

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G274	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2011
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NAME OF PROVIDER OR SUPPLIER PUTNAM COUNTY COMPREHENSIVE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 BLOOMINGTON GREENCASTLE, IN46135
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: October 3, 4, 5, 6, and 7, 2011.</p> <p>Facility number: 000794 Provider number: 15G274 AIM number: 100234880</p> <p>Surveyor: Brenda Nunan, RN, Public Health Nurse Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/2/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0125	<p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on interview and record review, the facility failed to allow 1 of 3 sampled clients (client #1) independent access to her home and personal items by restricting client #1 to a room away from other clients and without access to her personal</p>	W0125	<p>Client #1's Behavior Support Plan has an addendum dated 10-8-11 to address the criteria for removing the restricted access to her home and personal items. Staff were trained on the addendum on 10-11-11. Approval was obtained from her Guardian</p>	11/14/2011

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>belongings. The facility failed to indicate how the client's restricted access to her home and personal items would be removed from the Behavior Support Plan.</p> <p>Findings include:</p> <p>The Indiana Division of Disability and Rehabilitative Services incident reports were reviewed on 10/03/2011 at 1:25 p.m.</p> <p>An incident report, dated 02/02/2011 at 12:00 a.m., indicated, "...[Client #1] tore the protective cover off of her mat, she tore her clothes off several times, and continually punched at the windows and walls...She was banging on the bathroom window hard in an attempt to hurt herself and escape and had to be placed in a CPI (Crisis Prevention Intervention) hold to keep her from hurting herself...Staff will continue to follow her behavior support plan as written and keep her in isolation until she can remain aggression free for at least 72 hours...."</p> <p>An incident report, dated 02/13/2011 at 3:00 p.m., indicated, "...[Client #1] then dropped to the floor and began crawling towards staff trying to grab at her feet...proceeded to urinate on herself, while placing her hands down her pants and smelling them...she has been placed in isolation per recommendation of her</p>		<p>and HRC 10-10-11. Staff Meeting Agenda, Staff meeting minutes and signature page for 10-11-11 staff meeting attached. QDDP has reviewed all client records to see if we inadvertently failed to include a means/criteria by which a restrictive measure may be removed from a BSP. As of November 14, 2011 Client #1's Behavior Support Plan has an addendum striking the general strategy for severe aggression periods, ie the use of an isolation area. A staff meeting will be held on November 14, 2011 where staff were trained on the addendum to Client #1's BSP. November 14, 2011 Staff meeting agenda, minutes and signature page attached.</p>		

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	<p>Behavioralist...She must go 5 days without aggression before she can return to her room...."</p> <p>An incident report, dated 05/11/2011 at 1:30 p.m., indicated, "...She (client #1) tried to elope...cried and whined, pushed staff...Her shoes were requested to be given to staff, she also was asked for her sweatshirt, and glasses in order to avoid usage of these things as weapons...[Client #1] was not cooperative about shoes, shirt, glasses; however, she did allow staff to take them...."</p> <p>During an interview on 10/03/2011 at 1:15 p.m., the QDDP (Qualified Developmental Disabilities Professional) indicated the only items in the room when it was used for isolating client #1 were the chair and ottoman and client #1's mattress. The QDDP indicated the blinds remained on the window. He stated, "The relaxation room is no longer used." He indicated the room had been used for client #1 when she displayed severe physical aggression. The QDDP indicated the door to the room was closed, but not locked when the client was in the room. He indicated there were times when staff was not present in the room with client #1, but remained in the adjacent room and the door to the relaxation room was partially open. The QDDP indicated the</p>				

