

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/15/2014
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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1730 OSAGE DR KOKOMO, IN 46902
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: September 23, 24, 25 and October 15, 2014.</p> <p>Facility number: 011266 Provider number: 15G732 AIM number: 200840950</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/12/14 by Dotty Walton, QIDP and Ruth Shackelford, QIDP.</p>	W000000	<p>Toensure staff compliance and that training was effective, the followingcorrective actions will be implemented: All Residential Nurses will be required to developsystems in which they a) conduct weekly reviews of all medication records for all clients residing in the home b) observe staff on a routinely basis toensure that all medications are administered according to physician's ordersand agency policy. In the event of a medication error, the ResidentialNurse will immediately review all medication records for all clients residingin the home, not just those that are affected, to ensure that no othermedication errors have occurred, that staff fully comprehend and understanddirectives for medication administration as stated on the MAR (medicationadministration record), and that medications are being administered accordingto physician's orders and agency policy.</p>	
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview, the facility failed to develop and/or</p>	W000149	<p>Toensure that established agency policies and procedures for abuse and</p>	12/12/2014

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>implement a abuse/neglect policy to prevent a major medication administration error for 1 of 6 BDDS (Bureau of Developmental Disabilities Services) reports reviewed for medication administration errors for 1 of 4 sampled clients (#3).</p> <p>Based on record review and interview, the facility failed to develop and/or implement a abuse/neglect policy to prevent misappropriation of funds for 1 of 1 BDDS report reviewed for missing and/or stolen funds for 2 of 4 sampled clients (#2, #4).</p> <p>Based on record review and interview, the facility failed to develop and/or implement an abuse/neglect policy to prevent physical abuse for 1 of 1 BDDS report reviewed for physical abuse for 1 additional client (#5).</p> <p>Based on record review and interview, the facility failed to develop and/or implement an abuse/neglect policy to ensure client to client abuse was thoroughly investigated and reported to state agency (BDDS) for 1 of 4 sampled clients (#2).</p> <p>Findings include:</p> <p>1) On 9/24/14 at 12:32 PM, the facility's</p>		<p>neglectare being implemented and executed as written, the following corrective action(s) will be implemented:</p> <p>1) All direct care staff located at 1730 Osage Drive (Osage group home) will be re-trained on the agency Personnel Policies and Procedures, Policy III:13: Incident Reporting. Completed Record of Trainings will be obtained and submitted upon completion of training. <i>Refer to Appendix A for Record of Training form to be used.</i></p> <p>2) All investigations will be conducted in the manner outlined on the Residential Services Investigation Process. <i>Refer to Appendix B for process outline.</i> To ensure that all investigations are conducted in a uniform and consistent manner, all Residential House Managers, Qualified Development Disability Professionals, Nurses, the Director, and the Residential Services Coordinator will be trained on the newly</p>				

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	<p>BDDS (Bureau of Developmental Disabilities Services) reports from 2/14/14 to 9/24/14 were reviewed. A BDDS report dated 3/17/14 indicated "staff working with [Client #3], [DSP #3], administered another supported individual's 4pm medications to [Client #3] in error." The report indicated "the incorrect medications were: Carbamazepine ER (anticonvulsant, extended release) 200mg (milligrams) tablet x (times) 2 (400mg) and Olanzapine (antipsychotic) 10mg - 1/2 tablet (5mg)." The report indicated staff immediately contacted the nurse. The report indicated the facility nurse "phoned [Client #3]'s PCP (primary care physician) [Doctor]. [Doctor] instructed to hold [Client #3]'s routine 4pm medications, take vitals every hour for six consecutive hours, to call the nurse if B/P (blood pressure) were (sic) below 0/60, pulse below 55, or any s/s (signs or symptoms) of confusion, nausea, vomiting, or seizure activity." The report indicated "as a precautionary measure, [facility Nurse] sent [Client #3] to [hospital] via ambulance at 10pm due to a low pulse rate of 45-48 beats per minute." The report indicated Client #3 was released the next morning at 11:33 AM and was able to return to normal activities.</p>		<p>established investigation process outline. <i>Refer to Appendix C for Record of Training form to be used in documenting training.</i></p> <p>3) To ensure that incidents have been reported and investigated in the manner as outlined in agency policies, all investigation packets, regardless of type, will have an investigation process checklist included. The checklist will be completed by the Residential Services Coordinator as he/she is conducting the investigation. Upon the conclusion of the investigation, all investigation materials including the checklist will be given to the Vice President of Residential Services for review. The Vice President of Residential Services will sign-off on the checklist and accompanying materials once all items have been reviewed and approved. <i>Refer to Appendix D to review investigation process checklist.</i></p> <p>4) To prevent abuse and/or neglect of clients, all direct care staff located at 1730 Osage</p>				

