> <p>Client B's record was reviewed on 7/31/13 at 2 PM. Client B's record indicated a diagnosis of, but not limited to, MCAD (Medium Chain acyl CoA Dehydrogenase - a disorder of fatty acid oxidation that impairs the body's ability to</p>						

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	<p>break down fatty acids), Impaired Nutrition.</p> <p>Client B's undated dining plan indicated "MCAD can develop health problems such as: seizures, lethargy (extreme tiredness), breathing difficulties and heart failure if she has lack of eating or vigorous exercise." The plan indicated client B is on a special diet of 2000 calorie, 44 grams of fat per day over 3 meals and 3 snacks with 2 servings of skim milk per day. "Her MCAD physician is very Adamant that this diet is followed as it is prescribed.... Staff must remind her she is on a specific type of diet, and explain that she needs to go by what the menu serving sizes and types of food to eat in order to stay healthy...."</p> <p>Client B's 7/1/13 physician's orders indicated client B was to have a 2200 Calorie 44 gram fat diet in 3 meals and 3 snacks per day and 2 servings of skim milk. The physician's orders indicated client B was to have a "glucose containing fluids immediately after seizure activity - may include soda, sugar water, orange juice, etc."</p> <p>Client B's [name] Clinic Visit record of 1/9/13 from the client's metabolic physician treating her MCAD indicated client B's diet was to be decreased to 1800</p>						

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	<p>calorie 40 gram fat diet divided over 3 meals and 3 snacks per day. "May use Carnation Instant Breakfast with skim milk for breakfast."</p> <p>Interview with staff #1 on 7/30/13 at 4:30 PM indicated the menu has never included size of food portions to be served. When asked how the staff knew how much to give client B the staff stated, "We were told to just follow whatever is on the box of food." Staff #1 indicated all clients were on the same diet and followed the same menus.</p> <p>During interview with DP staff #1 on 7/31/13 at 11:35 AM indicated client B was not on any special diet. DP staff #1 indicated the staff had to watch her for not eating.</p> <p>Interview with the LPN (Licensed Practical Nurse) on 7/31/13 at 2:30 PM stated client B's diet orders were "conflicting" and she did not know for sure the exact diet client B was supposed to be on. The LPN stated, "[Name of client B's metabolic physician] is the one ordering her diet." When asked how the staff were to know the correct portion sizes, the LPN indicated the dietician refused to include portion sizes on the menu and that was one of the reasons the current dietician was being let go as of</p>			

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	<p>9/15/13. The LPN indicated the staff did not have a specific menu to follow in regard to client B's dietary requirements. The LPN indicated the facility was not providing client B with her specially-prescribed diet.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-8(a)</p>			

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W000473	<p>483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature.</p> <p>Based on observation, record review and interview, the facility failed for 4 of 4 sampled clients (clients A, B, C and D) and 1 additional client (client E) to ensure the meat was prepared and served at the correct temperature.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 07/30/13 from 3:30 PM until 6:02 PM and staff #1 and #2 were on duty. Staff #1 prepared the pork chops on an electric grill in the kitchen and at 5:07 PM placed the pork chops from the grill onto a serving plate and placed the plate on the dining room table. Staff #1 did not check the pork to insure if the pork chops were done or the internal temperature of the meat. Clients A, B, C, D and E went to the supper table at 5:15 PM passed the plate of pork chops around the table and placed the food on their plates. The pork was pink on the inside. At 5:20 PM client #1 stated, "Mine's a little pink too, not real pink, but a little." Staff #2 sat at the table with the clients and indicated her pork was pink also.</p> <p>An interview was conducted on 07/30/13</p>	W000473	A meat thermometer is in the home and staff are trained to use it. A guide for cooking temperatures is posted in the home. Programming Coordinator will ensure that site checks show that this device is available and working. Safety committee reviews site checks in bi-monthly meetings.	09/06/2013			

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	<p>with staff #1 at 5:07 PM when she was removing the pork from the grill. When asked if she used a meat thermometer to check the internal temperature of the pork she indicated they did not have one. She further indicated she knew they were to use one. She stated the pork chops did not look "real" done.</p> <p>A record review in the kitchen, of the posted December 2006, "Use A Food Thermometer" pamphlet from the USDA (United States Department of Agriculture) Food Safety and Inspection Service was conducted on 07/30/13 at 5:30 PM. The pamphlet indicated, "Proper cooking is one of the four key steps for fighting BAC - bacteria that can be found in food." The pamphlet indicated the temperature of pork was to be at 160 degrees for medium and 170 degrees for well done.</p> <p>On 08/01/13 at 11:10 AM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated the pork should have been prepared properly prior to eating. She indicated staff #1 should have checked the temperature of pork using a thermometer.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-8(a)</p>						