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	<p>isolation room was still written in client #1's current behavioral support plan as an intervention when needed for severe physical aggression. He indicated the intervention had not been implemented since July 2011.</p> <p>During an interview on 10/04/2011 at 9:00 a.m., DSP (Direct Support Professional) #7 indicated the isolation room was used in the past when client #1 was agitated. She stated, "[Client #1] would have to stay in the relaxation room if she was hitting other clients."</p> <p>During an interview on 10/04/2011 at 10:20 a.m., the House Manager indicated the isolation room had been used in the past when client #1 had severe physical aggression. The House Manager indicated client #1 was required to be free of behaviors for 72 hours before she was allowed to reintegrate into other parts of the home She stated, "[Client #1] remained in the room until she went 72 hours without behaviors." The House Manager indicated client #1 left the group home to attend day services, then returned to the isolation room when she returned home from the work center.</p> <p>During an interview on 10/04/2011 at 1:00 p.m., the RD (Residential Director) indicated staff were usually present in the</p>			

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	<p>isolation room when client #1 had been placed in the room. The RD indicated staff could monitor client #1 from the adjacent room if the client was sleeping or calm. She indicated client #1 was restricted from accessing areas outside the isolation room when she was actively aggressive to ensure safety of the other clients. The RD indicated client #1 had been in the isolation room for periods of time exceeding 1 hour.</p> <p>Attempts were made on 10/03/3011 at 4:25 p.m. to engage client #1 in causal conversation. Client #1 began to display hand wringing and indicated she did not want to have a conversation. Additional attempts to engage client #1 in conversation were not successful on 10/04/2011 between 7:00 a.m. and 11:30 a.m. and on 10/05/2011 at 3:45 p.m.</p> <p>Client #1's record was reviewed on 10/05/2011 at 11:05 a.m.</p> <p>A BSP (Behavioral Support Plan), dated, 04/21/2011, indicated, "<u>General Strategies</u>, <i>Severe Aggression Periods</i>-During periods of severe and ongoing physical aggression, [client #1] shall be isolated from other clients in the group home or workshop to protect her safety and that of other clients until the episodes are reduced in both frequency</p>						

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	<p>and severity. In addition, [client #1] shall lose access to various objects that may be used aggressively (shoes/slippers, objects/items she is holding, activity bag) until de-escalation is achieved...[Client #1] must have 1:1 (one on one) staff supervision at touch distance during all periods of physical aggression, and two staff must escort her to common areas of the home or workshop...Door alarms shall be installed at her home to alert staff of potential elopement...An audio monitoring device shall be placed in [client #1's] bedroom to enable closer supervision of [client #1] so as to assure her health and safety and that of others during aggressive or psychotic episodes...Criteria for reintegration at home or workshop include: 1. Absence of physical aggression for a period of 72 hours and absence of precursors (agitation, verbal aggression, or obsessive talk) for at least 24 hours..." The BSP did not indicate how the client's restricted access to her home and personal items would be removed from the Behavior Support Plan.</p> <p>A tracking form, titled, "Reintegration Documentation Step 1" indicated the isolation room had been used beginning 07/04/2011 at 5:30 p.m. through 07/15/2011 at 9 a.m. The QDDP stated, "The 72 hour period of isolation had to be</p>			

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W0252	<p>restarted when [client #1] displayed behaviors." He indicated the client progressed to "step 2" when she went 72 hours without precursors for at least 24 hours.</p> <p>An undated facility policy, titled, "USE OF TIME OUT," was reviewed on 10/06/2011 at 11:25 a.m. The policy indicated, "...Time out should not be employed for a period exceeding ten (10) minutes and only under the supervision of the direct service staff. A written record of time out will be kept at the residence. This record will include length of time, reason for time out, other methods attempted before time out was employed, and direct service staff responsible for administering time out procedure...."</p> <p>9-3-2(a)</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on interview and record review, the facility failed to ensure data collection at the recommended frequency for 10 of 32 training programs reviewed for measurable skills improvement for 1 of 3 sampled clients (client #2).</p> <p>Findings include:</p>	W0252	Residential Director met with QDDP about staff not documenting. Upon review of Clt #2's tracking it was found that 3 days not tracked were a result of her being on Thereputic Leave. Also noted that the Self Care Skills Tracking from August and September show the tracking for bathing, teeth brushing, hygiene and grooming which	11/14/2011	