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	<p>On 10/15/14 at 12:25 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated staff are trained to administer medications without error. The QIDP indicated the staff involved in the medication administration error with Client #3 had been retrained.</p> <p>2) On 9/24/14 at 12:32 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 2/14/14 to 9/24/14 were reviewed. A BDDS report dated 3/19/14 indicated "it was noted by house manager [HM] upon transferring money from the main money box to the petty cash money box for consumer [Client #4] that the main money packet for [Client #4] was missing the entire ledger amount of \$56." The report indicated "upon investigation of the misplaced/missing money it was learned that consumer [Client #2]'s main money packet was also missing the entire ledger amount of \$18."</p> <p>The investigation summary dated 3/21/14 indicated staff searched the home for the missing money and "were unable to make any discoveries of the funds."</p> <p>On 10/15/14 at 12:25 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional)</p>		<p>Drive (Osage group home) will be retrained on the agency abuse and neglect policy, Prohibition of Violation of Individual Rights. Refer to Appendix E for record of training form to be used.</p> <p>5) All direct care staff located at 2333 1730 Osage Drive (Osage group home) will be re-trained on the agency medication administration policy Completed Record of Trainings will be obtained and submitted upon completion of training. Refer to Appendix F for Record of Training forms to be used.</p>				

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	<p>indicated the investigation was inconclusive. The QIDP indicated Client #2 and Client #4 were reimbursed for their missing funds and staff were trained. The QIDP indicated all client funds should be accounted for at all times.</p> <p>3) On 9/24/14 at 12:32 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 2/14/14 to 9/24/14 were reviewed. A BDDS report dated 7/22/14 indicated "on 7/21/14 during a conversation with Residential Manager (sic) a staff person brought up that [DSP (Direct Support Professional) #3] had taken a plate of food from [Client #5] and then he became upset and threw water on her. She then, threw water on him. The time and date has yet been undetermined at this time." The report indicated "the residential manager reported this to the QDDP (Qualified Developmental Disabilities Professional)." The report indicated DSP #3 had been suspended pending an investigation.</p> <p>The investigation dated 7/21/14 indicated an interview in which DSP #3 was asked whether Client #5 had ever thrown water on her. DSP #3 indicated the incident "was months ago." DSP #3 indicated Client #5 "got mad because they had been</p>						

