

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G013	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/10/2014
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NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 817 MENDLESON DR RICHMOND, IN 47374
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W000000	<p>This visit was for a predetermined full annual recertification and state licensure survey.</p> <p>Dates of Survey: August 18, 19, 20, 21, 22, 25 and September 10, 2014.</p> <p>Facility Number: 000588 Provider Number: 15G013 AIMS Number: 100233310</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed September 18, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and for 4 additional clients (#5, #6, #7 and #8), the governing body failed to exercise general policy and operating direction over the facility: ___To ensure all allegations of neglect/abuse/mistreatment and injuries</p>	W000104	<p>In addition to below, please see W110, W140, W149, and W154.</p> <p>Corrective action for resident(s) found to have been affected. The carpet was assessed by AWS maintenance on 9/29/14. All of the carpet will be cleaned on 9/30/14 and the landlord will be contacted about any carpet needing replaced. The</p>	10/10/2014

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

TITLE

(X6) DATE

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

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	<p>of unknown origin were thoroughly investigated and/or an investigation was conducted for clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>__ To ensure a full and complete accounting of client #1's and #4's funds and expenditures.</p> <p>__ To ensure the facility was maintained and in good repair for clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>__ To ensure the clients' records were maintained for clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>Findings include:</p> <p>1. Observations were conducted in client #1's, #2's, #3's, #4's, #5's, #6's and #7's group home on 8/18/14 between 3:30 PM and 6:15 PM and on 8/21/14 between 5:45 AM and 8:15 AM. During both observation periods the following was observed:</p> <p>__ Client #6's bedroom carpet was frayed and strands of carpeting were pulled loose.</p> <p>__ Client #3's carpet was stained.</p> <p>__ The divider strip on the floor between the bathroom and the back hallway near client #3's bedroom was missing and bare flooring was exposed, no carpet or wood covered this area.</p> <p>__ The towel bar in the bathroom near client #3's bedroom was missing.</p>		<p>divider strip was replaced on 9/29/14 and the towel bar will be replaced on 9/30/14.</p> <p>How facility will identify other residents potentially affected and what measures taken</p> <p>All residents could be affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure recurrence</p> <p>The Group Home Manager and Supervisors will be retrained on facility maintenance by the Regional Director on 10-1-14.</p> <p>The GHM and the Q will be retrained on conducting and following up on monthly Quality Environmental Checks by the RD on 10-1-14.</p> <p>How corrective actions will be monitored to ensure recurrence</p> <p>The GHM will submit all maintenance requests to the AWS/Benchmark maintenance department and will copy the RD. The maintenance department will document on each request the date they fulfilled the maintenance request and will turn a copy back in to the GHM.</p> <p>Monthly a member of the management team conduct an environmental quality check (CQA) and turn it into the RD for tracking and compliance.</p>				

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	<p>Interview with the RM (Residential Manager) and QIDP (Qualified Intellectual Disabilities Professional) #1 on 8/22/14 at 2 PM indicated the facility was to be maintained and in good repair at all times.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the clients' records were maintained for clients #1, #2, #3, #4, #5, #6 and #7. Please see W110.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure a full and complete accounting of client #1's and #4's funds and expenditures. Please see W140.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to prevent neglect and abuse, to implement written policy and procedures to ensure all allegations of abuse/neglect, all client to client abuse and all injuries of unknown origin were thoroughly investigated and/or an investigation was conducted for clients #1, #3, #4, #5, #6, #7 and #8. Please see W149.</p>			

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W000110	<p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse/neglect, client to client abuse and injuries of unknown origin were thoroughly investigated for clients #1, #3, #4, #5, #6, #7 and #8. Please see W154.</p> <p>9-3-1(a)</p> <p>483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that includes a separate record for each client. Based on record review and interview for 4 of 4 sample clients (#1, #2, #3 and #4) and 3 additional clients (#5, #6 and #7), the facility failed to maintain each clients' record.</p> <p>Findings include:</p> <p>Client #1's, #2's, #3's, #4's, #5's #6's and #7's records were reviewed on 8/20/14 between 2 PM and 5 PM, on 8/21/14 between 10 AM and 5 PM, 8/22/14 between 11 AM and 4 PM and 8/25/14 between 11 AM and 1 PM, 2014. The clients' current records in their charts dated back 6 to 12 months previous with little current medical and/or program</p>	W000110	<p>Correctiveactionforresident(s)foundedtohavebeenaffected Filing days have been organized for 10-2-14 and10-3-14. On these dates all main filesand medical files will be filled with all required documentation for thecurrent 12 months. These charts will bemaintained by the QIDP and the LPN with assistance from the Medical Floater andthe GHM.</p> <p>Howfacilitywillidentifyotherresidentspotentiallyaffectedandwhatmeasuresstaken All residentscould be affected andcorrective action willaddress the needsof all clients.</p>	10/10/2014			

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	<p>information in the clients' records/binders that were provided for review.</p> <p>On 8/21/14 at 4 PM the RM (Residential Manager), QIDPs (Qualified Intellectual Disabilities Professionals) #1 and #2 and the facility LPN were given a list of client documentation required for review. The RM and QIDPs were asked to have the information requested available to the surveyor the following day by 9 AM.</p> <p>Interview with the RM on 8/22/14 at 1 PM indicated she, the QIDPs and the LPN were unable to find all of the items requested and stated, "But we're still looking." The RM indicated the facility had recently had a large turnover of administrative staff and stated, "We are not sure where everything is just yet."</p> <p>Interview with facility LPN #1 on 8/22/14 at 2 PM indicated the clients' records for the facility had not been filed in each client's individual binders for 6 to 12 months and she was unable to locate much of the requested survey items. The LPN stated, "I'm doing my best." LPN #1 indicated LPN #3 terminated employment with the facility on 12/31/13 and LPN #1 filled in for the facility from January through April 2013 when the facility hired LPN #2 in April 2013. LPN #2 worked four months and then LPN #2</p>		<p>Measures system changes facility put in place to ensure no recurrence The QIDP and LPN will be retrained on filing and purging all client documentation. Documentation is to be filed at least monthly and previous year information purged according to AWS/Benchmark purging policy. A QIDP-d has been hired to maintain filing. This QIDP-d will maintain files daily and turn a monthly file audits into the QIDP and the RD.</p> <p>How corrective actions will be monitored to ensure no recurrence A QIDP-d has been hired to maintain filing. This QIDP-d will maintain files daily and turn monthly file audits into the QIDP and the RD to ensure 100% compliance. The RD will conduct a random file audit to ensure compliance with purging and filing at least quarterly.</p>				

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	<p>terminated her employment with the facility on August 15, 2014. LPN #1 indicated in the interim the clients' documentation had not been filed.</p> <p>During interview with the RM (Residential Manager) and QIDPs (Qualified Intellectual Disabilities Professionals) #1 and #2 on 8/22/14 at 4 PM in the RM's office:</p> <p>__The RM stated, "I had no idea the records were in this bad of shape." __QIDP #1 stated, "Neither did I. We are all new and have been spending our time in the home trying to get to know the clients and staff. We had no idea the filing wasn't being done." __The RM indicated the clients' records were being stored in the RM's office and showed this surveyor several large stacks of papers and several card board boxes full of sheets of papers. The RM stated, "This is what we've been searching through to find what you need." __QIDP #1 stated, "If I were to guess, I would say the filing had not been done for over a year." __The RM and both QIDPs stated they had to search through "stacks and reams" of paper to find each client's requested information.</p> <p>Interview with the facility ADM (Administrator) on 8/25/14 at 1 PM</p>			

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W000140	<p>indicated the QIDP was responsible for maintaining the clients' records and stated "But there has been several turnovers of Qs (QIDPs) in the past year." The ADM indicated QIDP #4 left in September 2013 and the facility hired QIDP #3 and he left in May 2014 and that is when the facility hired QIDPs #1 and #2. The ADM stated the facility also hired a "medication floater" that was "supposed to help with the filing when she could. And that position was put into place in May but she's been too busy to be able to do much filing."</p> <p>9-3-1(a)</p> <p>483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on interview and record review for 2 of 4 sampled clients (#1 and #4), the facility failed to ensure a full and complete accounting of the clients' funds and expenditures.</p> <p>Findings include:</p> <p>Client #1's and #4's "Client Finance Transaction Receipts" (CFTRs) and COH</p>	W000140	<p>Corrective action for resident(s) found to have beenaffected The AWS/Benchmarkclient finance policy is already in place. All consumer finances, deposits and expenditures, are to be tracked onthe cash on hand ledger. When a clientrequests money from the COH bag, the client and a staff must sign that theconsumer has been given money. When anew deposit is made into the COH bag, the client and the</p>	10/10/2014			

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	<p>(Cash On Hand) records for January 2014 through August 2014 for the DP (Day Program) was reviewed on 8/21/14 at 10:30 AM.</p> <p>The CFTRs and COH indicated the following for client #1:</p> <p>__ On 2/27/14 a deposit of \$6.00. The CFTR was not signed by client #1.</p> <p>__ On 3/6/14 a deposit of \$15.00. The CFTR was not signed by client #1.</p> <p>__ On 3/27/14 a deposit of \$16.00. The CFTR was not signed by client #1.</p> <p>__ On 4/16/14 a deposit of \$20.50. The CFTR was not signed by client #1.</p> <p>__ On 5/23/14 a deposit of \$7.00. The CFTR was not signed by client #1 and indicated only one staff signature.</p> <p>__ On 6/2/14 a deposit of \$20.00. The CFTR was not signed by client #1 and indicated only one staff signature.</p> <p>__ On 6/23/14 a deposit of \$20.00. The CFTR was not signed by client #1 and indicated only one staff signature.</p> <p>__ On 7/29/14 a deposit of 5.00. The CFTR was not signed by client #1.</p> <p>__ On 8/4/14 a deposit of \$20.00. The CFTR was not signed by client #1 and indicated only one staff signature.</p> <p>The CFTRs and COH indicated the following for client #4:</p> <p>__ On 1/3/14 a deposit of \$0.30. The COH record indicated a discrepancy of \$0.05 in the balance.</p>		<p>staff must sign that money has been deposited.</p> <p>The day services PC will audit the COH bag at the day program at least weekly to ensure the correct money is present and will initial the ledger. The GHM or GHS will audit the COH bag at the home at least weekly to ensure the correct money is present and will initial the ledger.</p> <p>How facility will identify other residents potentially affected and what measures taken</p> <p>All consumers could potentially be affected and corrective action plans will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>The Day Services PC and GHM will be retrained on client finances by the RD on 10-1-14.</p> <p>The PC and GHM or GHS will audit the COH bags at least weekly to ensure the money is correct and will initial the ledger.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>Monthly the DPC will give a copy of each clients COH ledger to the GHM for tracking and to keep in the monthly finance packet. The original finance packet will be turned into the RD for review and signature before forwarding to the corporate AWS/Benchmark client finance compliance specialist.</p>				

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	<p>__ On 1/31/14 a deposit of \$14.00. The financial records indicated no CFTR for the deposit.</p> <p>__ On 3/19/14 a deposit of \$11.25. The CFTR was not signed by client #4.</p> <p>__ On 4/23/14 a deposit of \$7.00. The CFTR was not signed by client #4.</p> <p>__ On 5/21/14 a deposit of \$3.40. The financial records indicated no CFTR for the deposit.</p> <p>__ A CFTR dated 5/20/14 indicated a deposit of \$5.00. The CFTR indicated it was signed by the RM (Residential Manager) and indicated only one staff signature.</p> <p>__ On 5/28/14 a deposit of \$5.00. The financial records indicated no CFTR for the deposit.</p> <p>__ A CFTR dated 6/3/14 indicated a deposit of \$20.00. The COH record indicated the deposit was made on 6/4/14.</p> <p>__ On 7/9/14 a deposit of \$40.00. The CFTR was not signed by client #4 and indicated only one staff signature.</p> <p>Review of the 7/15/13 facility policy Financial Accountability on 8/22/14 at 11 AM indicated monthly the facility would provide a copy of the clients' COH ledger and receipts to the Representative Payee (RP).</p> <p>Interview with client #1's</p>						