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	<p>Client #2's record was reviewed on 10/06/2011 at 9:47 a.m.</p> <p>An Individual Program Plan (IPP), dated 10/18/2010, indicated an objective for "complete physical therapy as recommended by her physical therapist," indicated data was to be collected five times weekly. A review of data, indicated data was not collected on August 1, 3, 4, 5, 6, 7,10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 23, 24, 26, 27, 29, 2011. Data was not collected on September 1, 2, 3, 4, 5, 7, 9, 11, 12, 13, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 29, 30, 2011. Review of October data indicated data was not collected on October 1, 2, 3, 4, 2011.</p> <p>An objective for cleaning glasses indicated glasses should be cleaned five times weekly. Review of data indicated the objective was not completed August 1, 4, 5, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 24, 26, 2011. Data was not collected September 1, 2, 3, 5, 9, 13, 15, 16, 17, 18, 19, 21, 22, 24, 25, 26, 28, 2011. Review of October data indicated data was not collected October 1, 2, 4, 2011.</p> <p>An objective for washing body "appropriately" five times per week was not completed August 7,11, 12, 13, 14,</p>		<p>includes cleaning her glasses. See attached tracking for August and September. Staff failed to transfer the information to the IPP tracking in these cases. It was determined that there is some problem at times with staff failing to document. It was decided that failing to document would be treated in the same manner as medication errors and be subject to the same disciplinary action. A policy has been developed and was reviewed with staff on 10-11-11. Upon review of all six consumers tracking it is obvious that tracking has improved dramatically since the 10-11-11 staff meeting and implementation of the Policy on Documentation of Active Treatment. The Policy on Doucmentation of Active Treatment, Staff Meeting Agenda, Minutes and Signature page attached. Furthermore a staff meeting was held on November 14, 2011 at which time The Policy on Active Treatment was again reviewed and discussed. November 14, 2011 Satff meeting agenda, minutes and signature page attached.</p>		

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	<p>15, 18, 19, 20, 24, 26, 2011, Data was not collected September 1, 2, 4, 5, 9, 11, 12, 15, 16, 25 or October 3, 2011.</p> <p>An objective for learning her address indicated data was to be collected five times weekly. Review of data indicated data was not completed August 4, 5, 7, 11, 12, 13, 14, 19, 20, 24, 26, 31, 2011, September 1, 2, 3, 5, 9, 12, 15, 16, 22, 23, 24, 25, 26, 30, 31, and October 2, 2011.</p> <p>An objective for exercise at least 30 minutes four times weekly was not completed August 3, 4, 5, 6, 7, 11, 12, 13, 14, 18, 19, 20, 21, 23, 24, 25, 26, 27, 28, 2011. Data was not collected September 1, 2, 3, 5, 12, 13, 15, 16, 17, 18, 19, 20, 22, 23, 24, 26, 30, 31, 2011.</p> <p>An objective for brushing teeth and gums "appropriately" indicated data should have been collected four times per week. Review of data indicated no data was collected August 9, 11, 12, 13, 14, 15, 20, 24, 26, 2011, September 1, 2, 3, 5, 7, 11, 15, 16, 24, 30, 31, 2011.</p> <p>An objective for identifying her medication was to be collected four times weekly. Data was not collected August 4, 5, 7, 11, 12, 13, 14, 19, 20, 24, 26, 2011. There was no documentation of data on September 1, 2, 3, 5, 9, 12, 15, 16, 22, 23,</p>			