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	<p>doing takedowns on him for [dayprogram] and [House Manager (HM)] let him bring home the stuff on the string b/c (because) he was obsessing so when it came time for dinner he wouldn't eat b/c (because) he was sitting playing with these things. So I went up to him and got the beads off the table b/c had to get him to eat." The interview indicated DSP #3 took his other item "when he wasn't looking...". The interview indicated Client #5 "still had one on his fork so I pulled that one off. As I was walking away he threw his cup of water. I had turned away and [Client #5] took both hands and smacked me on my front and on my back. He slammed me a good one and [DSP #8] said I've never seen him act like that." The interview indicated DSP #3 "said he was mad b/c of the beads. I think [HM] was the HM and I said maybe next time we can leave those beads at [dayprogram] and not let him bring them home and she said well I didn't want to do another take down b/c he'd already had enough that week." DSP #3 was asked whether DSP #3 had "ever thrown water back on him?", DSP #3 indicated "I did that night but I got him right here on the chest b/c he was banging his head on the refrigerator and he was biting so I was trying to get him out of that behavior by shocking him. It was a little bit. Then</p>			
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	<p>later I went and bathed him and it was fine."</p> <p>The investigation "Summary of Events" dated 7/23/14 indicated "on Monday, July 21st, it was reported that staff member [DSP #3] threw water on consumer [Client #5]. After further investigation, it has been determined that there may be 2 similar incidences. One of two occurred on Friday, July 18th and it was reported by staff [DSP #9] that [Client #5] was at the table and staff [DSP #3] took his plate because he was upset and may have started choking. [DSP #9] stated that it may have looked like [DSP #3] had thrown water on him because [Client #5] started flailing his arms and hit over the water cup on the table." The investigation summary indicated "the other incident apparently occurred anywhere from 3-5 months ago. [Client #5] wanted to take an item to the dinner table with him but was told no by staff [DSP #3]. She did not want [Client #5] bringing items to the table as he should be focusing on eating not playing." The summary indicated "after multiple attempts from her to remove the item from [Client #5]'s hand he then got upset and went into a behavior. He smacked her on both the front and back sides of her body. He then threw water over his shoulder at her. [DSP #3] reported that</p>				

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	<p>during that evening of him having a behavior she did throw water on him to attempt to stop him from biting himself and banging his head on things." The summary indicated "in conclusion, the writer feels that the alleged abuse of throwing water on [Client #5] is substantiated as the alleged abuser did in fact admit to throwing the water at [Client #5]. It is recommended that staff [DSP #3] be terminated as she has violated [facility]'s Prohibition of Violations of Individual Rights. It is also being recommended that all staff at the [group home] house be retrained on incident reporting as well as [Client #5]'s ISP (Individual Support Plan)."</p> <p>During an interview on 10/15/14 at 12:25 PM, the QIDP (Qualified Intellectual Disabilities Professional) indicated the allegation of physical abuse was substantiated and DSP (direct support professional) #3 was terminated.</p> <p>4) On 9/24/14 at 12:32 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 2/14/14 to 9/24/14 were reviewed and facility investigations from 9/24/13 to 9/24/14 were reviewed. The review indicated no BDDS report or investigation for client to client abuse for Client #2.</p>						

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	<p>On 9/24/14 at 2:15 PM, record review indicated a "Psychologist's Statement" dated 9/10/14 which indicated "on 9/5/14 [Client #2] just started her menses during day program as she was wearing borrowed clothes. She became agitated walking out of the classroom wanting something out of the vending machine and swung her lunch box hitting another consumer." Record reviewed indicated a "Psychologist's Statement" dated 9/3/14 which indicated "[Client #2] had a good day until after going to movies, when she returned home she still had a partial tub of popcorn. Staff redirected her to put popcorn away until after dinner. [Client #2] became agitated, she headed toward her room and struck her roommate on her way."</p> <p>During an interview on 9/24/14 at 3:35 PM, the QIDP (Qualified Intellectual Disabilities Professional) indicated she was unaware client to client abuse was required to be reported and investigated when there was no sign of injury. The QIDP indicated no further documentation was available for review to indicate the two incidents were reported to a state agency and/or investigated.</p> <p>During an interview on 10/15/14 at 2:35 PM, the facility administrator indicated it</p>			

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W000153	<p>is the facility policy all incidents of client to client abuse are to be reported and investigated.</p> <p>On 9/25/14 at 11:35 PM, a review of the facility policy on "Prohibition of Violations of Individual Rights" (undated) indicated "In order to protect the general welfare of persons served, [facility] strictly prohibits the abuse of any form, neglect, exploitation or mistreatment of any individual or violation of an individual's rights by employees or agents delivering services on behalf of the agency."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported</p>				