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	<p>guardian/representative payee on 8/25/14 at 9 AM indicated she provided client #1 with his spending money and frequently provided money to the facility. Client #1's guardian indicated she had not received client #1's COH records "for months."</p> <p>The DPC (Day Program Coordinator) and the RM (Residential Manager) were interviewed on 8/21/14 at 10:30 AM.</p> <p>__The RM indicated the staff from the facility took money from the COH in the home to replenish the COH at the DP for clients #1 and #4.</p> <p>__The RM indicated all money taken from the clients COH in the home and deposited into the DP COH was to have a CFTR signed by the client and two staff.</p> <p>__The DPC indicated all money was to be accounted for on the COH ledgers as well as all deposits were to be recorded on the day of the transaction with a full accounting of the clients' money.</p> <p>__The DPC indicated she could not explain the discrepancy in client #4's COH ledger for 1/3/14 and stated, "The staff must have made a mistake and it was never corrected."</p> <p>__The RM indicated she had not provided client #1's RP the COH records and/or receipts. The RM indicated she was new to the facility and did not know that she was to provide the RPs copies</p>			

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W000149	<p>and stated, "But I will from now on."</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 4 sampled clients (#1, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to implement written policy and procedures to ensure all allegations of abuse/neglect, all client to client abuse and all injuries of unknown origin were thoroughly investigated and/or an investigation was conducted.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 8/19/14 at 12 PM.</p> <p>The 7/7/14 BDDS (Bureau of Developmental Disabilities Services) report for 7/7/14 at 2 PM indicated while at the DP (Day Program) client #5 "became upset with [client #7]" and hit client #7 in the stomach. __The 7/10/14 investigative record</p>	W000149	<p>Correctiveactionforresident(s)foun dtohavebeenaffected RD will retrain allgroup home staff at staff meetings on 10-1-14 on the AWS Abuse/Neglect Policyas well as the Incident Reporting Policy. This will include what is abuse/neglect, what incidents are reportable,and the mandate for immediate reporting to the QIDP. The RD will pass out Incident Report cards that provide a reminder of what incidents are reportable. Also the RD will place a reminder of whatincidents are reportable on the Staff Communication Board in the medicationroom. RD will retrain theQIDP, LPN and the GHM on necessary components of investigations. This will include conducting thoroughinterviews of all relevant individuals, and immediate reporting.</p> <p>Howfacilitywillidentifyotherreside ntspotentiallyaffectedandwhatmea surestaken All residentsare affected and correctiveaction will address</p>	10/10/2014			

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	<p>indicated an interview from one staff at the DP and no client interviews. The facility records did not indicate a thorough investigation was conducted.</p> <p>The 7/5/14 BDDS report indicated on 7/4/14 at 10 PM client #5 was arguing with client #7 and followed her (client #7) into her room and pushed her down. ___The 7/8/14 investigative report indicated no staff interviews. The facility records did not indicate a thorough investigation was conducted.</p> <p>The 5/25/14 BDDS report indicated on 5/24/14 at 1:50 PM client #7 "walked up to a housemate (no name indicated) who was sitting on the couch and knocked off his headphones. The housemate stood up and pushed [client #7], causing her to fall over." ___The facility records indicated no investigation was conducted.</p> <p>The 3/16/14 BDDS report indicated on 3/16/14 at 9:30 AM client #7 approached client #6 while she (client #6) was sitting in the living room and hit client #6 in the face with an open hand. Client #6 attempted to walk away from client #7 and client #7 slapped client #6 open handedly three more times in the left cheek. Client #6 retaliated and slapped client #7 twice on the right cheek.</p>		<p>theneeds of all clients.</p> <p>Measuresorsystemicchangesfacility putinplacetoensurenorecurrence RD will retrain allgroup home staff at staff meetings on 10-1-14 on the AWS Abuse/Neglect Policyas well as the Incident Reporting Policy. This will include what is abuse/neglect, what incidents are reportableand the mandate for immediate reporting to the QIDP. The RD will pass out Incident Report cards that provide a reminder of what incidents are reportable. Also the RD will place a reminder of whatincidents are reportable on the Staff Communication Board in the medicationroom. Any current group home staff notattending one of these meetings will be removed from the schedule until theyreceive this training from the RD or a designated representative. The RD will sign off on these trainings andwill give copies to HR to be placed in each employee's HR file. The RD will retrainthe QIDP, the LPN, and the GHM on necessary components of investigations. This included conducting thorough interviewsof all relevant individuals, and immediate reporting. The RD will sign off on these trainings andwill give copies to HR to be placed in each employee's HR file. Each client will also be asked about theirhome and living environment in their quarterly meetings. This will be documented on the meeting notesand saved in their main chart in the</p>	

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NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 817 MENDLESON DR RICHMOND, IN 47374			
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	<p>__The 3/19/14 investigative record indicated a statement from one staff and clients #6 and #7. The investigative record did not indicate how many staff and clients that were in the home at the time of the incident and/or any further staff or client interviews. The facility records did not indicate a thorough investigation was conducted.</p> <p>The 2/8/14 BDDS report indicated on 2/7/14 at 10:15 PM client #5 began complaining of abdominal pain. Client #5 was taken to the local ER (Emergency Room) and released with all test results returning normal.</p> <p>__The 2/21/14 investigative record indicated client #5 was taken to his PCP (Primary Care Physician) and had more tests ran. On 2/17/14 the TL (Team Leader) was notified client #5 had a "non-displaced fracture of the anterior lateral aspect of the right eighth and ninth ribs." The record indicated staff interviews and an interview with client #5. The investigative record did not indicate interviews with client #5's housemates and or co-workers at the day program. The facility records did not indicate a thorough investigation was conducted.</p> <p>The 1/14/14 BDDS report indicated on 1/14/14 at 7 AM client #1 had sat down</p>		<p>office.</p> <p>Howcorrectiveactionswillbemonitordtoensurenorecurrence Incidents are to bereported to the RD immediately. The RDwill write an email to document the date and time notified to be included withthe investigation packet. Theinvestigation packet is then sent to the RD for original signature. The RD sends the original investigationpacket to the Vice President for original signature. The Vice President sends the originalinvestigation packet to the Director of Compliance for original signature. Once all signatures are obtained, theDirector of Compliance scans the investigation packet to the RD to file. The RD will review100% of incident reports.</p>				

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	<p>to eat his breakfast and he refused to take his coat off the facility staff took his breakfast away from him and told him he couldn't eat until he took his coat off. The 1/20/14 investigative record did not indicate all staff and clients in the home at the time of the incident.</p> <p>__The investigative record indicated an interview with the staff accused of taking client #1's food, the reporting staff and clients #1 and #4. The investigative records did not indicate an interview with all staff that worked in the home and/or all clients that lived in the home. The investigative record indicated the abuse was not substantiated because "it came down to one staff's word against another." The facility records did not indicate a thorough investigation was conducted.</p> <p>The 1/18/14 BDDS report indicated on 1/14/14 at 7 AM a staff made an allegation another staff "left residents (clients #1, #3, #4, #5, #6 and #8) alone on a running van while she (the staff) was inside the group home."</p> <p>__The 1/21/14 investigative record indicated two staff interviews, one from the reporting staff and one from the staff accused of neglect. The investigative records did not indicate an interview with all staff that worked in the home and/or all clients that lived in the home. The</p>						

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	<p>investigative record indicated the neglect was not substantiated. The facility records did not indicate a thorough investigation was conducted.</p> <p>The 12/5/13 BDDS report indicated on 12/4/13 at 6:30 PM client #8 "punched" client #1 in the right hip and client #1 was leaving the dinner table. The 12/10/13 investigative record indicated two staff statements and statements from clients #1 and #8.</p> <p>__The investigative records indicated other clients were home but did not indicate how many staff and which clients were in the home at the time of the incident and/or any further staff or client interviews. The facility records did not indicate a thorough investigation was conducted.</p> <p>The 11/12/13 BDDS report indicated on 11/11/13 at 7:41 AM a staff reported to the TL (Team Lead the overnight staff told client #7 she was "crazy and belonged in a state institution."</p> <p>__The 11/11/13 indicated an interview with the staff accused of verbal abuse, the reporting staff and client #7. The investigative records did not indicate an interview with all staff that worked in the home and/or all clients that lived in the home. The investigative record indicated the abuse was not substantiated because</p>			

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	<p>"it was the word of one staff against another." The facility records did not indicate a thorough investigation was conducted.</p> <p>Interview with QIDPs (Qualified Intellectual Disabilities Professionals) #1 and #2 on 8/19/14 at 11 AM indicated all allegations of abuse/neglect/mistreatment and injuries of unknown origin were to be thoroughly investigated.</p> <p>Interview with QIDP #2 on 8/25/14 at 1 PM indicated when conducting an investigation all clients and all staff in the home at the time of the client to client abuse should be noted in the investigative paperwork and all staff and clients should then be interviewed for the investigation to be considered thorough. QIDP #2 indicated she had provided all investigations and reportable incidents for review.</p> <p>The facility policies were reviewed on 8/22/14 at 2 PM. ___The 3/2011 revised "Indiana Abuse and Neglect" policy indicated "AWS does not tolerate abuse, neglect or exploitation in any form by any person.... Alleged, suspected or actual abuse, (which must be reported to Adult Protective Services or Child Protective Services as indicated) which includes but</p>			

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	<p>is not limited to: physical abuse, including but not limited to: intentionally touching another person in a rude, insolent or angry manner, willful infliction of injury.... Alleged, suspected or actual neglect... which includes but is not limited to: failure to provide appropriate supervision, care or training, failure to provide a safe, clean and sanitary environment, failure to provide food and medical services as needed...."</p> <p>__The 6/13/13 revised "Incident Reporting and Investigation Policy - Indiana" indicated "Peer to peer aggression that results in significant injury. For Group Homes: All peer to peer aggression is reportable; including allegations of peer-to-peer aggression. Each of these types of incidents requires completion of an investigation.... Any injury to an individual when the cause is unknown and/or the injury could be indicative of abuse, neglect or exploitation. Any injury to an individual when the cause of the injury is unknown and the injury requires a medical evaluation or treatment.... Investigating and Incident: The investigator conducts interviews and collects written statement from all relevant individuals. Upon review of all evidence the investigator will complete the Investigative Report and will determine if the allegation(s) are substantiated or unsubstantiated and will</p>			

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W000154	<p>make recommendations as needed."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 9 of 10 allegations of abuse/neglect, client to client abuse and injuries of unknown origin reviewed for clients #1, #3, #4, #5, #6, #7 and #8, the facility failed to ensure a thorough investigation and/or an investigation was conducted.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 8/19/14 at 12 PM.</p> <p>The 7/7/14 BDDS (Bureau of Developmental Disabilities Services) report for 7/7/14 at 2 PM indicated while at the DP (Day Program) client #5 "became upset with [client #7]" and hit client #7 in the stomach. __The 7/10/14 investigative record indicated an interview from one staff at the DP and no client interviews. The facility records did not indicate a</p>	W000154	<p>Correctiveactionforresident(s)foun dtohavebeenaffected RD will retrain allgroup home staff at staff meetings on 10-1-14 on the AWS Abuse/Neglect Policyas well as the Incident Reporting Policy. This will include what is abuse, neglect, exploitation, and injuries ofunknown origin, what incidents are reportable, and the mandate for immediatereporting to the QIDP. The RD will passout Incident Report cards that provide a reminder of what incidents are reportable. Also the RD will place a reminder of whatincidents are reportable on the Staff Communication Board in the medicationroom. RD will retrain theQIDP, LPN and the GHM on necessary components of investigations. This will include conducting thoroughinterviews of all relevant individuals, and immediate reporting.</p> <p>Howfacilitywillidentifyotherreside ntspotentiallyaffectedandwhatmea surestaken</p>	10/10/2014	

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	<p>thorough investigation was conducted.</p> <p>The 7/5/14 BDDS report indicated on 7/4/14 at 10 PM client #5 was arguing with client #7 and followed her (client #7) into her room and pushed her down. ___The 7/8/14 investigative report indicated no staff interviews. The facility records did not indicate a thorough investigation was conducted.</p> <p>The 5/25/14 BDDS report indicated on 5/24/14 at 1:50 PM client #7 "walked up to a housemate (no name indicated) who was sitting on the couch and knocked off his headphones. The housemate stood up and pushed [client #7], causing her to fall over." ___The facility records indicated no investigation was conducted.</p> <p>The 3/16/14 BDDS report indicated on 3/16/14 at 9:30 AM client #7 approached client #6 while she (client #6) was sitting in the living room and hit client #6 in the face with an open hand. Client #6 attempted to walk away from client #7 and client #7 slapped client #6 open handedly three more times in the left cheek. Client #6 retaliated and slapped client #7 twice on the right cheek. ___The 3/19/14 investigative record indicated a statement from one staff and clients #6 and #7. The investigative</p>		<p>All residents are affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure recurrence RD will retrain all group home staff at staff meetings on 10-1-14 on the AWS Abuse/Neglect Policy as well as the Incident Reporting Policy. This will include what is abuse/neglect, what incidents are reportable and the mandate for immediate reporting to the QIDP. The AWS Reportable Incident Policy states that any unknown injuries over 3 inches in size in any way or indicative of abuse are to be reported. This is the policy that the staff will be trained on. The RD will pass out Incident Report cards that provide a reminder of what incidents are reportable. Also the RD will place a reminder of what incidents are reportable on the Staff Communication Board in the medication room. Any current group home staff not attending one of these meetings will be removed from the schedule until they receive this training from the RD or a designated representative. The RD will sign off on these trainings and will give copies to HR to be placed in each employee's HR file. The RD will retrain the QIDP, the LPN, and the GHM on necessary components of investigations. This included conducting thorough interviews of all relevant individuals, and immediate reporting. The RD</p>				

