

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/24/2015
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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 11/9, 11/10, 11/16 and 11/24/15.</p> <p>Facility number: 001194 Provider number: 15G628 AIM number: 100245710</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/9/15.</p>	W 0000		
W 0104 Bldg. 00	<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 and interview for 4 of 4 sampled clients (#1, #2, #3, and #4) and 2 additional clients (#5 and #6) the governing body failed to exercise operating direction over the facility to provide the group home with sufficient amounts of pots and pans to prepare meals.</p> <p>Findings include:</p>	W 0104	In regard to W104, the facility failed to exercise operating direction over the facility to provide the group home with sufficient amounts of pots and pans to prepare meals, the facility has replaced the pan that was burnt the day before the survey Staff has been retrained to immediately notify the PC or QIDP if a pot or pan is damaged This can be done by filling out a computer (ipad) entry that is	12/24/2015

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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W 0125 Bldg. 00	<p>During observations on 11/9/15 between 4:12pm and 6:35pm at the group home, client #1 was assisting staff #2 with cooking dinner. At 4:45pm staff #5 stated to staff #4 "We don't have a pan to make the mac (macaroni) and cheese". Staff #4 made a phone call and then returned to the kitchen and informed staff #5 they would get a pot tomorrow. At 4:55pm staff #5 took the broccoli she was making, drained it and placed it into a bowl. She asked client #1 to cover the broccoli with foil and put it in the microwave. Staff #5 then washed the pot the broccoli was made in so she could cook the macaroni noodles. This affected clients #1, #2, #3, #4, #5, and #6.</p> <p>Interview with the Qualified Intellectual Disability Professional (QIDP) and Program Coordinator (PC) on 11/16/15 at 2:36pm, indicated the group home should have enough pots and pans to cook the whole meal. The QIDP and PC indicated new pots were purchased after the 11/9/15 observation.</p> <p>9-3-1(a)</p> <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all</p>		<p>immediately sent to the QIDP, Director, PC, and nurse for immediate review. Additionally in weekly observations completed by the nurse, QIDP and or PC, site check paperwork will be completed to note any issues with supplies These are immediately forwarded to all team members</p>	

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	<p>clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (#1), the facility failed to ensure the client's rights in regard to not allowing the client to use the oven and/or stove with no plan in place to reduce the restriction.</p> <p>Finding include:</p> <p>During observations on 11/9/15 between 4:12pm and 6:35pm at the group home, client #1 was assisting staff #5 with cooking dinner. At 4:12pm client #1 asked staff #5 if she needed help opening vegetables and placing them in pot. Staff #5 shook her head no and continued to work on vegetables. Client #1 then indicated to staff #5 she forgot she couldn't cook on the stove. At 4:55pm client #1 also wanted to assist with cooking the macaroni and cheese. Staff #5 reminded client #1 that she couldn't cook on the stove and stated "I'll do the noodles then you can do the milk and cheese". At 5:15pm client #1 took the bowl of broccoli out of the microwave. Client #1 did not use any hot pads as she was removing the bowl from the</p>	W 0125	<p>In regard to W125, the facility failed to ensure the client's rights in regard to not allowing the client to use the oven and/or stove with no plan in place to reduce the restriction, the facility has reviewed all consumer restrictions to ensure proper paperwork is in place to allow for a restriction All restrictions have also been corrected to allow for a plan to be in place for the restriction to be reduced A review of the process for restrictions has been done by PC, QIDP, Director and Nurse Guidelines are made available for meetings and for use when talking to guardians to ensure the proper paperwork and procedures are followed Weekly review of ISP's will ensure proper documentation Review of paperwork checklist is sent to PC, QIDP, Nurse and Director</p>	12/24/2015

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	<p>microwave. Client #1 stated "Ouch, that's hot".</p> <p>Interview with client #1 on 11/9/15 at 4:12pm, indicated she could not use the stove or oven because in the past she had burned herself and her grandmother doesn't want her to use the stove.</p> <p>The facility's internal incident reports were reviewed on 11/9/15 at 3:17 PM. Incident report dated 8/5/15 at 10:15pm, indicated "[Client #1] told staff she burnt her right hand pointer finger on a pot off the stove. [Client #1] was given first aid. [Client #1] was reminded that her guardian does not want her cooking". Incident report dated 10/12/15 at 6:15am, indicated "[Client #1] was going to put pancakes in the microwave at 6:15am when she saw that there were already some in there. She reached into get them, but felt they were hot and pulled her hand back. [Staff #2] asked if she got burnt, [Client #1] said 'no, I didn't touch them.' At 6:25am [Client #1] came in for meds and told me that she did burn her hand. She said it was her left thumb. No burn mark was evident. No pain reported. I explained to [Client #1] that she needs to be more careful and if there is something hot she can ask staff for help. "</p> <p>Client #1's record was reviewed on</p>			