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	<p>24, 25, 26, 30, 31, 2011 or October 2, 2011.</p> <p>An objective to learn three letter words four times weekly was not completed August 4, 5, 7, 11, 12, 13, 14, 19, 20, 24, 26, 2011, September 1, 2, 3, 5, 9, 12, 15, 16, 23, 24, 26, 30, and October 2, 2011.</p> <p>An objective for learning the value of coins four times weekly was not completed August 4, 5, 7, 10, 11, 12, 13, 14, 19, 20, 24, 26, 2011, September 1, 2, 3, 5, 9, 11, 12, 15, 16, 22, 23, 24, 25, 26, 30, 31, 2011 and October 2, 2011.</p> <p>An objective for making a pitcher of iced tea five times weekly was not completed August 1, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15, 18, 19, 20, 21, 23, 24, 26, 27, 2011, September 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 26, 28, 30, 2011, and October 1, 2, 4, 2011.</p> <p>During an interview on 10/06/2011 at 11:45 a.m., the QDDP (Qualified Developmental Disabilities Professional) indicated the programs should have been implemented at the frequency listed on the program plan.</p> <p>9-3-4(a)</p>				

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W0261	<p>The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.</p> <p>Based on interview and record review, the facility failed to include a client member as appropriate on the specially constituted committee (Human Right Committee) for reviews of 3 of 3 sampled clients reviewed/monitored for risk to client rights and protections (clients #1, #2, and #3).</p> <p>Findings include:</p> <p>HRC (Human Rights Committee) minutes for 2010-2011 for clients #1, #2, and #3 were reviewed on 10/04/2011 at 3:30 p.m. The minutes indicated members included 5 facility staff, parents and legal guardians, and 4 persons with no controlling interest in the facility.</p> <p>During an interview on 10/06/2011 at 11:45 a.m., the QDDP (Qualified Developmental Disabilities Professional) indicated he was not aware that clients should be part of the committee.</p> <p>9-3-4(a)</p>	W0261	<p>The Clients held elections in September to elect a consumer representative to Human Rights Committee (HRC). The October HRC meeting was cancelled due to lack of a quorum. The client representative will be included at all future meetings of HRC. The Human Rights Committee policy has been updated to reflect a consumer, or consumer representative. Residential Director met with QDDP and reviewed all HRC policy and procedures. Human Rights Committee Policy attached.</p>	11/08/2011

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W0262	<p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on record review and interview, the facility failed to ensure its Human Rights Committee (HRC) deliberated and discussed plans that included restrictive interventions prior to approving the use of medications to control behavior, isolation, and restraints for 1 of 3 sampled clients reviewed for restrictive program plans (client #1).</p> <p>Findings include:</p> <p>HRC (Human Rights Committee) minutes were reviewed on 10/04/2011 at 3:30 p.m.</p> <p>HRC approval form, dated 04/20/2011, requesting approval of client #1's Behavior Support Plan, dated 04/21/2011, indicated 2 committee members approved the plan via personal contact and 7 members approved the plan via email correspondence.</p> <p>HRC approval form dated, 05/17/2011, requesting approval for increasing client #1's Clozapine (an antipsychotic</p>	W0262	<p>Effective immediately we PCCS will begin using a conference call system amongst HRC memebers when face to face meetings are not possible. Historically PCCS has held HRC meetings, made phone contacts and most recently utilized e-mail for plan reviews, approvals and monitoring of individual programs designed to manage inappropriate behavior when face to face contact was not available as a timely response to consumer needs. E-mail contact has been the most effective means of maintaining contact due to conflicting schedules and diffuculty in finding qualified individuals to volunteer to serve on the Human Rights Committee. In order to facilitate dialog amongst members we are now providing pros and cons or risk benefits of restrictive techniques, medications to control behavior, isolation and restraints. In conjunction with providing risk/benefit information we will begin using a conference call system. This should further facilitate dialog amongst HRC members. QDDP will also begin</p>	11/23/2011