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	<p>record did not indicate how many staff and clients were in the home at the time of the incident and/or any further staff or client interviews. The facility records did not indicate a thorough investigation was conducted.</p> <p>The 2/8/14 BDDS report indicated on 2/7/14 at 10:15 PM client #5 began complaining of abdominal pain. Client #5 was taken to the local ER (Emergency Room) and released with all test results returning normal.</p> <p>__The 2/21/14 investigative record indicated client #5 was taken to his PCP (Primary Care Physician) and had more tests ran. On 2/17/14 the TL (Team Leader) was notified client #5 had a "non-displaced fracture of the anterior lateral aspect of the right eighth and ninth ribs." The record indicated staff interviews and an interview with client #5. The investigative record did not indicate interviews with client #5's housemates and or co-workers at the day program. The facility records did not indicate a thorough investigation was conducted.</p> <p>The 1/14/14 BDDS report indicated on 1/14/14 at 7 AM client #1 had sat down to eat his breakfast and he refused to take his coat off the facility staff took his breakfast away from him and told him he</p>		<p>will sign off on these trainings and will give copies to HR to be placed in each employee's HR file. Each client will also be asked about their home and living environment in their quarterly meetings. This will be documented on the meeting notes and saved in their main chart in the office.</p> <p>How corrective actions will be monitored to ensure no recurrence Incidents are to be reported to the RD immediately. The RD will write an email to document the date and time notified to be included with the investigation packet. The investigation packet is then sent to the RD for original signature. The RD sends the original investigation packet to the Vice President for original signature. The Vice President sends the original investigation packet to the Director of Compliance for original signature. Once all signatures are obtained, the Director of Compliance scans the investigation packet to the RD to file. The RD will review 100% of incident reports for each QIDP until the QIDP is proficient in writing and submitting incident reports. After a QIDP is proficient in writing and submitting incident reports, the RD will place documentation in the QIDPs employee file and continue to review every incident reports once it is submitted. The AWS Policy on Reportable Incidents states that any injury of</p>		

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	<p>couldn't eat until he took his coat off. The 1/20/14 investigative record did not indicate all staff and clients in the home at the time of the incident.</p> <p>__The investigative record indicated an interview with the staff accused of taking client #1's food, the reporting staff and clients #1 and #4. The investigative records did not indicate an interview with all staff that worked in the home and/or all clients that lived in the home. The investigative record indicated the abuse was not substantiated because "it came down to one staff's word against another." The facility records did not indicate a thorough investigation was conducted.</p> <p>The 1/18/14 BDDS report indicated on 1/14/14 at 7 AM a staff made an allegation another staff "left residents (clients #1, #3, #4, #5, #6 and #8) alone on a running van while she (the staff) was inside the group home."</p> <p>__The 1/21/14 investigative record indicated two staff interviews, one from the reporting staff and one from the staff accused of neglect. The investigative records did not indicate an interview with all staff that worked in the home and/or all clients that lived in the home. The investigative record indicated the neglect was not substantiated. The facility records did not indicate a thorough</p>		<p>unknown origin must be reported and investigated if it is 3 inches insize in any direction or indicative of abuse. This is the policy that staff will be trained on.</p> <p>All allegations of abuse or neglect or exploitation will bereported and investigated per AWS policy. If an allegation is found to not be substantiated that will bedocumented on the incident report follow up.</p>				

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	<p>investigation was conducted.</p> <p>The 12/5/13 BDDS report indicated on 12/4/13 at 6:30 PM client #8 "punched" client #1 in the right hip and client #1 was leaving the dinner table. The 12/10/13 investigative record indicated two staff statements and statements from clients #1 and #8.</p> <p>__The investigative records indicated other clients were home but did not indicate how many staff and which clients were in the home at the time of the incident and/or any further staff or client interviews. The facility records did not indicate a thorough investigation was conducted.</p> <p>The 11/12/13 BDDS report indicated on 11/11/13 at 7:41 AM a staff reported to the TL (Team Lead the overnight staff told client #7 she was "crazy and belonged in a state institution."</p> <p>__The 11/11/13 indicated an interview with the staff accused of verbal abuse, the reporting staff and client #7. The investigative records did not indicate an interview with all staff that worked in the home and/or all clients that lived in the home. The investigative record indicated the abuse was not substantiated because "it was the word of one staff against another." The facility records did not indicate a thorough investigation was</p>				

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W000159	<p>conducted.</p> <p>Interview with QIDPs (Qualified Intellectual Disabilities Professionals) #1 and #2 on 8/19/14 at 11 AM indicated all allegations of abuse/neglect/mistreatment and injuries of unknown origin were to be thoroughly investigated.</p> <p>Interview with QIDP #2 on 8/25/14 at 1 PM indicated when conducting an investigation all clients and all staff in the home at the time of the client to client abuse should be noted in the investigative paperwork and all staff and clients should then be interviewed for the investigation to be considered thorough. QIDP #2 indicated she had provided all investigations and reportable incidents for review.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, interview and record review for 4 of 4 sample clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility QIDP (Qualified Intellectual Disabilities</p>	W000159	In addition to below, please see W140, W149, W210, W227, W249, W259, W312, W440, and W444. Corrective action for resident(s) found to have been affected	10/10/2014			

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	<p>Professional) failed to integrate, coordinate and monitor each client's active treatment program.</p> <p>The QIDP failed to ensure: Client #1's, #2's, #3's and #4's objectives were reviewed and revised quarterly.</p> <p>A full and complete accounting of client #1's and #4's funds and expenditures.</p> <p>All allegations of neglect/abuse/mistreatment and injuries of unknown origin were thoroughly investigated and/or an investigation was conducted for clients #1, #3, #4, #5, #6, #7 and #8.</p> <p>The Interdisciplinary Team (IDT) reviewed and/or updated client #1's, #2's, #3's and #4's CFAs (Comprehensive Functional Assessments) annually, to ensure the clients' fine and gross motor skills were assessed and client #2's mobility and dining needs were assessed.</p> <p>Client #1's Individual Support Plan (ISP) addressed client #1's identified training need in regards to safety while using an electric razor.</p> <p>Clients #1, #2, #3, #4, #5, #6 and #7 were provided medication training at every available opportunity.</p>		<p>The QIDP will beretrained by the RD on conducting monthly reviews of all clientobjectives. This includes reviewing,tracking, and reporting on the objectives. The QIDP will write and submit a Monthly Summary report to the RD andCompliance Officer by the 20th of the following month.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken All consumers couldpotentially be affected and corrective action plans will address the needs ofall clients.</p> <p>Measures or systemic changes facility put in place toensure no recurrence The QIDP will receivethe objective tracking from the Supervisor no later than the 1stbusiness day of the month. The QIDP willreview the monthly objectives, track them, and then report on them on themonthly summary report.</p> <p>How corrective actions will be monitored to ensure norecurrence The QIDP will report on the monthly objectives on a monthllysummary report. The QIDP will turn eachmonthly report into the GHM and the Compliance Officer no later than the 20thof each month. The QIDP will review anddiscuss objectives at each quarterly meeting, record meeting notes on themeeting notes form, and fill out the Meeting Checklist which will be turnedinto</p>				

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	<p>Client #3's use of Lexapro (for depression) and client #4's use of Cymbalta (for depression) and Quetiapine (an antipsychotic) were included in the clients' program plans with specific plans of reductions.</p> <p>All behavior modification medications were included in a program plan with a plan of reduction for each medication and written informed consent was obtained for the medications for clients #2, #3 and #4.</p> <p>Evacuation drills were conducted at least quarterly for clients #1, #2, #3, #4, #5, #6, #7 and #8 and the facility reviewed the effectiveness of the drills in regard to the time the drills were taking for the clients to get to a safe place.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Client #1's record was reviewed on 8/22/14 at 11 AM. Client #1's 10/15/13 ISP indicated objectives: To prepare a breakfast item. To choose a leisure activity. To add dollar bills. To brush his teeth. To keep items off of the fire box in his room. To shower within an appropriate amount 		<p>the RD within 24 hour of each meeting.</p> <p>One member of management will be in the home at least until 7pm at least weekly. One member of management will conduct random pop in visits at least weekly on varying shifts and days to ensure staff are providing active treatment and providing formal goal training. A QIDP-d has been hired to maintain filing and to conduct monthly chart audits. This will include monitoring goal objective reviews as well as completion of monthly summaries.</p>				

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	<p>of time. To state why he is taking his medications. To do some kind of physical exercise for 20 - 30 minutes. Client #1's record indicated the QIDP did not review client #1's objectives from August 2013 through May 2014.</p> <p>Client #2's record was reviewed on 8/22/14 at 1 PM. Client #2's 1/15/14 ISP indicated objectives: To shower or bathe. To state why she takes her medications. To allow the staff to teach her to use the microwave. To eat in a safe manner. To use a washer and dryer. To wake up and arrive at the workshop on time. To state an example of what she could buy with various amounts of money. To clean and trim her fingernails. Client #2's record indicated the QIDP did not review client #2's objectives from August 2013 through May 2014.</p> <p>Client #3's record was reviewed on 8/22/14 at 10 AM. Client #3's 10/28/13 ISP indicated objectives: To brush his teeth for 30 seconds or more. To use medication related sign language when receiving his medications.</p>			

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	<p>To take a shower or a bath.</p> <p>To improve his sign language skills by learning new signs with flashcards.</p> <p>To set the table.</p> <p>To regulate the water temperatures.</p> <p>To clean his bedroom.</p> <p>To use an appropriate amount of paper towels when drying his hands.</p> <p>Client #3's record indicated the QIDP did not review client #3's objectives from August 2013 through May 2014.</p> <p>Client #4's record was reviewed on 8/22/14 at 12 PM. Client #4's 10/8/13 ISP indicated objectives:</p> <p>To wash her face after breakfast.</p> <p>To take small bites and put her utensils down between bites.</p> <p>To prepare a dinner item.</p> <p>To choose a leisure activity.</p> <p>To clean her bedroom.</p> <p>To apply chap stick after brushing her teeth.</p> <p>To state why she was taking her medications.</p> <p>To add dollar bills.</p> <p>Client #4's record indicated the QIDP did not review client #4's objectives from August 2013 through May 2014.</p> <p>Interview with the QIDP on 8/22/14 at 2 PM stated, "The only reviews I can find are the ones I did for June and July." The</p>			

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	<p>QIDP indicated she was employed with the facility in May 2014 and was unable to find evidence of reviews prior to her hire for the previous QIDPs that worked at the facility.</p> <p>2. The QIDP failed to ensure a full and complete accounting of client #1's and #4's funds and expenditures. Please see W140.</p> <p>3. The QIDP failed to ensure the facility's written policy and procedures were implemented to ensure all allegations of abuse/neglect, all client to client abuse and all injuries of unknown origin were thoroughly investigated and/or an investigation was conducted and neglected to prevent client to client abuse for clients #1, #3, #4, #5, #6, #7 and #8. Please see W149.</p> <p>4. The QIDP failed to ensure all allegations of neglect/abuse/mistreatment and injuries of unknown origin were thoroughly investigated and/or an investigation was conducted for clients #1, #3, #4, #5, #6, #7 and #8. Please see W154.</p> <p>5. The QIDP failed to ensure the Interdisciplinary Team (IDT) assessed/reassessed client #2's mobility and dining needs and to ensure client</p>				