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	<p>immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, the facility failed to ensure client to client abuse was reported to the administrator and to the state agency (BDDS-Bureau of Developmental Disabilities Services) for 1 of 4 sampled clients (#2) in accordance with state law.</p> <p>Findings include:</p> <p>On 9/24/14 at 12:32 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 2/14/14 to 9/24/14 were reviewed and facility investigations from 9/24/13 to 9/24/14 were reviewed. The review indicated no BDDS report for client to client abuse for Client #2.</p> <p>On 9/24/14 at 2:15 PM, record review indicated a "Psychologist's Statement" dated 9/10/14 which indicated "on 9/5/14 [Client #2] just started her menses during day program as she was wearing borrowed clothes. She became agitated walking out of the classroom wanting something out of the vending machine and swung her lunch box hitting another consumer." Record reviewed indicated a "Psychologist's Statement" dated 9/3/14 which indicated "[Client #2] had a good</p>	W000153	<p>Toensure that established agency policies and procedures for incident reportingis being implemented and executed as written, the following corrective action(s)will be implemented:</p> <p>1) All staff located at 1730 OsageDrive (Osage group home) will be re-trained on the agency Personnel Policiesand Procedures, Policy III:13: Incident Reporting. Completed Record ofTrainings will be obtained and submitted upon completion of training. <i>Referto Appendix A for Record of Training form to be used.</i></p>	12/12/2014

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W000289	<p>day until after going to movies, when she returned home she still had a partial tub of popcorn. Staff redirected her to put popcorn away until after dinner. [Client #2] became agitated, she headed toward her room and struck her roommate on her way."</p> <p>During an interview on 9/24/14 at 3:35 PM, the QIDP (Qualified Intellectual Disabilities Professional) indicated she was unaware client to client abuse was required to be reported when there was no sign of injury. The QIDP indicated no further documentation was available for review to indicate the two incidents were reported to a state agency.</p> <p>During an interview on 10/15/14 at 2:35 PM, the facility administrator indicated it is the facility policy all incidents of client to client abuse are to be reported to BDDS.</p> <p>9-3-2(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must</p>			

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	<p>be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based on interview and record review for 1 additional client (#5), the facility failed to ensure systematic interventions in the Behavior Support Plan (BSP) were specifically written in the BSPs.</p> <p>Findings include:</p> <p>On 9/24/14 at 12:32 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 2/14/14 to 9/24/14 and investigations from 9/24/13 to 9/24/14 were reviewed. A BDDS report dated 7/22/14 indicated "on 7/21/14 during a conversation with Residential Manager (sic) a staff person brought up that [DSP (Direct Support Professional) #3] had taken a plate of food from [Client #5] and then he became upset and threw water on her. She then, threw water on him. The time and date has yet been undetermined at this time." The report indicated "the residential manager reported this to the QDDP (Qualified Developmental Disabilities Professional)." The report indicated DSP #3 had been suspended pending an investigation.</p> <p>The investigation dated 7/21/14 indicated</p>	W000289	<p>To ensure that the Behavior Support Plan for Client #5 clearly states all systematic interventions, the following corrective action(s) will be implemented: 1) The Qualified Intellectually Disabilities Professional (QIDP) will revise the Behavior Support Plan to include verbal prompts to be used before utilizing deep pressure techniques and step by step instructions on how and when to apply deep pressure techniques. 2) All direct care staff working at 1730 Osage Drive (Osage group home) and day programming will be trained on the revised BSP for Client #5. Record of trainings for Individua lSpecific training will be submitted once training is complete. <i>Refer to Appendix G for record of training form to be used.</i></p>	12/12/2014			