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	<p>medication) from 100 mg (milligrams) daily to 150 mg, indicated 2 committee members approved the plan via personal contact and 7 members approved the plan via email correspondence.</p> <p>HRC approval form, dated 06/14/2011, requesting approval for increasing client #1's Clozapine from 150 mg daily to 200 mg daily, indicated 2 committee members approved the plan via personal contact and 6 members approved the plan via email correspondence.</p> <p>HRC approval form, dated 09/08/2011, requesting increasing client #1's Pristiq (an antidepressant) from 50 mg to 100 mg, indicated 1 committee member approved the plan via personal contact and 7 members approved the plan via email correspondence.</p> <p>During an interview on 10/04/2011 at 3:30 p.m., the QDDP (Qualified Developmental Disabilities Professional) indicated emails were used for correspondence since it was difficult for committee members to attend meetings. The QDDP indicated the committee did not discuss and deliberate risks versus benefits for the behavioral interventions.</p> <p>9-3-4(a)</p>		utilizing a newly developed checklist "Human Rights Assessment Checklist" with any new or revised medication to control behavior, restrictive technique, isolation or restraint. This should further promote dialog. PCCS will continue to identify potential HRC members with experience and/or vested interest in advocating for the rights of the consumers. Every attempt will be made to conduct face to face meetings when possible. See attached checklist and HRC Process for Deliberations and Electronic Approvals.		

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W0263	<p>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. Based on record review and interview for 1 additional client (#4), the facility failed to obtain written informed consent from client #4's legal guardian prior to implementing use of an audio monitor in her bedroom.</p> <p>Findings include:</p> <p>During observations on 10/03/2011 at 3:25 p.m., an audio monitor was observed in client #4's bedroom during a tour provided by the client of her home. Client #4 shared a bedroom with client #1.</p> <p>Client #1's BSP (Behavior Support Plan), dated 04/21/2011, was reviewed on 10/05/2011 at 11:05 a.m. The BSP included an audio monitoring device in the bedroom that was shared with client #4.</p>	W0263	<p>Due to an oversight by staff informed consent from client 4's guardian was not obtained prior to implementing use of an audio monitor in her room. This situation occurred when two clients decided they wanted to switch bedrooms. Direct Care staff made the switch over a weekend and management/QDDP didnt catch the audio restriction affecting the new roommate. Since then informed consent has been obtained from client 4's guardian, dated 10-7-2011. A Human Rights Assessment Checklist has been developed and will be completed anytime a right is going to be restricted. The form indicates others which may be impacted by the restriction to ensure informed consent is obtained from them or their guardian/advocate. The QDDP will complete the Checklist and</p>	11/08/2011

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	<p>Client #4's record was reviewed on 10/06/2011 at 12:10 p.m. The record did not include documentation of guardian approval for the audio monitor in client #4's bedroom.</p> <p>During an interview on 10/06/2011 at 12:15 p.m., the QDDP Qualified Developmental Disabilities Professional indicated he had not contacted client #4's legal guardian to obtain written consent for the monitoring device.</p> <p>9-3-4(a)</p>		<p>obtain the necessary approvals.</p>		
W0292	<p>Placement of a client in a time-out room must not exceed one hour.</p> <p>Based on record review and interview, the facility failed to ensure client #1 did not exceed one hour in an isolation room.</p> <p>Findings include:</p> <p>The Indiana Division of Disability and Rehabilitative Services incident reports for incidents beginning January 28, 2011-September 22, 2011 were reviewed on 10/03/2011 at 1:25 p.m.</p> <p>An incident report, dated 02/02/2011 at</p>	W0292	<p>As of November 14, 2011 Client #1's Behavior Support Plan has an addendum striking the general strategy for severe aggression periods, ie the use of an isolation or Time out room. Staff were trained on Client # 1's BSP addendum on November 14, 2011. It was further explained to staff that we do not have a time out room in our group homes. In the event that a client is exhibiting aggression or other disruptive behaviors staff are to suggest the client go to a quiet area in the home until they can regain their</p>	11/14/2011	