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	<p>#1's, #2's, #3's and #4's Comprehensive Functional Assessments (CFAs) included an assessment of the clients' fine and gross motor skills and/or ensure a PT/OT (Physical Therapy/Occupational Therapy) assessment. Please see W210.</p> <p>6. The QIDP failed to ensure client #1's Individual Support Plan (ISP) addressed the client's identified training need in regards to safety while using an electric razor. Please see W227.</p> <p>7. The QIDP failed to ensure the staff provided clients #1, #2, #3, #4, #5, #6 and #7 formal/informal training during all available opportunities. Please see W249.</p> <p>8. The QIDP failed to ensure the IDT (Interdisciplinary Team) reviewed and/or updated the clients' CFAs (Comprehensive Functional Assessments) annually for clients #1, #2 and #4. Please see W259.</p> <p>9. The QIDP failed to obtain written informed consent from the clients and/or the clients' legal representatives for the clients' restrictive programs and/or the use of behavior modification medication for clients #2, #3 and #4. Please see W263.</p>			

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W000210	<p>10. The QIDP failed to ensure client #3's use of Lexapro (for depression) was included in a BSP (Behavior Support Plan) and client #4's use of Cymbalta (for depression) and Quetiapine (an antipsychotic) were included in the client's BSP with specific plans of reductions for each medication to reduce and eventually eliminate the behaviors for which each psychoactive medication was to target. Please see W312.</p> <p>11. The QIDP failed to ensure evacuation drills were conducted at least quarterly for clients #1, #2, #3, #4, #5, #6 and #7. Please see W440.</p> <p>12. The QIDP failed to ensure the facility reviewed the effectiveness of the evacuation drills in regard to the length of time the evacuations were taking for the clients to get to a safe area for clients #1, #2, #3, #4, #5, #6, #7 and #8. Please see W444.</p> <p>9-3-3(a)</p> <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>			

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	<p>Based on observation, record review and interview for 1 of 4 sampled clients (#1, #2, #3 and #4), the Interdisciplinary Team (IDT) failed to ensure:</p> <p>__ Client #2's mobility and dining needs were assessed</p> <p>__ Client #1's, #2's, #3's and #4's Comprehensive Functional Assessments (CFAs) included an assessment of the clients' fine and gross motor skills and/or a PT/OT (Physical Therapy/Occupational Therapy) assessment.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/18/14 between 3:30 PM and 6:15 PM and on 8/21/14 between 5:45 AM and 8:15 AM.</p> <p>__ During both observation periods client #2 required staff assistance to get up from a sitting position and to sit down from a standing position. Client #2 used a seated wheeled walker while ambulating and walked with a slow gait and staff assistance.</p> <p>__ During both observation periods client #3 walked on his toes with an unsteady uneven gait.</p> <p>__ During both observation periods client #4 ambulated with a slow unsteady gait while using a wheeled walker and wearing a gait belt. The staff provided hands on assistance to client #4 for all</p>	W000210	<p>Corrective action for resident(s) found to have beenaffected</p> <p>All clients willhave an annual Comprehensive Functional Assessment as well as other necessaryassessments such as OT and PT. The QIDPwill ensure the CFAs are completed by 10-10-14. The LPN will ensure the clients receive OT/PT evaluations or thatappointments are scheduled.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken</p> <p>All residentsare affected and correctiveaction will address theneeds of all clients.</p> <p>Measures or systemic changes facility put in place toensure no recurrence</p> <p>The QIDP and LPNwill be retrained on the need for annual assessments including but not limitedto the CFA and OT/PT by the RD on 10-1-14. The QIDP and the LPN will secure the assessments are completed orappointments scheduled by 10-10-14.</p> <p>How corrective actions will be monitored to ensure norecurrence</p> <p>The RD will sign offon the record of training for the QIDP and LPN. The RD will conduct quarterly random file reviews to ensure current assessmentsare present for each client.</p> <p>A new QIDP-d hasbeen hired to</p>	10/10/2014			

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	<p>ambulation and transfers.</p> <p>1. Client #2's record was reviewed on 8/22/14 at 1 PM.</p> <p>__ Client #2's record indicated client #2 was admitted to the facility on 1/15/14.</p> <p>__ Client #2's record indicated diagnoses of, but not limited to, Obesity, Rheumatoid Arthritis (inflammation of the joints and surrounding tissues) and Osteoarthritis (wear on the joints due to aging).</p> <p>__ Client #2's admission nursing assessment dated 1/15/14 indicated client #2 was at risk for falls due to Arthritis and a falls risk plan was implemented.</p> <p>__ Client #2's nursing note indicated on: 4/2/14 client #2 was complaining of pain and swelling in her left knee.</p> <p>"[Name of doctor] - left knee severe arthritis - gave (client #2) left knee... steroid injection."</p> <p>4/14/14 client #2's father brought a walker to the facility for client #2 to use while ambulating. The note indicated the LPN called client #2's PCP (Primary Care Physician) for an order for client #2 to use a walker.</p> <p>__ Client #2's physician's order on 4/30/14 indicated client #2 "may use a walker to assist with ambulation."</p> <p>__ Client #2's record indicated no assessment of client #2's fine and gross</p>		<p>maintain filing. The Q-dwill file daily and turn in a monthly file audit form to the Q and the RD to ensure files are maintained and current.</p>	

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	<p>motor skills by the IDT and/or an assessment for PT/OT. Client #2's record indicated no assessment for the use of a walker for ambulation.</p> <p>__ Client #2's Nutritional Assessment dated 2/9/14 indicated client #2 was to have her foods cut into 1/4 inch to 1/2 inch bites due to choking risk.</p> <p>__ Client #2's Risk Summary dated 12/18/13 indicated client #2 was at risk of choking due to unsafe eating habits. The summary indicated client #2's father reported to the facility client #2 required assistance in cutting her food up in small pieces to decrease the risk of choking.</p> <p>__ Client #2's record indicated no swallow assessment and/or an assessment by a SLP (Speech/Language Pathologist) in regards to client #4's need to have her food cut into small bite sized pieces and/or dining needs.</p> <p>Interview with the facility LPN on 8/22/14 at 2 PM indicated client #2 had not had a PT/OT assessment since her admission to the facility on 1/15/14. The LPN indicated client #2's father brought a walker to the facility for client #2 to assist client #2 while ambulating. The LPN indicated no swallow study and/or assessment from a SLP in regard to client #2's dining needs due to choking.</p>			

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	<p>2. Client #1's record was reviewed on 8/22/14 at 11 AM. Client #1's record indicated diagnoses of, but not limited to, Downs Syndrome and Tinea Pedis (foot fungus). ___ Client #1's CFA dated 9/19/12 indicated no assessment of client #1's fine and gross motor skills. Client #1's record indicated no assessment from PT/OT.</p> <p>Client #3's record was reviewed on 8/22/14 at 10 AM. Client #3's record indicated diagnoses of, but not limited to, COPD (Chronic Obstructive Pulmonary Disease), Asthma and Emphysema (lung disorders), Bilateral Hearing Loss, Retinal Detachment (vision impairment), Hamstring (tendons in the thighs) and heel cord tightness. Client #3's updated Risk Summary of 10/23/13 indicated "[Client #3] has constrictures in his heel that cause him to walk on his toes. He has a home exercise program that was recommended by physical therapy that he should do 2 times daily to prevent furthering of constrictures." ___ Client #3's CFA dated 9/7/12 indicated no assessment of client #3's fine and gross motor skills. Client #3's record indicated no assessment from PT/OT.</p> <p>Client #4's record was reviewed on 8/22/14 at 12 PM. Client #4's record</p>			

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W000227	<p>indicated a diagnosis of, but not limited to, Osteoarthritis and a history of falls. Client #4's CFA dated 9/7/12 indicated no assessment of client #4's fine and gross motor skills. Client #4's Risk Summary dated 11/1/13 indicated client #4 was at risk for falling and was being evaluated by PT for strengthening and gait training. Client #4's record indicated no assessment from PT/OT.</p> <p>Interview with the RM (Residential Manager) and QIDP (Qualified Intellectual Disabilities Professionals) #1 on 8/22/14 at 4 PM indicated the RM and QIDP were unable to find assessments of client #1's, #2's, #3's and #4's fine and gross motor skills.</p> <p>Interview with the facility's LPN on 8/22/14 at 2 PM indicated client #1's, #2's, #3's and #4's records had not been filed in each individual client's binder for 6 to 12 months and she was unable to locate PT/OT assessments for clients #1, #2, #3 and #4.</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the</p>			

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	<p>comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 1 of 4 sampled clients (#1), the client's Individual Support Plan (ISP) failed to address the client's identified training need in regards to safety while using an electric razor.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/18/14 between 3:30 PM and 6:15 PM.</p> <p>__At 4 PM client #1 was in the bathroom across from his bedroom standing in front of the sink and shaving his head with an electric razor that was plugged into an outlet next to the sink. When client #1 had finished shaving his head, client #1 left the razor plugged into the outlet and laying on the edge of the sink with the cord touching and draped down the edge of the sink.</p> <p>__At 4:50 PM the razor was pointed out to QIDP (Qualified Intellectual Disabilities Professional) #1. QIDP #1 stated, "He (client #1) probably just left it (the razor) there." When asked if that was a safety hazard the QIDP stated, "Yes."</p> <p>Client #1's record was reviewed on 8/22/14 at 11 AM. Client #1's 10/15/13 ISP indicated no training objectives in</p>	W000227	<p>Corrective action for resident(s) found to have beenaffected All clients will have a assessments completed and plans written for any identified needs. The QIDP will ensure the CFAs are completed by 10-10-14. Client #1 will be assessed for electric razor use and an IDT will meet to decide if a new plan will need to be implemented.</p> <p>How facility will identify other residents potentially affected and what measures taken All residents are affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence The QIDP and LPN will be retrained on the need for annual assessments including but not limited to the CFA and OT/PT by the RD on 10-1-14. The IDT will meet to decide if a new plan will need to be implemented in regards to client #1 electric razor use.</p> <p>How corrective actions will be monitored to ensure no recurrence The RD will sign off on the record of training for the QIDP and LPN. The RD will conduct random file reviews to ensure current assessments are present for each client. The RD will also monitor monthly summaries</p>	10/10/2014			

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	<p>interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 3 additional clients (#5, #6 and #7), the facility failed to implement formal/informal training objectives when opportunities were available.</p> <p>Findings include:</p> <p>Observation of the medication pass was conducted on 8/21/14 between 5:45 AM and 8:15 AM. During this time staff #3 was observed giving clients #1, #2, #3, #4, #5, #6 and #7 their AM medications.</p> <p>At 6:25 AM client #6 received Abilify (an antipsychotic), Cogentin for muscle spasms, stiffness and tremors, Calcium for bone support, Omeprazole (to decrease stomach acid), Paxil for depression, Zocor to lower her cholesterol, Detrol for urinary incontinence related to an overactive bladder, Flonase (to treat sinus issues) and Clindamycin (an antibiotic).</p> <p>At 6:55 AM client #3 received Enalapril and Toprol XL for high blood pressure, Lexapro for depression, Ativan for anxiety, Chlorhexidine Gluconate (a dental rinse), Nasonex nasal spray for allergies, Symbicort for symptoms of asthma and Vaseline lip balm.</p>		<p>found to have beenaffected Staff are to provideactive treatment, both formal and informal at all times. Staff will be retrained by the RD at an allstaff meeting on 10-1-14 and the record of training will be placed in theemployee HR file.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken All residents areaaffected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place toensure no recurrence One member ofmanagement stays in the home at least weekly until 7pm to provide on the spottraining. This will include thenecessity for teaching staff how to provide active treatment and how to followformal training programs. The member ofmanagement will record their observations and any teachable moments on theManager Observation Log. A member ofmanagement will conduct random pop in visits no less than weekly on varyingdays and shifts to ensure staff are awake and providing active treatment. These random pop in visits will be documentedon the MOL. Also a member ofmanagement (GHM, LPN, Q, Q-d, GHS, or RD) will observe in the home daily toensure active treatment is being conducted at all times. These</p>				

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	<p>At 7:05 AM client #5 received Erythromycin cream to his face (an antibiotic), Cal-Gest (to strengthen bones), CIB (Carnation Instant Breakfast - a dietary supplement), Lamictal (for seizures), Omeprazole and Polyethylene glycol (a laxative).</p> <p>At 7:25 AM client #1 received Artificial tears, Loratadine (an antihistamine), Vaseline lip balm and Restasis eye drops (for chronic dry eye).</p> <p>At 7:35 AM client #7 received Glucosamine (to promote healthy joints), Lubrisoft lotion to both hands, Clindamycin to her face and body, Vaseline lip balm and Chlorhexidine Gluconate rinse.</p> <p>At 7:40 AM client #4 received Wellbutrin and Cymbalta for depression, Cal-Gest and Oyster Shell for bone health, Clonazepam (an antipsychotic), Colace (a stool softener), Neurontin for seizure control, Oxybutynin (used to treat symptoms of an overactive bladder), Pilocarpine eye drops for glaucoma, Sulfasalazine for symptoms of arthritis and Folic acid, Centrum, Vitamin D3 and Boost (dietary supplements).</p> <p>At 8:15 AM client #2 received Mupirocin topical (an antibiotic ointment) and</p>		<p>observations will be documented on theMOL.</p> <p>How corrective actions will be monitored to ensure norecurrence The RD will ensure all staff are retrained on active treatment and formal training programs. The RD will monitor Provide, the time entry program, and the Manager Observation Log, to ensure a member of management is observing in the home until 7pm at least weekly and to ensure management staff are providing random pop in visits no less than weekly at varying shifts and days. A member of management (GHM, LPN, Q, Q-d, GHS, or RD) will observe in the home daily to ensure active treatment is being conducted at all times. These observations will be documented on theMOL.</p>	