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	<p>an interview in which DSP #3 was asked whether Client #5 had ever thrown water on her. DSP #3 indicated the incident "was months ago." DSP #3 indicated Client #5 "got mad because they had been doing takedowns on him for [day program] and [House Manager (HM)] let him bring home the stuff on the string b/c (because) he was obsessing so when it came time for dinner he wouldn't eat b/c he was sitting playing with these things. So I went up to him and got the beads off the table b/c had to get him to eat." The interview indicated DSP #3 took his other item "when he wasn't looking...". The interview indicated Client #5 "still had one on his fork so I pulled that one off. As I was walking away he threw his cup of water. I had turned away and [Client #5] took both hands and smacked me on my front and on my back. He slammed me a good one and [DSP #8] said I've never seen him act like that." The interview indicated DSP #3 "said he was mad b/c of the beads. I think [HM] was the HM and I said maybe next time we can leave those beads at [day program] and not let him bring them home and she said well I didn't want to do another take down b/c he'd already had enough that week." DSP #3 was asked whether DSP #3 had "ever thrown water back on him?", DSP #3 indicated "I did that night but I got him right here on</p>			

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	<p>the chest b/c he was banging his head on the refrigerator and he was biting so I was trying to get him out of that behavior by shocking him. It was a little bit. Then later I went and bathed him and it was fine."</p> <p>The investigation "Summary of Events" dated 7/23/14 indicated "on Monday, July 21st, it was reported that staff member [DSP #3] threw water on consumer [Client #5]. After further investigation, it has been determined that there may be 2 similar incidences. One of two occurred on Friday, July 18th and it was reported by staff [DSP #9] that [Client #5] was at the summary indicated "in conclusion, the writer feels that the alleged abuse of throwing water on [Client #5] is substantiated as the alleged abuser did in fact admit to throwing the water at [Client #5]. It is recommended that staff [DSP #3] be terminated as she has violated [facility]'s Prohibition of Violations of Individual Rights. It is also being recommended that all staff at the [group home] house be retrained on incident reporting as well as [Client #5]'s ISP (Individual Support Plan)."</p> <p>On 9/24/14 between 10:45 AM and 11:50 AM, the facility day program observation was conducted. During an interview at 11:11 AM, with the Team Lead, L-QIDP</p>			

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	<p>and the day program administrator, the Team Lead (TL) stated Client #5 had a "deep pressure technique" used to calm him. The TL stated Client #5 would "ask" for the deep pressure technique when he had agitation to prevent "aggressive behavior." The TL indicated Client #5 would lie on a mat on the floor independently when he wanted the deep pressure technique. The QIDP stated staff "never put him in that position." The QIDP stated some staff may use the "old term" of "take downs" to describe the deep pressure technique but indicated Client #5 was able to indicate when he wanted out of the deep pressure technique and therefore, the deep pressure technique was not considered an "take down" or a restraint. The L-QIDP (Lead-Qualified Intellectual Disabilities Professional) indicated communication notes are shared with the residential program to inform them of any incidents regarding Client #5. The TL indicated staff document Client #5's behaviors on a tracking sheet which is reviewed at the end of each month. The day program Administrator indicated any restraints of Client #5 would have been reported in a BDDS report and she would have had to review the report. The Administrator indicated she was unaware of any recent BDDS reports for Client #5.</p>			

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	<p>On 9/24/14 at 11:35 PM, day program communication notes from 7/1/14 to 9/2/14 for Client #5 indicated the following communication notes (not all inclusive):</p> <p>7/2/14 at 11AM - "[Client #5] was switching out objects every minutes (sic) or so, and staff gave him a magazine and let [Client #5] know that staff would be setting his time for 15 mins. (minutes) before he could chose another object. [Client #5] wanted another object 3 mins into his time and staff explained he had to wait 10 more mins and [Client #5] went and got object anyway and threw it across the room and bit his arm. Staff then performed a deep pressure technique to help him relax."</p> <p>7/3/14 at 1PM - "[Client #5] went outside for a fire drill and when it was time to go back into the classroom [Client #5] would not go. Staff prompted [Client #5] 3 times and on the 3rd time he started to come in and stopped at the door and threw his cheetos and bit his arm. So staff had to (sic) 2 person carry him to a safer area and there performed a deep pressure technique and [Client #5] came inside the building."</p> <p>7/7/14 at 11AM - "...[Client #5] became irritated and threw them (objects) and bit</p>				