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	<p>12:00 a.m., indicated, "...Staff will continue to follow her behavior support plan as written and keep her in isolation until she can remain aggression free for at least 72 hours..." Client #1's record did not indicate the length of time she was kept in isolation.</p> <p>An incident report, dated 02/13/2011 at 3:00 p.m., indicated, "...she has been placed in isolation per recommendation of her Behavioralist...She must go 5 days without aggression before she can return to her room...." Client #1's record did not include the length of time she was kept in isolation.</p> <p>Client #1's record was reviewed on 10/05/2011 at 11:05 a.m.</p> <p>A Behavioral Support Plan, dated, 04/21/2011, indicated, "...General Strategies <i>Severe Aggression Periods</i>-During periods of severe and ongoing physical aggression, [client #1] shall be isolated from other clients in the group home or workshop to protect her safety and that of other clients until the episodes are reduced in both frequency and severity. In addition, [client #1] shall lose access to various objects that may be used aggressively (shoes/slippers, objects/items she is holding, activity bag)</p>		<p>composure. A quiet area can be any room in the house where they are not able to disrupt the routine of others in the home. The quiet area may be different for each client or each incident. Staff are advised to follow individual behavior support plans for de-esulation techniques. PCCS Time Out policy has been revised to allow for only 50 minutes in the event that we ever use a Time Out room. The criteria for a Time Out Room were reviewed along with revised Time Out Policy. It was stressed that we do not have a Time Out Room and no room in the house is to be treated as a Time Out Room. In the event that PCCS implements the use of a Time Out room at any time in the future it will meet the criteria outlined in the regulations and appropriate approvals and staff training will occur prior to implementation. November 14, 2011 Staff meeting agenda, minutes and signature page attached. PCCS has contacted the Maintenance Supervisor to remove the dryer vent from the corner of the rec room. This room will not be treated like a Time Out Room but as a recreation and or client training/Hab area.</p>		

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	<p>until de-escalation is achieved...[Client #1] must have 1:1 (one on one) staff supervision at touch distance during all periods of physical aggression, and two staff must escort her to common areas of the home or workshop...Door alarms shall be installed at her home to alert staff of potential elopement...An audio monitoring device shall be placed in [client #1's] bedroom to enable closer supervision of [client #1] so as to assure her health and safety and that of others during aggressive or psychotic episodes...."</p> <p>A "Reintegration Documentation Step 1" indicated the isolation room had been used beginning 07/04/2011 at 5:30 p.m. through 07/15/2011 at 9 a.m. The QDDP indicated client #1 could come out of room with her 1:1 staff when she was calm and other clients were not in the area of the home where client #1 accessed.</p> <p>During an interview on 10/03/2011 at 1:15 p.m., the QDDP (Qualified Developmental Disabilities Professional) indicated he could not recall specific number of hours that client #1 remained in the isolation room but indicated she was restricted to the isolation room longer than one hour when the intervention was implemented. He indicated the intervention had not been implemented</p>				

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W0293	<p>since July 2011.</p> <p>During an interview on 10/04/2011 at 10:20 a.m., the House Manager indicated the isolation room was used when client #1 had severe physical aggression. She stated, "[Client #1] remained in the room until she went 72 hours without behaviors."</p> <p>During an interview on 10/04/2011 at 1:00 p.m., the RD (Residential Director) indicated staff were present in the isolation room when client #1 had been placed in the room. The RD indicated staff could monitor client #1 from the adjacent room if the client was sleeping or calm. She indicated client #1 was restricted from accessing areas outside the isolation room when she was actively aggressive to ensure safety of the other clients. The RD indicated client #1 had been in the isolation room for periods of time exceeding 1 hour.</p> <p>9-3-5(a)</p> <p>Clients placed in time-out rooms must be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.</p> <p>Based on observation and interview, the facility failed to ensure a room used for isolating client #1 was free of hazardous</p>	W0293	The room used for isolating Client #1 was not intended to be a Time Out room but simply a place for	11/14/2011	