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	<p>Fluocinonide (a steroid skin cream) to both ears, Theragran-M and Folic acid (dietary supplements), OxyContin and Carbamazepine for pain, Prednisone (an anti-inflammatory), Paxil for depression and Phenobarbital (an anticonvulsant/hypnotic).</p> <p>During this observation period staff #3 prepared each client's medications and then asked the client to come to the medication room for their medications. Staff #3 handed each client their medications, the clients took their medications and then left the medication room. While giving clients #1, #2, #3, #4, #5, #6 and #7 their morning medications staff #3 did not provide the clients with any medication training.</p> <p>Client #1's record was reviewed on 8/22/14 at 11 AM. Client #1's 10/15/13 ISP (Individual Support Plan) indicated client #1 was not independent with administering his own medications and required staff assistance and training. Client #1's ISP indicated client #1 had a medication objective to state why he was taking his medications.</p> <p>Client #2's record was reviewed on 8/22/14 at 1 PM. Client #2's 1/15/14 ISP indicated client #2 was not independent with administering her own medications</p>						

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	<p>and required staff assistance and training. Client #2's ISP indicated client #2 had a medication goal to state why she took her medications.</p> <p>Client #3's record was reviewed on 8/22/14 at 10 AM. Client #3's 10/28/13 ISP indicated client #3 was not independent with administering his own medications and required staff assistance and training. Client #3's ISP indicated client #3 had a medication objective to use medication related sign language while getting his medications.</p> <p>Client #4's record was reviewed on 8/22/14 at 12 PM. Client #4's 10/8/13 ISP indicated client #4 was not independent with administering her own medications and required staff assistance and training. Client #4's ISP indicated client #4 had a medication objective to state why she was taking Neurontin, Klonopin and Oyster Shell.</p> <p>Client #5's record was reviewed on 8/22/14 at 3 PM. Client #5's 10/23/13 ISP indicated client #5 was not independent with administering his own medications and required staff assistance and training. Client #5's ISP indicated client #5 was on a medication objective to state why he took his medications.</p>			

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	<p>Client #6's record was reviewed on 8/22/14 at 3:30 PM. Client #6's 10/8/13 ISP indicated client #6 was not independent with administering her own medications and required staff assistance and training. Client #6's ISP indicated client #6 had a medication objective to repeat the names of her medications and to tell the staff why she takes them.</p> <p>Client #7's record was reviewed on 8/22/14 at 4 PM. Client #7's 10/28/13 ISP indicated client #7 was not independent with administering her own medications and required staff assistance and training. Client #7's ISP indicated client #7 had a medication objective to give staff an appropriate response as to why she takes her medications.</p> <p>During interview with QIDP (Qualified Intellectual Disabilities Professional) #1, the facility LPN and the ADM (Administrator) on 8/25/14 at 1 PM, the LPN indicated the staff are taught that it is ok to pre-set one client's medication at a time then ask that client to come to the medication room and take their medication. QIDP #1 stated, "Even though the client was not in the medication room at the time the client's medication was prepared, the staff are still to provide the clients medication training with every medication pass."</p>			

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W000259	<p>9-3-4(a)</p> <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. Based on record review and interview for 3 of 4 sampled clients (#1, #3 and #4), the facility failed to ensure the IDT (Interdisciplinary Team) reviewed and/or updated the clients' CFAs (Comprehensive Functional Assessments) annually.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/22/14 at 11 AM. Client #1's record indicated a CFA dated 9/19/12. The record indicated the IDT had not reviewed and/or updated client #1's CFA within 365 days from the date of the previous CFA of 9/19/12.</p> <p>Client #3's record was reviewed on 8/22/14 at 10 AM. Client #3's record indicated a CFA dated 9/7/12. The record indicated the IDT had not reviewed and/or updated client #3's CFA within 365 days from the date of the previous CFA of 9/7/12.</p>	W000259	<p>Corrective action for resident(s) found to have beenaffected All clients willhave an annual Comprehensive Functional Assessment. The QIDP will ensure the CFAs are completedby 10-10-14 and these are placed in the main file.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken All residentsare affected and correctiveaction will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place toensure no recurrence The QIDP will beretrained on the need for annual assessments including but not limited to theCFA by the RD on 10-1-14. The QIDP willensure the assessments are completed and filed in the main charts by 10-10-14.</p> <p>How corrective actions will be monitored to ensure norecurrence The RD will sign offon the record of training for the QIDP. The RD will</p>	10/10/2014			

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W000263	<p>Client #4's record was reviewed on 8/22/14 at 12 PM. Client #4's record indicated a CFA dated 9/7/12. The record indicated the IDT had not reviewed and/or updated client #4's CFA within 365 days from the date of the previous CFA of 9/7/12.</p> <p>Interview with the RM (Residential Manager) and QIDP (Qualified Intellectual Disabilities Professionals) #1 on 8/22/14 at 4 PM indicated the clients' CFAs were to be updated annually (every 365 days).</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on interview and record review for 3 of 3 sampled clients (#2, #3 and #4) with restrictive programs and/or receiving medications to control behaviors, the facility failed to obtain written informed consent from the clients and/or the clients' legal representatives for the clients' restrictive programs and/or the use of behavior modification</p>	W000263	<p>conduct a file audit on 10-2-14 and andom file reviews toensure current assessments are present for each client.</p> <p>Correctiveactionforresident(s)foun dtohavebeenaffected The LPN is responsiblefor seeking HRC approval for a new or changed psychotropic medicationorder. Once guardian or client approvalis received, the LPN will seek HRC approval and will updatethe BC who will update the BSP. The QIDPwill ensure the BSPis complete and accurate.</p>	10/10/2014

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	<p>medication.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 8/22/14 at 1 PM. Client #2's 2/2014 BSP (Behavior Support Plan) indicated client #2 received Paxil 20 mg a day for depression. Client #2's record indicated client #2 was represented by a legal guardian. Client #2's record indicated the facility had not obtained written informed consent from client #2 and/or client #2's guardian for client #2's restrictive program including the use of Paxil.</p> <p>Client #3's record was reviewed on 8/22/14 at 10 AM. Client #3's Medical Appointment Form dated 7/15/14 indicated a "New diagnosis" of Anxiety and a new medication order for Lexapro 10 mg (milligrams) a day. Client #3's record indicated the facility had not obtained written informed consent from client #2 and/or client #2's guardian for client #2 to be given Lexapro.</p> <p>Client #4's record was reviewed on 8/22/14 at 12 PM. Client #4's physician's orders dated 7/14/14 indicated client #4 was taking: Cymbalta (an antidepressant) 60 mg a day, Clonazepam (for behavior modification) 0.5 mg three times a day, Quetiapine (an antipsychotic) 25 mg a</p>		<p>Staff will be trained on all new or updated BSPs by the BC or a Q or supervisor trained by the BC.</p> <p>How facility will identify other residents potentially affected and what measures taken All residents receiving psychotropic medications are affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence Monitoring the BSP and physician orders will be added to the meeting checklist. The team including the BC, QIDP, and LPN will compare the physician orders to the BSP at each quarterly to ensure compliance, HRC approval, and guardian approval. The QIDP is responsible for the meeting agenda. The LPN and QIDP will be retrained by the RD on 10-1-14 on obtaining proper HRC, guardian, and client approval for restrictive programs.</p> <p>How corrective actions will be monitored to ensure no recurrence The QIDP will follow up to ensure the BC updates all BSPs and all staff are trained on new or updated plans. The Regional Director will be sent the meeting checklist following each consumer meeting by the QIDP to ensure compliance.</p>				

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	<p>day and Wellbutrin XL (an antidepressant) 150 mg twice a day. Client #4's updated BSP of 8/16/13 indicated client #4 was taking: Lexapro (an antidepressant), Clonazepam, Wellbutrin and Abilify (an antipsychotic). Client #4's record indicated client #4 was represented by a legal HCR. Client #4's record indicated the facility had not obtained written informed consent for the use of Cymbalta and Quetiapine. Client #4's record did not include a written informed consent from client #4's legal representative for client #4's restrictive program including the use Lexapro, Clonazepam, Wellbutrin and Abilify.</p> <p>During interview with QIDP (Qualified Intellectual Disabilities Professional) #2 on 8/22/14 at 4 PM, QIDP #2 indicated the facility had not obtained written informed consent from client #3's legal representative for client #3's use of Lexapro. QIDP #2 indicated she was unable to locate client #2's, #3's and #4's written informed consents for their restrictive BSPs including the use of the clients' behavior modification medications.</p> <p>9-3-4(a)</p>			

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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. Based on record review and interview for 2 of 3 sampled clients receiving medications to control behaviors (#3 and #4), the facility failed to ensure client #3's use of Lexapro and client #4's use of Cymbalta and Quetiapine were included in the clients' program plans with specific plans of reduction to reduce and eventually eliminate the behaviors for which each psychoactive medication was to target.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 8/22/14 at 10 AM. __ Client #3's Medical Appointment Form dated 7/15/14 indicated a "New diagnosis" of Anxiety and a new medication order for Lexapro 10 mg (milligrams) a day. __ Client #3's record did not indicate a BSP (Behavior Support Plan) and/or a program plan that included the use of Lexapro.</p> <p>Client #4's record was reviewed on</p>	W000312	<p>Correctiveactionforresident(s)fou dtohavebeenaffected The BC will update the BSP to include a titration plan orplan of reduction for any consumer prescribed a psychotropic medication. The BC or supervisor trained by the BC willtrain all staff on the updated BSP.</p> <p>Howfacilitywillidentifyotherreside ntspotentiallyaffectedandwhatmea surestaken All residentscould be affected andcorrective action planwill be put in place to protect allconsumers.</p> <p>Measuresorsystemicchangesfacility putinplacetoensurenorecurrence A pharmacist comes to the group homesquarterly to check medications and discuss titration plans. These titration plans will be included in theBSP by the BC. The QIDP is responsiblefor ensuring the BSPs are updated and complete. The QIDP will seek guardian approval for any new or updated BSP.</p> <p>Howcorrectiveactionswillbemonito redtoensurenorecurrence Monitoring the BSPand physician orders willbe added to thequarterly</p>	10/10/2014	

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	<p>8/22/14 at 12 PM. Client #4's physician's orders dated 7/14/14 indicated client #4 was taking: Cymbalta (an antidepressant) 60 mg a day. Clonazepam (for behavior modification) 0.5 mg three times a day. Quetiapine (an antipsychotic) 25 mg a day. Wellbutrin XL (an antidepressant) 150 mg twice a day.</p> <p>Client #4's updated BSP of 8/16/13 indicated client #4 was taking: Lexapro (an antidepressant), Clonazepam, Wellbutrin and Abilify (an antipsychotic). Client #4's BSP did not include the use of Cymbalta and Quetiapine. Client #4's BSP did not indicate client #4's BSP was updated to reflect the current medications client #4 was taking for behavior modification.</p> <p>Interview with QIDP (Qualified Intellectual Disabilities Professional) #2 on 8/22/14 at 4 PM indicated her employment began with the facility in May 2014 as the behavior specialist and she was still getting to know the clients and had not had time to update and/or revise the clients' BSPs and/or to ensure plan of reduction were in place for the medications the clients were currently taking.</p>		<p>meeting checklist. The team including the BC, QIDP, and LPN will compare the physician orders to the BSP at each quarterly meeting to ensure compliance, HRC approval, and guardian/client approval. The QIDP is responsible for the meeting agenda. The Regional Director will be sent the meeting checklist following each consumer meeting by the QIDP to ensure compliance.</p>		