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W 0154	<p>11/16/15 at 12:46pm. Client #1's 6/12/15 Individualized Support Plan (ISP) indicated her grandmother was her current guardian. Client #1's ISP did not indicate a need for the restriction of using the stove and/or oven.</p> <p>Client #1's 2/9/15 risk profile did not indicate she was at risk for severe injuries or patterns of injuries.</p> <p>Client #1's 6/8/15 Functional Behavior Assessment did not address Client #1's restriction from using the stove and/or oven and how she may get the right to use the oven and/or stove back.</p> <p>Interview with the Qualified Intellectual Disability Professional (QIDP) and Program Coordinator (PC) on 11/16/15 at 2:36pm, indicated Client #1's guardian said she did not want client #1 cooking on the stove and/or oven. The QIDP and PC indicated they did not have written informed consent from the guardian or Human Rights Committee for the restriction of use of the oven and/or stove.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p>						

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Bldg. 00	<p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 6 of 8 allegations of abuse and/or neglect, the facility failed to conduct a thorough investigation in regard to incidents of abuse and/or neglect and client to client abuse for clients #1, #3, #5, #6, and #7.</p> <p>Findings include:</p> <p>1. The facility's internal incident reports were reviewed on 11/9/15 at 3:17 PM. Incident report dated 9/8/15 at 7:45pm stated "[Client #3] was telling staff she broke up with a consumer from the workshop. He was asking her to take naked pictures of herself and she said he was talking about porn, and she was on her way to the workshop. She said she was having a seizure in her heart. Staff listened to what she was saying about the consumer and she rested on the way to the workshop." The facility's investigations were reviewed on 11/9/15 at 3:17 pm. There was no investigation of this incident available for review.</p> <p>Interview with the Qualified Intellectual Disability Professional (QIDP) and Program Coordinator (PC) on 11/16/15 at 2:36pm indicated no investigation was completed for the incident dated 9/8/15</p>	W 0154	<p>In regard to W154, the facility failed to conduct a thorough investigations of abuse/neglect, and client to client abuse. The system failed in the instances cited in this W for a few reasons:</p> <p>1. Confusion as to exact incidents needing investigated in consumer to consumer abuse and injuries of unknown origin 2. Thorough review of investigation once completed. To address these issues, ASI has revamped its Incident Reporting process for all Group Homes. Any time an Incident Report is written, it is immediately sent to the Director, Programming Coordinator, QIDP, and Nurse electronically. This begins the notification process for them in case a BDDS report is required or an investigation must be initiated. These individuals are on-call 24-7. The Incident Report is then electronically sent to these same persons so that the paperwork process follows their actions. There is no opportunity for delay in an investigation process with this notification system. If it is an investigation of unknown injury or consumer to consumer abuse, the QIDP and Nurse conduct the investigation. ASI has up-dated the guidelines for investigations, to ensure investigations are completed. If the allegation involves staff</p>	12/24/2015			