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	<p>himself on the arm. So staff performed a deep pressure technique on [Client #5] and it seemed to calm him down."</p> <p>7/18/14 at 2:30 PM - "...staff prompted [Client #5] to return book, he declined and became agitated and threw the book across the room and started biting himself on the left wrist/arm. Staff performed a 'deep pressure technique' on [Client #5] and were successful in helping him relax."</p> <p>7/73/14 at 1 PM - "...began biting himself (Client #5) and hitting himself on the head and staff redirected [Client #5] to stop and he continued so staff performed a 'deep pressure technique' and he relaxed."</p> <p>7/31/14 at 2PM - "[Client #5] was standing behind another consumer when that consumer hit [Client #5] and he stood there for a minute and then began hitting that consumer repeatedly on the top of his head. So staff performed a deep pressure technique and he relaxed."</p> <p>8/11/14 (no time indicated) - "[Client #5] got into cabinet and was getting multiple objects out and would not respond to redirection of staff and refused to give back property and he bit himself on the arm and hit himself on the the head 1x</p>				

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	<p>(time) so staff performed a 'deep pressure technique' on him and calmed down for a little while until he stole a pencil from another consumer and refused to give it back so staff performed a 'deep pressure technique' on him. [Client #5] bit himself multiple times and had to be cleaned up by nursing while staff performed the 'DPT (deep pressure technique) on him. After that [Client #5] complied with staff...".</p> <p>8/12/14 at 1PM and 1:30PM - "[Client #5] refused to get out of the middle of the hallway and started biting himself and threw his magazines so staff used a deep pressure technique."</p> <p>8/19/14 at 1:00PM - "[Client #5] refused to give staff back an extra fork he had and when staff tried to retrieve it he became physically aggressive towards staff and started banging his head on the cabinet. Staff performed a 'deep pressure technique' on [Client #5]...".</p> <p>8/29/14 at 2:00PM - "[Client #5] had a plate and a nurse took the plate from him and [Client #5] bit her on her chest area and then [Client #5] started banging his head on the wall and biting his own arm so staff had to perform a 'deep pressure technique' and [Client #5] calm down and stopped behavior."</p>						

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	<p>On 9/24/14 at 11:40 PM during an interview, the day program Administrator reviewed Client #5's communication log and indicated it did appear staff were not following Client #5's Behavior Support Plan. The day program Administrator indicate staff needed to be retrained on Client #5's deep pressure technique and his BSP should be clarified. The day program Administrator indicated the communication notes might indicate Client #5 was not initiating the 'deep pressure technique' to calm himself as the Team Lead indicated.</p> <p>On 9/24/14 at 2:35 PM, Client #5's record review indicated a Behavior Support Plan (BSP) dated November 2013 which included the target behaviors of property destruction, self injurious behavior, and physical aggression. Client #5's BSP indicated in the "Physical Intervention" section "request that [Client #5] stop engaging in physically aggressive behavior. Have two trained staff available for if the behavior escalates to the need for a 2 person floor deep pressure technique. While the deep pressure technique happens, have a third staff remove any objects that were a target or a trigger for [Client #5]'s behavior. After [Client #5] calms down, you do not want to have another behavior</p>				