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W000322	<p>9-3-5(a)</p> <p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 3 of 4 sampled clients (#1, #3 and #4), the facility failed to ensure clients were provided annual routine physicals and annual screening for early detection of cancer.</p> <p>Findings Include:</p> <p>Client #1's record was reviewed on 8/22/14 at 11 AM. Client #1's record indicated client #1's last physical examination by the client's physician was on 6/19/13. Client #1's record indicated client #1 was over the age of 50 and had not had a preventative annual Prostate-Specific Antigen (PSA) screening for early detection of cancer.</p> <p>Client #3's record was reviewed on 8/22/14 at 10 AM. Client #3's record indicated no physical examination by the client's physician. Client #3's record indicated client #3 was over the age of 50 and had not had a preventative annual PSA screening.</p>	W000322	<p>Corrective action for resident(s) found to have been affected The LPN will be retrained by the RD on 10-1-14 that all consumers must have annual physicals including pre cancer screenings able to be located in their medical file. All consumers must have a physical annually. All consumers will have annual physicals in their medical chart by 10-10-14.</p> <p>How facility will identify other residents potentially affected and what measures taken All residents could be affected and corrective action plan will be put in place to protect all consumers.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence The LPN has included on the monthly nursing summary the dates of each client's last physical. This will ensure the dates are reviewed monthly to ensure compliance. Also these dates will be included on the quarterly meeting checklist that will be reviewed at each quarterly meeting and signed off on by the RD.</p> <p>How corrective actions will be monitored to ensure no recurrence The LPN's monthly nursing summary</p>	10/10/2014			

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W000323	<p>Client #4's record was reviewed on 8/22/14 at 12 PM. Client #4's record indicated client #4 was over 40 years of age. Client #4's record indicated no preventative annual Mammogram and/or Pap screening for early detection of cancer.</p> <p>Interview with the facility LPN on 8/22/14 at 2 PM indicated the clients' records for the facility had not been filed for 6 to 12 months and she was unable to locate many of the files.</p> <p>Interview with the RM (Residential Manager) and QIDP (Qualified Intellectual Disabilities Professionals) #1 on 8/22/14 at 4 PM indicated she was unable to find a PSA screening for clients #1 and #3. QIDP #1 indicated all clients were to have an annual physical and were to be provided annual screenings for cancer.</p> <p>9-3-6(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and</p>	W000323	<p>is sent to the QIDP monthly to include in the QIDP's monthly programming summary. These dates will be viewed monthly by the QIDP to ensure compliance. The monthly programming summary is sent to the AWS compliance department.</p> <p>The dates will also be included and reviewed on the quarterly meeting checklist. This checklist will be sent to the RD after each meeting to be reviewed and signed off on.</p> <p>Corrective action for resident(s) found to have been affected The LPN will be retrained by the RD</p>	10/10/2014	

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	<p>#4), the facility failed to ensure the clients' hearing and vision were evaluated annually.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/22/14 at 11 AM. Client #1's record indicated client #1's most recent physical evaluation was conducted on 6/19/13. Client #1's record indicated client #1's most recent vision evaluation was on 7/22/13. Client #1's record indicated client #1's vision was not evaluated annually.</p> <p>Client #2's record was reviewed on 8/22/14 at 1 PM. Client #2's record indicated client #2 was admitted to the facility on 1/15/14 and had a physical evaluation on 1/3/14 by her physician. Client #2's physical indicated no vision and/or hearing evaluation. Client #2's record indicated client #2's hearing and vision was not evaluated annually.</p> <p>Client #3's record was reviewed on 8/22/14 at 10 AM. Client #3's record indicated no annual physical evaluation and/or hearing evaluation. Client #3's record indicated client #3 wore bilateral hearing aids. Client #3's record indicated client #3's hearing was not evaluated annually.</p>		<p>on 10-1-14 that allconsumers must have annual vision and hearing appointments able to be locatedin their medical file. All consumersmust have a physical annually. Allconsumers will have annual physicals in their medical chart by 10-10-14.</p> <p>Howfacilitywillidentifyotherresidentspotentiallyaffectedandwhatmeasuresstaken All residentscould be affected andcorrective action planwill be put inplace to protect allconsumers.</p> <p>Measuresorsystemicchangesfacility putinplacetoensurenorecurrence The LPN has included on the monthlynursing summary the dates of each client's last physical. This will ensure the dates are reviewedmonthly to ensure compliance. Also thesedates will be included on the quarterly meeting checklist that will be reviewedat each quarterly meeting and signed off on by the RD.</p> <p>Howcorrectiveactionswillbemonitoredtoensurenorecurrence The LPN's monthly nursing summary is sent to the QIDPmonthly to include in the QIDP's monthly programming summary. These dates will be viewed monthly by theQIDP to ensure compliance. The monthlyprogramming summary is sent to the AWS compliance department. The dates will also be included and reviewed on thequarterly meeting</p>				

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	<p>Client #4's record was reviewed on 8/22/14 at 12 PM. Client #4's record indicated a physical evaluation of 2/4/14. The evaluation indicated no hearing and/or vision evaluation. Client #4's record indicated client #4's most recent hearing evaluation was 9/20/13 and vision evaluation was 2/24/13. Client #4's record indicated client #4's vision and hearing was not evaluated annually.</p> <p>Interview with the facility LPN on 8/22/14 at 2 PM indicated she was unable to locate client #2's hearing and vision evaluations and client #3's hearing evaluations. The LPN stated client #1's last vision evaluation was 7/23/13 and "to my knowledge he has not had an evaluation since that one." The LPN indicated client #4's most current hearing evaluation was 9/20/13 and vision evaluation was 2/24/13. The LPN indicated the clients' records for the facility had not been filed for 6 to 12 months and she was unable to find all of the clients' records.</p> <p>Interview with the RM (Residential Manager) and QIDP (Qualified Intellectual Disabilities Professionals) #1 on 8/22/14 at 4 PM indicated they were unable to locate all of the records for clients #1, #2, #3 and #4 and were unsure</p>		<p>checklist. This checklist will be sent to the RD after each meeting to be reviewed and signed off on.</p>	

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W000327	<p>of when the clients had their last vision and hearing evaluations.</p> <p>9-3-6(a)</p> <p>483.460(a)(3)(iv) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both.</p> <p>Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to ensure the clients received an annual TB (Tuberculosis) testing and/or screening.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/22/14 at 11 AM. Client #1's May 2014 nursing Monthly Health Review indicated client #1 received a TB test on 2/28/14. Client #1's record indicated no results for the TB test.</p> <p>Client #2's record was reviewed on 8/22/14 at 1 PM. Client #2's June 2014 nursing Monthly Health Review indicated client #2 received a TB test on 1/17/14. Client #2's record indicated no</p>	W000327	<p>Correctiveactionforresident(s)fou dtohavebeenaffected</p> <p>All consumers must have a physical annually which includes a TB test. The LPN will be retrained bythe RD on 10-1-14 that all consumers must have an annual TD test and that mustbe located in the medical file. Allconsumers will have a TB test in the main file or an appointment scheduled by10-10-14.</p> <p>Howfacilitywillidentifyotherreside ntspotentiallyaffectedandwhatmea surestaken</p> <p>All residentscould be affected andcorrective action planwill be put inplace to protect allconsumers.</p> <p>Measuresorsystemicchangesfacility putinplacetoensurenorecurrence</p> <p>The LPN has included on the monthlynursing summary the dates of each client's last physical and TB</p>	10/10/2014

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W000331	<p>results for the TB test.</p> <p>Client #3's record was reviewed on 8/22/14 at 10 AM. Client #3's May 2014 nursing Monthly Health Review indicated client #3 received a TB test on 12/23/13. Client #3's record indicated no results for the TB test.</p> <p>Client #4's record was reviewed on 8/22/14 at 12 PM. Client #4's June 2014 nursing Monthly Health Review indicated client #4 received a TB test on 2/11/13. Client #3's record did not indicate further testing since the test of 2/11/13.</p> <p>Interview with the facility LPN on 8/22/14 at 2 PM indicated the clients' records for the facility had not been filed for 6 to 12 months and she was unable to locate the results of the TB tests for clients #1, #2 and #3. The LPN indicated she was unable to find a more recent TB testing and/or screening for client #4. The LPN indicated the testing for February 2013 was the most current results she was able to find at the present time.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing</p>		<p>test. This will ensure the dates are reviewed monthly to ensure compliance. These dates will be included on the meeting checklist that will be reviewed at each quarterly meeting and signed off on by the Regional Director.</p> <p>How corrective actions will be monitored to ensure no recurrence The LPN's monthly nursing summary is sent to the QIDP monthly to include in the QIDP's monthly programming summary. These dates will be viewed monthly by the QIDP to ensure compliance. The monthly programming summary is sent to the RD and the AWS compliance department. The dates will also be included and reviewed on the meeting checklist. This will be sent to the Regional Director after each quarterly meeting to be reviewed and signed off on.</p>				

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	<p>services in accordance with their needs.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 3 additional clients (#5, #6 and #7), the facility nursing services failed to ensure:</p> <p>__ All medications were labeled with the clients' name, medication, dosage, route and time to be given and all pharmacy recommendations on the label were followed and/or clarified for clients #1, #3, #4, #6 and #7.</p> <p>__ Clients #1 and #3 were provided an annual physical examination.</p> <p>__ Clients #1, #3 and #4 were provided routine annual screening for early detection of cancer.</p> <p>__ Clients #1, #2, #3 and #4 were provided annual hearing/vision/dental evaluations and annual TB (Tuberculosis) testing/screening.</p> <p>__ Clients #1, #3 and #4 were provided quarterly health assessments.</p> <p>__ The pharmacist reviewed the clients' drug regimen at least quarterly for clients #1, #2, #3 and #4.</p> <p>__ Clients #1, #2, #3, #4 and #6 received their medications as ordered by the physician.</p> <p>__ All controlled substances were secured for client #3.</p> <p>Findings include:</p>	W000331	<p>In addition to below, please see W322, W323, W336, W352, W362, W368 and W381.</p> <p>Corrective action for resident(s) found to have been affected</p> <p>All staff will be retrained on Medication Administration in a refresher course taught by the Group Home LPN on 10-1-14. Staff are also retrained in Medication Administration annually at our Staff Annual Training. This medication administration training will include the appropriate way to pass medication and read and follow physician orders and pharmacy labels.</p> <p>The Team Leaders will observe one medication pass for each staff monthly and the LPN will observe one medication pass for each TL monthly.</p> <p>How facility will identify other residents potentially affected and what measures taken</p> <p>All residents are affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>The Team Leaders will observe one medication pass for each staff monthly. This will ensure staff are continually reading labels, following physician orders, and passing medications as trained in Core A Core B. The LPN will observe one medication pass for each</p>	10/10/2014			

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	<p>1. Observation of the medication pass was conducted on 8/21/14 between 5:45 AM and 8:15 AM. During this time staff #3 was observed giving clients #1, #2, #3, #4, #5, #6 and #7 their AM medications.</p> <p>At 6:25 AM staff #3 gave client #6 Calcium (for bone support) 600 mg (milligrams), Omeprazole 20 mg (to decrease stomach acid), Zocor (for cholesterol) 40 mg and Clindamycin cream (an antibiotic).</p> <p>__ The pharmacy instructions indicated the Calcium was to be taken with food, the Omeprazole was to be taken before a meal and the Zocor indicated "Take in evening as directed."</p> <p>__ Client #6 was not given food with her medications</p> <p>__ Client #6 ate her breakfast at 6:45 AM.</p> <p>__ The label on the bag for the Clindamycin was out dated, faded and illegible.</p> <p>At 6:55 AM staff #3 gave client #3 Nasonex nasal spray for allergies, Symbicort for symptoms of asthma and Vaseline lip balm.</p> <p>__ The pharmacy label on the Nasonex indicated "Shake well before use." Staff #3 and/or client #3 did not shake the Nasonex bottle prior to use.</p> <p>__ The pharmacy label on the Symbicort</p>		<p>TL monthly.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The Team Leaders will sign off on a medication observationsheet for each staff and turn it into the LPN and Group Home Manager monthly to ensure they are doing all required medication observations monthly. The LPN will sign off on a medication observation sheet for each TL and turn it in to the GHM monthly. The RD will ensure all staff receive this training on 10-1-14 by the LPN or they will be removed from the schedule until they receive the training and the record of training is placed in their employee HR file. One member of management will be in the home at least until 7pm at least weekly. One member of management will conduct random pop in visits at least weekly on varying shifts and days to ensure staff are providing active treatment.</p>	