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	<p>regarding client #3 and possible abuse.</p> <p>2. The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 11/9/15 at 3:17 PM. The facility's 10/24/15 reportable incident report indicated "Manager [Program Coordinator-PC #1] received a verbal abuse allegation toward [client #6] by staff [staff #2]. [Staff #2] was suspended pending investigation."</p> <p>The facility's 10/26/15 Abuse, Neglect, Exploitation Investigation Form (Staff to Consumer, Consumer to Consumer, and Injury of Unknown Origin) indicated "At approximately 2:15, staff [staff #2] pulled into [name of convenience store] Gas station with 2 consumers, [client #6] and [client #1]. [Staff #2] put gas in the van and sat with [client #6] and [client #1] while they ate chips and drank a pop. [Staff #2] then proceeded to remind [client #6] that [client #1] was going to ride up front on the way back to the group home and because [client #6] rode up front to the grocery store and gas station and he agreed that he would let [client #1] ride up front on the way back. [Client #6] refused to let [client #1] come up front and [staff #2] continued to try to redirect [client #6] to the back seat to ride home. While she kept trying to redirect [client #6], he became agitated. She (staff #6) continued to redirect him. He began trying to hit and bite [staff #2]. Another staff [staff #6] pulled into the gas station and approached the van. [Client #6] got out of the van and gave [staff #6] a hug and talked with [staff #6] until [PC], the Coordinator arrived. During that time, [staff #2] was still talking to [client #6] about sitting in the back. It is unclear in what way a comment about [client #6] going to a state hospital was made. It appears that he was told that if he was biting and hitting, the police would not take him but they would</p>		<p>abuse, the Director is notified and she/he initiates the investigation. Staff are immediately suspended in these instances. The policy, procedure, and form for investigating allegations of abuse/neglect/exploitation have been up-dated to address the timeliness and thoroughness of the investigation. When a Director initiates an investigation, she will email the Executive Director with the staff's name and brief description of the allegation. When the investigation is complete, a second email will be send to the ED for him to ensure it is completed in a timely manner. This also ensures that he has been informed and is up-to-date on any allegations. In addition, the Quality Assurance Committee is tracking all staff investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. In regard to allegations of unknown injury or consumer to consumer abuse, the investigating QIDP will send an email to the ED upon the initiation of an investigation as well as at the conclusion of the investigation so that he is able to monitor the timeliness of these events.</p>				

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	<p>have to have someone take him that knew he wasn't doing it on purpose but needed help, and this would be a state hospital. Whatever way the statement was made, it was inappropriate. It is unclear whether [client #6] even knew what she said about the state hospital or if he would know what that was."</p> <p>The facility's 10/26/15 investigation indicated under the "Investigators Findings" "[Staff #6] continued to try to get [client #6] to sit in the back seat of the van. It was unnecessary to try to redirect [client #6] until he became upset." The investigation indicated "[Staff #2] did not yell at [client #6], however, she should not have mentioned a state hospital and should not have continued to redirect [client #6] over sitting in the back seat." The facility's 10/26/15 investigation indicated the allegation of staff to client verbal abuse was "Partially substantiated." The facility's investigation indicated client #1 was interviewed, but client #1's attached witness statement was not attached. The facility's investigation indicated staff #2, the store clerk and staff #6 were also interviewed but the staff's witness statements were not attached. The facility's 10/26/15 investigation indicated no additional staff and/or client interviews were conducted in regard to how staff treated clients.</p> <p>Interview with the PC and the Qualified Intellectual Disabilities Professional (QIDP) on 11/16/15 at 2:30 PM indicated the facility conducted an investigation in regard to the allegation of abuse/neglect. The QIDP stated "Everyone interviewed would be in that stack."</p> <p>3. The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 11/9/15 at 3:17 PM. The facility's 12/17/14 reportable incident</p>			

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	<p>report indicated "During the skin check it was noted that [client #5] had 2 bruises on his legs that were green in color. One was above his knee, the other was on his inner thigh. Origin is unable to be determined at this time and internal investigation being completed. They are not of suspicious nature...[Client #5] is unable to tell us what they are from...."</p> <p>The facility's 12/22/14 follow-up report to the 12/17/14 reportable incident report indicated "...Investigation is completed and origin of bruise is unable to be determined." The facility's 12/17/14 reportable incident report and/or follow-up report did not indicate any additional documentation and/or information in regard to client #5's injury of unknown source.</p> <p>Interview with the PC and the QIDP on 11/16/15 at 2:30 PM indicated the investigation had been completed by a nurse who no longer worked for the agency. The PC stated "She did not give us the investigation."</p> <p>4. The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 11/9/15 at 3:17 PM. The facility's 7/30/15 reportable incident report indicated "[Client #3], walked down the hallway and stood by [client #7's] bedroom door. [Client #7] walked out of her room to come get staff. [Client #3] started saying '[client #7] you are a b..., I hate you, why don't you just f..... hit me.' Staff reminded [client #3] of her Physical Safety Contract. Staff [staff #4] had arrived back from an outing and was in the garage. [Client #7] came to staff and stated that [client #3] was yelling at her in the house so she came out to the garage. [Client #7] started banging her head on the van. Staff put herself between [client #7] and the van. [Client #7] went back in the house with</p>			