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	<p>over the same item or issue. Staff will be able to tell that [Client #5] has calmed by his muscles relaxing and his breathing returning to a more relaxed rhythm. Ask [Client #5] if he is calm and then guide him toward his room or another quiet area. [Client #5] is visibly relieved after a deep pressure technique due to deep pressure calming." Client #5's BSP indicated "Note: Please keep the safety of [Client #5], the other consumers, and staff in mind when intervention becomes necessary. Use approved CPI (crisis prevention intervention) techniques and 2 person floor deep pressure technique for intervention." Client #5's BSP indicated "Criteria and guidelines for 2 person floor deep pressure technique: Deep pressure technique is to be used only:</p> <p>"* When [Client #5] is already on the floor/ground</p> <p>* When his actions cannot be blocked with reasonable safety</p> <p>* When he is in immediate jeopardy of injuring himself or others through self-injurious or physically aggressive behavior."</p> <p>Client #5's BSP indicated this technique "Requires 2 trained staff" and has the following steps:</p>			

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	<p>"1. [Client #5] must be lying on his back, face up.</p> <p>2. Protect his head with his helmet.</p> <p>3. Place [Client #5]'s arm at 90-degree angle at shoulder level, flat on the ground. Do not bend or twist arms or hands.</p> <p>4. Place your hand on his shoulder, the side of the body you are on.</p> <p>5. Do not talk to him or to each other, so as to not verbally reinforce SIB (self-injurious behavior) or physically aggressive behavior.</p> <p>6. When he is kicking his legs, each staff person extends their body down next to [Client #5] (not on top of him) and covers his legs only with their interior leg, crossing their own leg above [Client #5]'s knee and below [Client #5]'s knee so that no pressure is placed on his knee and so that his groin area is untouched.</p> <p>7. When he is calm (no longer attempting SIB or physical aggression), assist him up if needed and let him relax in his room."</p> <p>On 9/24/14 at 2:57 PM during an</p>			

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W000368	<p>interview, the residential QIDP indicated Client #5 did not use a mat for deep pressure technique in the residential setting. The QIDP stated Client #5 would "normally" be in "his room" or in the "living room" when he would request the deep pressure technique. The QIDP stated usually Client #5 would already be lying down and staff "would add pressure." The QIDP stated she knew "when we first developed (Client #5's BSP) it was more of a take down." The QIDP stated "yes, I can see the need to clarify" Client #5's BSP.</p> <p>9-3-5(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed to ensure medications</p>	W000368	To ensure that all medications are administered as prescribed by physicians' orders, the following corrective action(s)	12/12/2014

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	<p>were administered as prescribed by physicians orders for 2 of 4 sampled clients (#2, #4) and 2 additional clients (#6, #7).</p> <p>Findings include:</p> <p>On 9/24/14 at 12:32 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) from 2/14/14 to 9/24/14 were reviewed. A BDDS report dated 2/14/14 indicated "[Client #4] went on an outing with his family at 5pm. [Client #4]'s 8pm medications were sent for his family to administer per his mother's request. [Client #4] was returned to his home at 10pm. It was later noted that [Client #4] had not been given two of the medications sent with him for his outing. The missed medications were Divalproex ER (anticonvulsant, extended release) 500mg (milligrams) tab - take one tablet BID (twice daily), and Desmopressin (for excessive urine passage, bedwetting) .2mg tab - take 1 tab @ (at) HS (bedtime)."</p> <p>A BDDS report dated 2/17/14 indicated "staff working with [Client #3], DSP (direct support professional) [#4], failed to administer his 8pm medications as follows: Clonidine (hypertension) .1mg (milligram) tab, Abilify (antipsychotic)</p>		<p>will be implemented: 1) All direct care staff located at 2333 1730 Osage Drive (Osage group home) will be re-trained on the agency medication administration policy Completed Record of Trainings will be obtained and submitted upon completion of training. Refer to Appendix F for Record of Training forms to be used. It is the intent that this training will prevent future medication errors for the clients affected as well as all other clients residing in the home. To ensure staff compliance and that training was effective, the following corrective actions will be implemented: All Residential Nurses will be required to develop systems in which they a) conduct weekly reviews of all medication records for all clients residing in the home b) observe staff on a routinely basis to ensure that all medications are administered according to physician's orders and agency policy. In the event of a medication error, the Residential Nurse will immediately review all medication records for all clients residing in the home, not just those that are affected, to ensure that no other medication errors have occurred, that staff fully comprehend and understand directives for medication administration as stated on the MAR (medication administration record), and that medications are being</p>				