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	<p>indicated client #3 was to have two puffs. The label indicated to shake the Symbicort container prior to use and to wait one minute between puffs. Staff #3 and/or client #3 did not shake the container prior to use. Staff #3 handed the Symbicort to client #3 and client #3 quickly pumped the inhaler three times into his mouth. The staff did not prompt client #3 to take one puff and then to wait one minute and the take another puff.</p> <p>__There was no expiration date on the Symbicort inhaler.</p> <p>__The Vaseline lip balm did not have a pharmacy label with the client's name, medication, time of administration and/or dosage.</p> <p>At 7:25 AM staff #3 gave client #1 Vaseline lip balm. The lip balm did not have a pharmacy label with the client's name, medication, time of administration and/or dosage.</p> <p>At 7:35 AM staff #3 gave client #7 Vaseline lip balm and Chlorhexidine Gluconate rinse for her mouth. The lip balm did not have a pharmacy label with the client's name, medication, time of administration and/or dosage. The pharmacy's instructions on the mouth rinse indicated "No food or drink for 30 minutes" after using the rinse. Client #3 ate her breakfast at 7:45 AM.</p>			

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	<p>At 7:40 AM staff #3 gave client #4 Centrum and Vitamin D3 (dietary supplements). The pharmacy's instructions indicated the Centrum was to be taken on an empty stomach and the Vitamin D3 was to be taken with food. Client #4 did not receive food and/or nourishment with her medications. Client #4 ate her breakfast at 7:15 AM.</p> <p>Review of client #1's, #3's, #4's, #6's and #7's MARs (Medication Administration Records) for August 2014 on 8/21/14 at 8:30 AM did not indicate the medications observed during the AM medication pass were to be taken with or without food.</p> <p>Interview with the facility's LPN on 8/25/14 at 1 PM indicated all medications were to be labeled with a pharmacy label and staff were to report all discrepancies in the pharmacy labels and the clients' MARs to nursing staff to be clarified with pharmacy and/or the doctor.</p> <p>2. Nursing failed to ensure clients #1 and #3 were provided annual physical examinations and clients #1, #3 and #4 were provided routine annual screening for early detection of cancer. Please see W322.</p> <p>3. Nursing failed to ensure the clients'</p>			

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W000336	<p>hearing and vision were evaluated annually for clients #1, #2, #3 and #4. Please see W323.</p> <p>4. Nursing failed to ensure clients #1, #3 and #4 were provided quarterly nursing/health assessments. Please see W336.</p> <p>5. Nursing failed to ensure annual dental examinations for clients #2, #3 and #4. Please see W352.</p> <p>6. Nursing failed to ensure the facility pharmacist conducted quarterly reviews of the clients' drug regimens for clients #1, #2, #3 and #4. Please see W362.</p> <p>7. Nursing failed to ensure the clients received their medications as ordered by the physician. Please see W368.</p> <p>8. Nursing failed to ensure all controlled substances were secure for client #3. Please see W381.</p> <p>9-3-6(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more</p>			

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	<p>frequent basis depending on client need. Based on record review and interview for 3 of 4 sample clients (#1, #3 and #4), the facility failed to provide evidence of a quarterly nursing/health assessment for each of the clients.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/22/14 at 11 AM. Client #1's record indicated: __ Client #1 did not require a medical care plan. __ Diagnoses of, but not limited to, Seasonal Allergies and Athletes Foot. __ Monthly Heath Reviews by the facility LPN for September 2013 and May, June and July 2014. __ No quarterly nursing assessments for the fourth quarter of 2013.</p> <p>Client #3's record was reviewed on 8/22/14 at 10 AM. Client #3's record indicated: __ Client #3 did not require a medical care plan. __ Diagnoses of, but not limited to, Asthma, Emphysema, Hypertension (high blood pressure), Bilateral Hearing Loss and Allergies. __ Monthly Heath Reviews by the facility LPN for September 2013 and May 2014. __ No quarterly nursing assessment for</p>	W000336	<p>Corrective action for resident(s) found to have beenaffected All clients are tohave a quarterly nursing summary completed and on file in their medicalchart. The LPN will be retrained on thisrequirement by the RD on 10-1-14.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken All residentsare affected and correctiveaction will address theneeds of all clients.</p> <p>Measures or systemic changes facility put in place toensure no recurrence Quarterly nursingsummaries will be turned into the QIDP quarterly to include in the monthllysummary. Summaries will also be turnedinto the Manager of Health Services for oversight and to ensurecompliance.</p> <p>How corrective actions will be monitored to ensure norecurrence The RD will conductquarterly random file audits to ensure quarterly nursing summaries and up todate and present in the medical file. The RD will ensure the LPN's retraining on completing quarterly nursingsummaries is placed in the LPN's employee file.</p>	10/10/2014			

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	<p>the third quarter of 2013 and the first quarter of 2014.</p> <p>Client #4's record was reviewed on 8/22/14 at 12 PM.</p> <p>Client #4's record indicated: ___ Client #4 did not require a medical care plan. ___ Diagnoses of, but not limited to, Gingivitis (gum disease), Vitamin C Deficiency, Hyperlipidemia (high cholesterol levels in the body), Hypertension (high blood pressure) and non insulin dependent Diabetes ___ Monthly Heath Reviews by the facility LPN for August and September 2013 and April, May, June and July 2014. ___ No quarterly nursing assessment for the fourth quarter of 2013 and the first quarter of 2014.</p> <p>Interview with facility LPN #1 on 8/22/14 at 2 PM indicated the clients' records for the facility had not been filed for 6 to 12 months and she was unable to locate all of the quarterly nursing assessments for clients #1, #2 and #4. LPN #1 indicated LPN #3 terminated employment with the facility on 12/31/13 so LPN #1 filled in for the facility from January through April 2013 when the facility hired LPN #2 in April 2013. LPN #2 worked four months and then LPN #2 terminated her employment with the</p>						

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W000362	<p>facility on August 15, 2014. LPN #1 stated the clients' Health Reviews "were being done monthly when [LPN #3] was doing them but [LPN #2] went back to quarterly and I'm (LPN #1) just trying to get everything caught up." LPN #1 indicated most of the information on the Monthly Health Reviews was copied from one month to the next and many of the reviews did not indicate a nursing signature.</p> <p>9-3-6(a)</p> <p>483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on record review and interview for 4 of 4 sample clients (#1, #2, #3 and #4), the facility failed to ensure the facility's pharmacist conducted quarterly reviews of the clients' drug regimens.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/22/14 at 11 AM. Client #1's record indicated client #1 was ordered multiple medications by his physician. Client #1's record indicated a review by the facility's pharmacist of client #1's drug regimen on 6/11/13. Client #1's record did not</p>	W000362	<p>Corrective action for resident(s) found to have beenaffected All clients willhave a quarterly pharmacy review. Thepharmacist will work with the LPN to schedule and complete these quarterlyreviews. The LPN will track these reviewsand ensure all recommendations are taken to the client's IDT. The LPN will beretrained by the RD on 10-1-14 about the need for quarterly pharmacy reviews to be completed and filed.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken</p>	10/10/2014

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	<p>indicate quarterly reviews of client #1's drug regimen by the pharmacist for 2013/2014.</p> <p>Client #2's record was reviewed on 8/22/14 at 1 PM. Client #2's record indicated client #2 was admitted to the facility on 1/15/14. Client #2's record indicated client #2 was ordered multiple medications by her physician. Client #2's record indicated no reviews of client #2's drug regimen by the pharmacist for 2014.</p> <p>Client #3's record was reviewed on 8/22/14 at 10 AM. Client #3's record indicated client #3 was ordered multiple medications by his physician. Client #3's record indicated a review by the facility's pharmacist of client #3's drug regimen on 6/11/13. Client #3's record did not indicate quarterly reviews of client #3's drug regimen by the pharmacist for 2013/2014.</p> <p>Client #4's record was reviewed on 8/22/14 at 12 PM. Client #4's record indicated client #4 was ordered multiple medications by her physician. Client #4's record indicated a review by the facility pharmacist of client #4's drug regimen on 3/12/14 and 6/2/14. Client #4's record did not indicate quarterly review of client #4's drug regimen by the pharmacist for 2013/2014.</p>		<p>All residents are affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence The LPN will track the quarterly pharmacy reviews and bring that information to the quarterly meeting. The LPN will mark on the quarterly meeting checklist the date the pharmacy review was completed that quarter.</p> <p>How corrective actions will be monitored to ensure no recurrence The QIDP will fill out the quarterly meeting checklist and ensure all information is complete and accurate and will turn it into the RD after the meeting for tracking and compliance. The RD will ensure the record of training for the LPN will be placed in the LPNs employee file.</p>				

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W000368	<p>Interview with the facility LPN on 8/22/14 at 2 PM indicated the clients' records for the facility had not been filed for 6 to 12 months and she was unable to locate all of the quarterly pharmacy reviews for each of the clients.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) plus 1 additional client (#6), the facility nurse failed to ensure all drugs were administered in compliance with each clients' physicians' orders.</p> <p>Findings include:</p> <p>The facility's reportable records, staff training records and personal records were reviewed on 8/19/14 at 12 PM.</p> <p>The 8/12/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 8/11/14 client #3 did not get his 10 PM dose of Ativan (for anti-anxiety). The report indicated the</p>	W000368	<p>Correctiveactionforresident(s)foun dtohavebeenaffected All staff willbe retrained on MedicationAdministration in a refreshercourse taught by theGroup Home LPN on 10-1-14. This medicationadministration training willinclude the appropriate way to pass medicationand the appropriate way to ensure medications are properly labeled. The Supervisorswill observe one medicationpass for each staffmonthly and the LPN will observe one medication pass for each TLmonthly.</p> <p>Howfacilitywillidentifyotherreside ntpotentiallyaffectedandwhatmea surestaken All residentsare affected and correctiveaction will address</p>	10/10/2014

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	<p>facility staff had "popped [client #3's] dose out and went to get him to find that he (client #3) was in the shower. [Name of staff] then locked up the medication to administer to [client #3] after his shower was finished. [Name of staff] then forgot to administer the medication." The report indicated the staff responsible for the error would be retrained.</p> <p>__The undated record of training indicated "This error was not found during buddy check as the med (medication) was removed from the package, making the counts correct and the med was signed off on the MAR (Medication Administration Record). The medication was left on the desk in the med room in a cup. This is a controlled substance and should be locked under two locks at all times. This is also a safety risk as any med should never be left unattended. Per report the MAR was signed off that the med was given. Medications are only to be signed off on the MAR once the med as (sic) been administered to the client."</p> <p>The 8/6/14 BDDS report indicated on 8/6/14 client #1 did not receive his 7 AM dose of Loratadine (an antihistamine) 10 mg (milligrams).</p> <p>The 7/29/14 BDDS report indicated client #4 was not given her Isopto</p>		<p>theneeds of all clients.</p> <p>Measuresorsystemicchangesfacility putinplacetoensurenorecurrence The Team Leaderswill observe one medicationpass for each staffmonthly. This will ensurestaff are continuallypassing medicationsas trained in CoreA Core B. The LPN will observe one medication pass foreach TL monthly. These medication passobservations will be turned into the GHM for tracking and to ensure compliance.</p> <p>Howcorrectiveactionswillbemonitordtoensurenorecurrence The Team Leaderswill sign off ona medication observationsheet and turn itinto the LPN andGroup Home Manager monthlyto ensure they aredoing all required medicationobservations monthly. The RD will ensure all Group Home staffreceive this retraining on 10-1-14 and will sign off on all Record ofTrainings. If staff fail to attend, theywill be removed from the schedule until they receive the retraining. One member ofmanagement will be in the home at least until 7pm at least weekly. One member of management will conduct randompop in visits at least weekly on varying shifts and days to ensure staff areproviding active treatment and passing medications appropriately.</p>		

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	<p>Carpine Ophthalmic Solution (for glaucoma) on 7/28/14 at 4 PM and 8 PM and on 7/29/14 at 4 PM. The report indicated the staff responsible for the error would be retrained and disciplinary action would be taken "if necessary." ___The undated record of training indicated the staff had signed off and circled the medication on the MAR as not being given because the medication was not available but failed to notify the facility nurse the medication was not available to give the client.</p> <p>The 7/26/14 BDDS report indicate client #3 was not given his 10 PM dose of Ativan 0.5 mg on 7/25/14. The report indicated the "buddy checker" (the staff that checks the MARs after a med pass to ensure all medications were given as indicated for that med pass) failed to catch the error when doing the buddy check on 7/25/14. The report indicated the staff that missed giving the medication and the buddy checker would be retrained and disciplinary action would be taken.</p> <p>The 7/17/14 BDDS report indicated client #4 was given a double dose of her Oyster Shell Calcium on 7/16/14 at 7 AM and was not given her 4 PM dose of Oyster Shell Calcium on 7/16/14. The report indicated the staff responsible for</p>			