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	<p>staff. [Client #7] was in the homes (sic) office and [client #3] sat in a chair starring (sic) at her. Staff again reminded [client #3] of her Safety Contract. Approximately 40 minutes later (sic) [client #3] came to the office and stated to [client #7], 'you need a chill pill b.....' [Client #7] asked [client #3] to leave her alone. [Client #3] walked closer to [client #7] yelling, 'b.... need a chill pill?' [Client #7] said, 'leave me alone.' Suddenly [client #3] and [client #7] began hitting each other. Staff intervned and the two stopped after a couple of minutes. [Client #3] went into a peers (sic) room and [client #7] went outside. [Client #3] has a small scratch on her neck and [client #7] did not have any marks...." The facility's 7/30/15 reportable incident report indicated client #7 went home on a home visit and would be staying with her family until the interdisciplinary team could meet on 7/31/15. The facility's reportable incident report did not include any documentation of an investigation in regard to the client to client incident. The facility's 7/30/15 reportable incident report also did not include an investigation in regard to neglect due to the incident as the facility failed to determine how/why the incident was allowed to occur as there had been previous altercations between the two clients.</p> <p>Interview with the PC and the QIDP on 11/16/15 at 2:30 PM indicated the facility had conducted an investigation in regard to the client to client allegation of abuse incident. The QIDP stated "They should not have made contact." The QIDP indicated the facility conducted an investigation in regard to staff neglect for allowing the clients to get into an altercation. The QIDP and/or the QIDP did not provide any additional information and/or investigation in regard to the allegation of neglect.</p>			

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	<p>5. The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 11/9/15 at 3:17 PM. The facility's 9/3/15 reportable incident reports indicated "[Client #1] reported to staff at 2:00 pm that when she was in the kitchen earlier in the day, a male consumer lightly hit her under her chin with a closed fist. Staff took a look at [client #'s] chin and there were no visible marks or bruises. [Client #1] and no other consumers or staff was in the kitchen when this happened. Both consumers were cleaning which is part of daily task. Staff questioned [client #1] as to why the male consumer would hit her. [Client #1] said that the consumer told her it was an accident. Male consumer told staff that he bumped into [client #1] but did not hit her. Once the male consumer went home with his staff, he told his staff that he did hit [client #1] under his chin and laughed. Staff will keep male consumer away from [client #1].</p> <p>The facility's 9/4/15 Abuse, Neglect, Exploitation Investigation Form (Staff to Consumer, Consumer to Consumer, and Injury of Unknown Origin) indicated the incident occurred at the facility's owned day program. The facility's investigation indicated the names of both clients present (client #1 and the perpetrator). The facility's investigation did not include the documented interviews with both clients. The facility's investigation also did not indicate why staff was not present in the kitchen/area when the clients were cleaning up and/or include any interviews of staff and/or clients in regard to being treated and/or hit in the same fashion. The facility's investigation in the section entitled Investigators Findings were blank and did not indicate a conclusion and/or recommendations.</p> <p>Interview with the PC and the QIDP on 11/16/15</p>			

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	<p>at 2:30 PM indicated only client #1 and the perpetrator was interviewed. The PC and the QIDP indicated no other clients and/or staff were present when the incident occurred. The QIDP and the PC did not indicate what staff were doing at the time of the incident. The QIDP stated "There is no more documentation."</p> <p>6. The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 11/9/15 at 3:17 PM. The facility's 12/13/14 reportable incident report indicated client #3 was in the bathroom taking a shower. The reportable incident report indicated staff checked on client #3 at 8:15 PM and the client was "Ok." The reportable incident report indicated at 8:21 PM, staff heard a "bang" coming from the hallway. The reportable incident report indicated client #3 was found "...laying on floor. Laying on (L) (left) side with back of head against bathroom closet. 911 was called...."</p> <p>Client #3's record was reviewed on 11/16/15 at 10:35 AM. Client #3's 5/13/15 Individual Support Plan (ISP) indicated client #3's diagnosis, included, but was not limited to, Epilepsy. Client #3's record and/or 12/13/14 reportable incident report did not indicate the facility conducted an investigation in regard to the client's fall and/or in regard to possible neglect as client #3 had seizures and was allowed to bathe/shower in the bathroom alone.</p> <p>Interview with the QIDP and the PC on 11/16/15 at 2:30 PM indicated client #3 wore a helmet due to falls from seizures. The QIDP and the PC indicated facility staff were to be in the bathroom with client #3 when she took her shower. The PC indicated this was put in place after the 12/13/14 incident. The PC and the QIDP indicated the facility did not conduct an investigation in regard</p>			