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	<p>30mg tab, Fluvoxamine (antidepressant) 100mg tab x (times) 3, Lamotrigine (anticonvulsant) 200mg tab x 2, Trazodone (antidepressant) 200mg x2, Desmopressin (controls thirst and excessive amounts of urine) .2 mg tab x 2, Docqlace (stool softener) 100 mg cap, Propranolol 60mg ER cap."</p> <p>A BDDS report dated 3/17/14 indicated "staff working with [Client #3], [DSP #3], administered another supported individual's 4pm medications to [Client #3] in error." The report indicated "the incorrect medications were: Carbamazepine ER (anticonvulsant, extended release) 200mg (milligrams) tablet x 2 (400mg) and Olanzapine (antipsychotic)10mg - 1/2 tablet (5mg)." The report indicated staff immediately contacted the nurse. The report indicated the facility nurse "phoned [Client #3]'s PCP (primary care physician) [Doctor]. [Doctor] instructed to hold [Client #3]'s routine 4pm medications, take vitals every hour for six consecutive hours, to call the nurse if B/P (blood pressure) were (sic) below 0/60, pulse below 55, or any s/s (signs or symptoms) of confusion, nausea, vomiting, or seizure activity." The report indicated "as a precautionary measure, [facility Nurse] sent [Client #3] to [hospital] via ambulance at 10pm due to a low pulse rate of 45-48 beats per</p>		administered according to physician's orders and agency policy.				

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	<p>minute." The report indicated Client #3 was released the next morning at 11:33 AM and was able to return to normal activities.</p> <p>A report dated 3/23/14 indicated "[Client #4] left the [group] home approx. (approximately) 10:30 AM on Friday 3/21/2014 for a visit with his parents for the weekend. He returned home on Sunday 3/23/2014 at approx. 3:00 pm with extra pills." The report indicated Client #4 must have missed Desmopressin 0.2 mg 1 tablet (used to prevent excess urine passage, bed wetting), Benazepril 20mg 1 tab (hypertension) and Divalproex ER (anticonvulsant, extended release). The report indicated "[Client #4]'s physician was contacted by the nurse and the physician instructed to monitor vitals."</p> <p>A report dated 3/31/14 indicated "[Client #6] returned to her SLG (supported living group home) home from a stay with her guardians/parents [name of guardians] on 3/23/14. At that time, [guardian] reported to [DSP (direct support professional) #2], that she had left [Client #6]'s medications at home and she would bring them to her later in the week and to call if [Client #6] were to need the medication sooner." The report indicated a communication error caused Client #6</p>			

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	<p>to miss "the following medications from the dates 3/23/14 through 3/28/14:</p> <p>Refresh PM OP Ointment - Apply to both eyes every night at bedtime Salicylic Acid 6% Lotion - Apply to affected area(s) on skin every morning Carbamoxide 6.5% OT Solution - Instill 1 drop in each ear every night at bedtime Urea 40% Cream - Apply to skin all over every night at bedtime."</p> <p>A report dated 4/16/14 indicated "on Tuesday, April 15, 2014, [Client #7] left his SGL (supported group living) home for an overnight stay with his [sister] at 4:30pm. [Client #7]'s needed medications were pack (sic) and double checked per company protocol for accuracy." The report indicated "[Client #7] returned home early morning on Wednesday, April 16, 2014. Upon checking in his meds, staff working with [Client #7] [DSP (direct support professional) #1] noted that [Client #7] had not been given his 8pm medication Cetirizine (allergy medication) 10mg tablet on April 15, 2014." The report indicated the facility nurse "was notified of the medication error immediately by house manager [HM]."</p> <p>During an interview on 10/15/14 at 2:35 PM, the facility administrator indicated</p>						

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	staff are expect to administer client medications without error. 9-3-6(a)				