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	<p>the error would be retrained.</p> <p>The 7/12/14 BDDS report indicated client #4 was not given her 4 PM dose of calcium supplement on 7/11/14. The report indicated the staff responsible for the error would be retrained.</p> <p>The 7/2/14 BDDS report indicated client #4 was not given her 7 AM dose of Quetiapine (an antipsychotic) 25 mg on 7/2/14. The report indicated "The MAR and the medication bubble pack did not match, one said 7 am and one said 8 pm. Instead of calling a nurse when the MAR and bubble pack do not match as staff are taught..., the staff just did not administer the medication." The report indicated the staff responsible for the error would be retrained and disciplined.</p> <p>The 7/2/14 BDDS report indicated client #6 was not given her 7 AM dose of Abilify (an antipsychotic medication) 10 mg on 7/1/14 and "instead she (client #6) was given this dose of medication at 6 p.m." The report indicated the staff responsible for the error would be retrained. The records indicated the buddy checker and two staff were retrained and disciplined.</p> <p>The 6/30/14 BDDS report indicated client #4 was not given her 10 AM dose</p>				

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	<p>of Erythromycin EC (an antibiotic) 250 mg on 6/29/14. The report indicated the staff responsible for the error would be retrained and disciplined.</p> <p>The 6/12/14 BDDS report indicated client #6 was not given her 6 PM dose of Abilify 15 mg and her 6 PM dose of Saphris (an antipsychotic medication) 10 mg on 6/11/14. The report indicated the staff responsible for the error would be retrained and disciplined.</p> <p>The 6/2/14 BDDS report indicated client #4 was not given her 6 AM dose of Fosamax (for bone health) 70 mg on 6/2/14. The report indicated the staff responsible for the error would be retrained and disciplined.</p> <p>The 4/17/14 BDDS report indicated client #2 "had a new order for a Medrol (a steroid/anti-inflammatory) pack. The medication was scheduled to start 4/15/14 due to the need to hold her Prednisone (an anti-inflammatory) while taking Medrol and she had taken her Prednisone the morning of 4/14/14. Staff gave the initial dose the evening of 4/14/14 instead of 4/15/14 as scheduled. The report indicated the staff responsible for the error would be disciplined.</p> <p>The 4/13/14 BDDS report indicated</p>						

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	<p>client #2 was not given her AM or PM dose of Phenobarbital (an anticonvulsant/hypnotic) 97.2 mg on 4/13/14 because the medication was not available in the home. "It is expected she will receive the 4/14 a.m. dose as the pharmacy will not be open prior to that time." The report indicated the facility nurse would contact the pharmacy on 4/14/14 to request a "stat (immediate) delivery."</p> <p>The 9/16/13 BDDS report indicated client #6 did not receive the full dose of two tablets of her 7 AM Clarithromycin (an antibiotic) for sinus infection on 9/15/13. The report indicated the staff gave client #6 one tablet instead of two at 8 AM on 9/15/13. The report indicated the staff responsible for the error would be retrained and disciplined.</p> <p>The 9/13/13 BDDS report indicated client #6 was prescribed a medication that would interact with her Simvastatin (to lower cholesterol). The report indicated the facility nurse instructed the staff on the MAR not to give client #6 the medication and the staff gave the medication without reading the MAR and as a result, the client could not be given her antibiotic as ordered. The report indicated the staff responsible for the error would be retrained and disciplined.</p>			

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W000381	<p>During interview with the facility's LPN and the ADM (Administrator) on 8/25/14 at 1 PM, the LPN indicated all clients were to receive their medications as ordered by their physician. The ADM indicated medication errors were an ongoing problem in the facility.</p> <p>9-3-6(a)</p> <p>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. Based on record review and interview for 1 of 1 clients (#3) whose medications included a controlled substance, the facility failed to ensure controlled substances were double locked.</p> <p>Findings include:</p> <p>The facility's reportable records and staff training records were reviewed on 8/19/14 at 12 PM.</p> <p>The 8/12/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 8/11/14 client #3 did not get his 10 PM dose of Ativan (for anti-anxiety). The report indicated facility staff #1 had "popped [client #3's] dose out and went to get him to find that he</p>	W000381	<p>Correctiveactionforresident(s)foundedtohavebeenaffected All staff willbe retrained on MedicationAdministration in a refreshercourse taught by theGroup Home LPN on 10-1-14. This medicationadministration training willinclude the appropriate way to pass medicationand the appropriate way to measure liquidmedication. The Team Leaderswill observe one medicationpass for each staffmonthly and the LPN will observe one medication pass for each TLmonthly.</p> <p>Howfacilitywillidentifyotherresidentspotentiallyaffectedandwhatmeasures taken All residentsare affected and correctiveaction will address theneeds of all clients.</p>	10/10/2014

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	<p>(client #3) was in the shower. [Staff #1] then locked up the medication to administer to [client #3] after his shower was finished. [Staff #1] then forgot to administer the medication." The report indicated the staff responsible for the error would be retrained.</p> <p>___The undated record of training for staff #1 indicated "This error was not found during buddy check as the med (medication) was removed from the package, making the counts correct and the med was signed off on the MAR (Medication Administration Record). The medication was left on the desk in the med room in a cup. This is a controlled substance and should be locked under two locks at all times. This is also a safety risk as any med should never be left unattended. Per report the MAR was signed off that the med was given. Medications are only to be signed off on the MAR once the med as (sic) been administered to the client."</p> <p>During interview with the facility LPN on 8/25/14 at 1 PM, the LPN indicated the staff were not to leave prepared medications unattended and/or unlocked. The LPN indicated all controlled medications were to be double locked.</p> <p>9-3-6(a)</p>		<p>Measures systemic changes facility put in place to ensure no recurrence The Team Leaders will observe one medication pass for each staff monthly. This will ensure staff are continually passing medications as trained in Core A Core B. The LPN will observe one medication pass for each TL monthly. These medication pass observations will be turned into the GHM for tracking and to ensure compliance.</p> <p>How corrective actions will be monitored to ensure no recurrence The Team Leaders will sign off on a medication observationsheet and turn it into the LPN and Group Home Manager monthly to ensure they are doing all required medication observations monthly. The RD will ensure all Group Home staff receive this retraining on 10-1-14 and will sign off on all Record of Trainings. If staff fail to attend, they will be removed from the schedule until they receive the retraining. One member of management will be in the home at least until 7pm at least weekly. One member of management will conduct random pop in visits at least weekly on varying shifts and days to ensure staff are providing active treatment and passing medications appropriately.</p>	

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W000440	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 4 of 4 sampled clients (#1, #2, #3 and #4) and 3 additional clients (#5, #6 and #7) who resided in the group home, to ensure evacuation drills were conducted at least quarterly for the evening shift (3 PM to 11 PM) of personnel for the third quarter (July, August and September) 2013/2014 and the night shift (11 PM to 7 AM) of personnel for the second quarter (April, May and June) 2014 and the third quarter 2013/2014.</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 8/19/14 at 11 AM. The review indicated the facility had failed to conduct an evacuation drill for clients #1, #2, #3, #4, #5, #6 and #7 for the third quarter of 2013/2014 for the evening shift and the second and third quarters for the nights shift.</p> <p>Interview with QIDPs (Qualified Intellectual Disabilities Professionals) #1 and #2 on 8/22/14 at 1 PM indicated they were not able to locate any additional evacuation drills for the facility for</p>	W000440	<p>Corrective action for resident(s) found to have beenaffected</p> <p>An annual emergencydrill calendar has been designed and will be implemented which includes drills on each shift quarterly. Supervisors will post this annual calendar and mark on the monthly calendar the dates and times drills are due to be completed. Supervisors will check the next day to ensure the drills were completed and will turn the drill into the QIDP for tracking.</p> <p>The GHM and QIDP will be retrained on the need for all drills to be completed and filed. This retraining will be done by the RD on 10-1-14. Staff and Supervisors will be retrained on 10-1-14 by the RD for the need to follow the drill calendar and always do drill when indicated.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken</p> <p>All residents could potentially be affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>An annual emergencydrill calendar has been designed and implemented. This annual schedule will include drills to be conducted on each shift</p>	10/10/2014			

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W000444	<p>2013/2014.</p> <p>9-3-7(a)</p> <p>483.470(i)(1)(iii) EVACUATION DRILLS The facility must hold evacuation drills to evaluate the effectiveness of emergency and disaster plans and procedures. Based on record review and interview, the facility failed for 4 of 4 sampled clients (#1, #2, #3 and #4) and 3 additional clients (#5, #6 and #7) who resided in the group home, to ensure the facility evaluated the effectiveness of the evacuation drills in regard to the length of time the evacuations were taking for</p>	W000444	<p>quarterly. Supervisors will post this calendar and mark on the monthly calendar the dates and times drills are to be conducted. The Supervisors will pick up the drill the following day to ensure it was completed and will turn it into the QIDP for tracking.</p> <p>How corrective actions will be monitored to ensure norecurrence Staff will be trained to follow emergency drill calendar by the RD on 10-1-14. Supervisors will check the following day to ensure drills are being completed as scheduled. A member of management will check monthly during the environmental quality assessment to ensure drills are being completed as scheduled. Director will sign off on retraining. RD will review the monthly environmental quality checks to ensure compliance.</p> <p>Corrective action for resident(s) found to have been affected Drills will be completed monthly as scheduled on the annual drill calendar. Drills are to be completed within 3 minutes. If a client does not complete a drill within 3 minutes that will be documented on the drill form. If a client does not complete the drill within 3 minutes this will be</p>	10/10/2014	

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	<p>the clients to get to a safe area.</p> <p>Findings include:</p> <p>The facility's evacuation drill reports were reviewed on 8/19/14 at 11 AM. The reports indicated "To be considered a prompt drill all clients must evacuate in three minutes or less."</p> <p>The reports indicated the following evacuation times for the clients living at the facility (clients #1, #2, #3, #4, #5, #6 and #7):</p> <p>__ 8/16/14 at 6:10 AM - 7 minutes. __ 7/23/14 at 7:30 (AM/PM not indicated) - 4 minutes. __ 7/8/14 at 6:20 AM - 4 minutes and 12 seconds. __ 6/3/14 at 7:35 (AM/PM not indicated) - 10 minutes. The report indicated "Told clients there was a tornado and needed to take cover. [Client #1] refused to participate and all other clients were resistant to going to safety." __ 6/8/14 at 8:30 PM - 4 minutes. __ 7/3/14 at 7:15 AM - 10 minutes. __ 2/4/14 at 6 AM- 4 minutes. __ 1/17/14 at 7 PM - 5 minutes. __ 12/26/13 at 6 PM - Completion time of drill not indicated. __ 12/18/13 at 7 AM - Completion time of drill not indicated. __ 12/11/13 at 6:30 AM - 10 minutes.</p>		<p>discussed at the next client quarterly meeting oran IDT will be called. This will also bedocumented on the annual CFA.</p> <p>The GHM and QIDPwill be retrained on the need for all drills to be completed and the need totrack client compliance. This retrainingwill be done by the RD on 10-1-14.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken</p> <p>All residents couldpotentially be affected and corrective action will address the needs of allclients.</p> <p>Measures or systemic changes facility put in place toensure no recurrence</p> <p>It will be added tothe quarterly meting checklist to look at and discuss client results ondrills. IF there are concerns or issues the team will discuss the issues and any necessary retraining or planimplementation. The QIDP will turn inthe quarterly meeting checklist into the RD within 24 hours of the meeting.</p> <p>How corrective actions will be monitored to ensure norecurrence</p> <p>Staff will be trained to follow emergency drill calendar by the RD on 10-1-14. The management team will be retrained by theRD on 10-1-14 to assess the drills and schedule client quarterlies or IDTs todiscuss the results as needed. Director will signoff on retraining.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G013	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/10/2014
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	<p>__ 11/19/13 at 3 AM - 10 to 15 minutes __ 11/1/13 at 7:15 PM - 6 minutes.</p> <p>During interview with QIDPs (Qualified Intellectual Disabilities Professionals) #1 and #2, the ADM (Administrator) and the RM (Residential Manager) on 8/25/14 at 1 PM, the RM stated the total time of the evacuation of the clients from the home "should be 3 minutes or less." The ADM indicated the facility had not evaluated the effectiveness of the drills in regard to the length of time the drills were taking as compared to what the facility considered to be a prompt drill.</p> <p>9-3-7(a)</p>		RD will review themonthly environmental quality checks to ensure compliance.		