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W 0210 Bldg. 00	<p>to the allegation of possible neglect.</p> <p>9-3-2(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. Based on record review and interview for 1 of 4 sampled clients (#4), the facility failed to assess client's sensorimotor skills within 30 days of being admitted to the group home.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 11/16/15 at 10:14am. Client's #4's 8/2/15 Functional Behavior Assessment indicated client #4 moved into the group home on 7/2/15. Client #4's 7/29/15 Comprehensive Functional Assessment and/or 7/29/15 Individual Support Plan did not indicate the client's sensorimotor skills had been assessed within 30 days of being admitted into the group home.</p> <p>Interview with the Program Coordinator (PC) and the Qualified Intellectual Disabilities Professional (QIDP) on</p>	W 0210	In response to W210, the facility failed to assess client's sensorimotor skills within 30 days of being admitted to the group home, the facility has reviewed all recent admittance to group home to ensure proper assessments are completed To ensure all assessments are completed in the 30 day time limit, all completed paperwork will be forwarded to the director for review upon completion All assessments have been reviewed for content and are complete	12/24/2015

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W 0227 Bldg. 00	<p>11/16/15 at 2:36pm, indicated client #4 was a new admission to the group home. The QIDP and the PC indicated they were not able to locate a sensorimotor assessment in regards to client #4's sensorimotor needs.</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 comprehensive assessment required by paragraph (c)(3) of this section. Based on record review, observation, and interview for 1 of 4 sampled clients (#1) the client's ISP (Individual Support Plan) failed to address the client's identified safety need in regards to kitchen safety.</p> <p>Findings include:</p> <p>During observations on 11/9/15 between 4:12pm and 6:35pm at the group home client #1 was assisting Staff #5 with cooking dinner. At 4:12pm client #1 asked staff #5 if she needed help opening vegetables and placing them in pot. Staff #5 shook her head no and continued to work on vegetables. Client #1 then stated she forgot she couldn't cook on the stove.</p>	W 0227	In regard to W227, the facility failed to address the client's identified safety need in regard to kitchen safety, the facility has reviewed all consumer restrictions to ensure proper paperwork is in place to allow for a restriction and that all safety needs are assessed prior to any restrictions All restrictions have also been corrected to allow for a plan to be in place for the restriction to be reduced A review of the process for safety assessments has been done by PC, QIDP, Director and Nurse Guidelines are made available for meetings and for use when talking to guardians to ensure the proper paperwork and procedures are followed Weekly review of ISP's will ensure proper	12/24/2015			

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	<p>At 4:55pm client #1 also wanted to assist with cooking the macaroni and cheese. Staff #5 reminded client #1 that she couldn't cook on the stove and stated "I'll do the noodles then you can do the milk and cheese". At 5:15pm client #1 took the hot bowl of broccoli out of the microwave. Client #1 did not use any hot pads when removing bowl from microwave. Client #1 bowl stated "Ouch, that's hot".</p> <p>The facility's internal incidents reports were reviewed on 11/9/15 at 3:17 PM. Incident report dated 8/5/15 at 10:15pm, indicated "[Client #1] told staff she burnt her right hand pointer finger on a pot off the stove. [Client #1] was given first aid. [Client #1] was reminded that her guardian does not want her cooking". Incident report dated 10/12/15 at 6:15am indicated "[Client #1] was going to put pancakes in the microwave at 6:15am when she saw that there were already some in there. She reached into get them, but felt they were hot and pulled her hand back. [Staff #2] asked if she got burnt, [Client #1] said "no, I didn't touch them." At 6:25am [Client #1] came in for meds and told me that she did burn her hand. She said it was her left thumb. No burn mark was evident. No pain reported. I explained to [Client #1] that she needs to be more careful and if there is something</p>		documentation Review of paperwork checklist is sent to PC, QIDP, Nurse and Director				