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W000480	<p>483.480(c)(1)(iv) MENUS Menus must include the average portion sizes for menu items.</p> <p>Based on observation, record review and interview, the facility failed for 4 of 4 sampled clients (clients A, B, C and D) to ensure the facility menu included the serving size for menu items.</p> <p>Findings include:</p> <p>1. Observations were conducted in the group home on 07/30/13 from 3:30 PM until 6:02 PM and staff #1 and #2 were on duty. Clients A, B, C and D went to the supper table at 5:15 PM, passed dishes around the table and placed food on their plates. Supper included pork chops, green beans and baked potatoes. Staff #1 or #2 did not indicate to the clients how much a serving of the item was and the posted menu did not include serving sizes.</p> <p>A record review of the posted Summer 2013 week one menu for 7/30/13 was conducted at 5:00 PM. The menu did not indicate what a serving size of the listed item was. The menu only listed the food items.</p> <p>On 08/01/13 at 11:10 AM an interview with the LPN (Licensed Practical Nurse)</p>	W000480	<p>ASI is contracting with a new nutritionist beginning Sept 16th. Portion sizes of individual diets will be listed and staff will be trained on dining plan. Each client will received a nourishing and well balanced diet including modified and specially prescribed diets. Food will be weighed and measured to ensure portions size, according to menu. The menu will be followed for packed lunches for Day Services. Dietary intake will be tracked in home and at Day Services. Weekly review of charts will be done to ensure tracking is completed. Staff will be trained to use family style dining. Nurse will work closely with dietician providing updated diet orders, monthly weights, and BMI's. Nutritionist will assess clients upon admission and quarterly and give recommendations for clients diets. A dehydration protocol will be monitored through dietary intake and a dysphasia protocol will be in place for clients assessed to need this. Staff will be trained on all protocols. Oversight of Nutritionist Services will be done by Programming Director. All contracted services will be evaluated annually by the leadership team in a monthly meeting. Programming</p>	09/06/2013			

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	<p>was conducted. The LPN indicated the agency was having problems with the current dietitian and a new one was starting in September 2013. She indicated one of the problems with the current dietitian was the serving size for menued items was not defined on the client menus. She further indicated that was a problem especially for clients B and D who were not on regular diets as well as those on a regular diet as they still needed to know what an appropriate size portion was.</p> <p>This federal tag relates to complaint #IN00132706.</p> <p>9-3-8(a)</p>		<p>Coordinator and Nurse will review monthly dietary information in the home to ensure items needed are available. Safety Committee will review Nutritionist reports in bi-monthly meeting. In response to a letter dated 9/10, the deficiency noted was a result of inadequate follow up by the nurse. This has been addressed as a performance issue. ASI has a contract with an RN who will be utilized to do monthly reviews of medical and nursing care for group home clients. The intent of this is to identify consumer needs that may be missed by the agency's nurse. The RN will provide a written report to the Director of Programming and Executive Director regarding her findings and recommendations to ensure that they are addressed.</p>		

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W009999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-3(e)</p> <p>Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review for 2 of 7 employee records reviewed (employees #1 and #7), the facility failed to obtain an annual Mantoux and/or chest x-ray from staff #1 and #7.</p>	W009999	<p>Prior to assuming residential job duties and annually, each staff will submit written evidence that a Mantoux, tuberculosis skin test or chest x-ray was completed. Records Coordinator will review personnel records to ensure staff have been notified of required mantoux. Programming Coordinators and Recruiter are responsible for following up with staff to ensure written evidence of mantoux. The Director of Programming ensures that personnel records are reviewed and Programming Coordinator and Trainer are following up.</p>	09/06/2013			

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	<p>Findings include:</p> <p>The facility's personnel records were reviewed on 7/31/13 at 4 PM. Staff #1's file indicated staff #1's last recorded Mantoux test was conducted on 5/5/12. Staff #7's file indicated staff #7's last recorded Mantoux test was conducted on 4/5/12.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/2/13 at 10:30 AM indicated staff #1's last Mantoux was completed on 5/5/12 and staff #7's last Mantoux was completed on 4/5/12. The QIDP indicated staff #1 and #7 were overdue in getting their annual Mantoux test.</p> <p>9-3-3(e)</p>			