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	<p>hot she can ask staff for help."</p> <p>Client #1's record was reviewed on 11/16/15 at 12:46pm. Client #1's 6/12/15 Individualized Support Plan (ISP) indicated her grandmother was her current guardian. Client #1's ISP did not indicate a need for the restriction of using the stove and/or oven. Client #1 had the following objectives listed in her ISP: 1. "[Client #1] will inform staff of and falls, headaches, body pains, rashes, aggression by other consumers, etc." 2. "[Client #1] will remind staff that she takes birth control every night." 3. "[Client #1] will call her grandmother on Wednesday to decide how much money she is spending that week." 4. [Client #1] will assist staff with counting her money at the end of the evening. This includes any money she may be carrying on her person." 5. "[Client #1] will be able to properly do her laundry from start to finish. She will take her cloths from the dryer, fold them and then put away." 6. "[Client #1] will keep her room clean this includes: keeping trash picked up, clothes picked up, making her bed, keeping the floor clear of debris, and sweeping floor (as needed)." 7. "[Client #1] will begin to look up jobs on the Internet. She will write down any jobs she is interested in and can talk with her...counselor about filling out their application." 8. "[Client</p>			

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W 0268 Bldg. 00	<p>#1] will fill out applications to gain experience with filling out applications for employment." and 9. "[Client #1] will not accept anything form anyone whether this is a peer in the workshop, at her group home or someone in the community." Client #1's ISP did not include a training objective to address kitchen safety.</p> <p>Interviews with the Qualified Intellectual Disability Professional (QIDP) and Program Coordinator (PC) on 11/16/15 at 2:36pm, indicated Client #1's guardian said she did not want client #1 cooking on the stove and/or oven. When asked if Client #1 had a cooking safety plan, kitchen safety plan, or objectives related to kitchen safety in place, the QIDP and PC indicated she did not have any because the guardian did not want them in place. The QIDP and PC stated she should have a safety plan or objective in place for kitchen safety.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.</p>			

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W 0312	<p>Based on observation, interview and record review for 1 of 4 sampled clients (#2), the facility failed to ensure the client's dignity in regard to hair brushing.</p> <p>Findings include: During the 11/16/15 observation period between 5:42 AM and 8:05 AM, at the group home, client #2 came out of her bedroom dressed for the day with her hair uncombed. Client #2 left for the day program with her hair uncombed. Facility staff #2 and/or #3 did not encourage client #2 to comb her hair before going to work.</p> <p>During the 11/16/15 observation period between 9:00 AM and 9:55 AM, at the day program, client #2's hair was uncombed.</p> <p>Interview with the Program Coordinator (PC) and the Qualified Intellectual Disabilities Professional (QIDP) on 11/16/15 at 2:30 PM indicated facility staff should have encouraged client #2 to comb her hair prior to going out into the community/to work.</p> <p>9-3-5(a)</p> <p>483.450(e)(2)</p>	W 0268	In response to W268, the facility failed to ensure the client's dignity in regard to hair brushing, the facility has retrained the staff in regard to dignity and what that means for consumers. To ensure that staff are ensuring all consumers dignity, PC will oversee morning, afternoon and evening routines once a week and address any issues on site Goals will be revised in an effort to address issues that consumers would like reminded to do and or have assistance in doing Routines will be reviewed regularly to ensure consistency in ensuring clients dignity	12/24/2015			

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Bldg. 00	<p>DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 1 of 4 sampled clients (#1) on behavior controlling medications, the facility failed to ensure a medication to treat sleep issues was part of plan which included an active treatment program which addressed the behaviors for which the medication was prescribed.</p> <p>Findings include: Client #1's record was reviewed on 11/16/15 at 12:46 PM. Client #1's 10/27/15 physician's order indicated client #1 received Melatonin 3 milligrams at bedtime for "Insomnia."</p> <p>Client #1's 6/8/15 Behavior Support Plan (BSP) indicated client #1's sleeplessness was not being monitored and/or tracked. Client #1's 6/8/15 BSP did not include an active treatment program for the use of the Melatonin.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) and the Program Coordinator (PC) on 11/16/15 at 2:30 PM indicated client #1 received the Melatonin to help the client sleep at night. The QIDP indicated the facility</p>	W 0312	In regard to W312, the facility failed to ensure a medication to treat sleep issues was part of plan which included an active treatment program which addressed the behaviors for which the medication has been prescribed, the facility has reviewed all medications that treat sleep issues and has provided sleep tracking and active treatment To ensure active treatment is always addressed, all medication tracking will be reviewed regularly (monthly) by Nurse and medical records assistant weekly tracking book checks results will be submitted to PC, QIDP, and Director for review	12/24/2015			

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W 0331 Bldg. 00	<p>was not tracking sleep, and the client did not have an active treatment program to address the client's insomnia/sleeplessness.</p> <p>9-3-5(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on interview, observation and record review for 2 of 4 sampled clients (#2 and #3), the facility's nursing services failed to meet the nursing needs of clients in regard to developing risk plans. The facility's nursing services failed to ensure the facility had a PRN (as needed) medication to administer when requested.</p> <p>Findings include:</p> <p>1. During observations on 11/9/15 between 4:12pm and 6:35pm at the group home, at 6:30pm during client #3's med pass she asked staff #4 if the group home had any Ibuprofen yet. Staff #4 asked staff #5 and staff #5 responded "No not yet".</p> <p>Interview of the Qualified Intellectual Disabilities Professional (QIDP) and Program Coordinator (PC) on 11/16/15 at</p>	W 0331	In regard to W331, the facility's nursing services failed to meet the nursing needs of clients in regard to developing risk plans, the facility has reviewed all of the high risk plans of the consumers to ensure all risks are addressed Retraining of staff has been completed for any risk updates Risk plans are being reviewed quarterly or as medical needs change Risk plans will be reviewed by PC, QIDP and Nurse to ensure no issues are missed. All risk plan changes will be sent to Director for review. Medications in home are being checked daily to ensure that no medication is unavailable These medications will be checking daily by leads in the home and any issues noted electronically to the Nurse, QIDP, PC and Director	12/24/2015

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	<p>2:36pm, indicated all PRN medications should be available when the client is at need.</p> <p>2. During the 11/9/15 observation period between 4:10pm and 6:40pm and the 11/16/15 observation period between 5:42am and 8:05am at the group home client #2 utilized a wheelchair for her primary means of mobility.</p> <p>Client #2's record was reviewed on 11/16/15 at 12:56pm. A 2/9/2015, Risk Profile indicated client #2 is at risk for Pressure Sores and Falls. A 9/17/15, High Risk Plan indicated a protocol for Impaired vision, Anxiety management challenges, pain, and skin integrity. The skin integrity plan indicated "[Client #2] is at risk for impaired skin integrity due to bilateral leg braces, utilization of wheelchair related to dx (diagnosis) of cerebral palsy. [Client #2] also has incontinent episodes of bladder. She will wait too long to proceed to the bathroom. Check skin daily when showering". The protocol did not indicate how pressure areas will be prevented or treated. Client #2's High Risk Plan did not address the client's fall risk.</p> <p>Interview of the Qualified Intellectual Disabilities Professional (QIDP) and Program Coordinator (PC) on 11/16/15 at</p>						

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W 0455 Bldg. 00	<p>2:36pm, indicated Client #2 did not have a protocol to address her fall risk or prevention and treatment of pressure areas.</p> <p>9-3-6(a)</p> <p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 2 of 4 sampled clients (#2 and #3), the facility failed to encourage the clients to wash their hands before setting the table and during the medication pass.</p> <p>Findings include:</p> <p>An observation was done at the group home on 11/9/15 for 4:12pm and 6:35pm. At 5:05pm client #2 transferred to her wheelchair from her walker. Client #2 wheeled herself into the kitchen and Staff #5 handed her cups to place on the table. Client #2 did not wash her hands before taking the cups and setting the table. At 6:30pm client #3 was observed to receive her medication without washing her hands. Staff #4 did not prompt the client to wash her hands prior to the medication</p>	W 0455	In response to W455, the facility failed to encourage the clients to wash their hands before setting the table and during medication pass, the facility has retrained staff in universal precautions, and the facility has implemented the use of hand sanitizer at each group home for clients and staff to use during med passes and at any other times needed. Med pass evaluations are completed weekly by the agency nurse to ensure compliance and random med pass evals and facility checks are completed weekly by the nurse, QIDP or PC to ensure staff are properly training consumers especially at meal times. Additionally, when there is a med error, the staff that had the med error will be observed at the next med pass following the error. This is to ensure they know what they did wrong and to	12/24/2015

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	administration. Interview of the Qualified Intellectual Disabilities Professional (QIDP) and Program Coordinator (PC) on 11/16/15 at 2:36pm, indicated all clients should be washing their hands prior to setting the table and receiving medication. 9-3-7(a)		immediately observe any issues that might play a role in the med errors when they are passing meds. Documentation of the observation will be submitted to the Director of Programming for review and possible scheduling of additional monitoring based on results of observation.		