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	<p>conditions.</p> <p>Findings include:</p> <p>The room used for isolating client #1 during times she displayed severe physical aggression was observed on 10/03/2011 at 1:15 p.m. The room was located adjacent to the kitchen. The door to the room opened inward. A large "picture" window was covered with horizontal blinds that had cords dangling. A metal vent pipe was located in the Southeast corner of the room. A bathroom was located off the West side of the isolation room. The only access to the bathroom was via the isolation room. The bathroom had a small porcelain sink and a toilet. A small window was covered with fabric curtains. The door to the bathroom could be locked from the bathroom side. The room had a chair and ottoman, a TV/game system, and was used to store a cabinet from the kitchen during a remodel project. The room was also used to charge electric wheel chairs when not in use.</p> <p>During an interview on 10/03/2011 at 1:15 p.m., the QDDP (Qualified Developmental Disabilities Professional) indicated the only items in the room when it was used for isolating client #1 were the chair and ottoman and client #1's mattress. The QDDP indicated the blinds</p>		<p>Client #1 to go when her behaviors were violent and a danger to her self or others. This restrictive technique was developed at a point when all other options failed including multiple hospitalizations and medication changes. The team discussed mechanical restraints prior to using isolation and decided that giving client #1 her own space while she was actively aggressive and until she could demonstrate that she was capable of controlling her actions was the most dignified way to keep both client #1 and her housemates safe. This room has not been used for isolation since July 2011 and has been converted back to a rec/training area. It is agreed that there are potentially hazardous conditions in the area and the Maintenance man has moved the dryer vent located in one corner of the room. In the event that this area is ever to be used as a Time Out area all hazardous conditions will be addressed including but not limited to sharp corners and objects, uncovered light fixtures, unprotected electrical outlets, large picture window and the door which opens inward. As a further measure an addendum to Client #1's BSP has been obtained striking the general strategy for severe aggression periods, ie isolation area. Staff were trained on November 14, 2011. Staff meeting agenda,</p>		

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W0369	<p>remained on the window. He indicated the door to the room was closed, but not locked when the client was in the room. He indicated there were times when staff was not present in the room with the client #1, but remained remained in the adjacent room and the door to the relaxation room was partially open.</p> <p>During an interview on 10/04/2011 at 1:00 p.m., the RD (Residential Director) indicated staff were usually present in the isolation room when client #1 had been placed in the room. The RD indicated staff could monitor client #1 from the adjacent room if the client was sleeping or calm.</p> <p>9-3-5(a)</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, interview and record review, the facility failed to ensure all medications were administered without error for 1 of 3 sampled clients (client #3).</p> <p>Findings include:</p> <p>1. During observation of medication</p>	W0369	<p>minutes and signature page are attached. HRC has been contacted to re-schedule the October meeting and will meet at their earliest convenience. We will complete a walk through at the group home and specifically discuss future options in the event client #1 experiences another longterm psychotic episode.</p> <p>Residential Director, House Manager and Nurse met to discuss the discrepancy between the MAR and the Nurses directive to give client # 3's liquid medication via g-tube. The nurse's directive was based on client #3's gastroentologist training staff on giving medications via g-tube. It was</p>	11/14/2011	

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	<p>administration on 10/03/2011 at 4 p.m., DSP (Direct Support Professional) #6 administered Reglan 5 mg (milligrams)/5 ml (milliliters) via g-tube to client #3. The MA R (Medication Administration Record) was reviewed on 10/03/2011 at 5:15 p.m. The MAR, dated October 2011, indicated, "...give one teaspoonful (5 ml) by mouth three times qd (every day)...."</p> <p>During observations of medication administration on 10/03/2011 at 5:00 p.m., DSP #6 gave client #3 Calcium Carbonate 125 mg/5 ml per g-tube. The MA R (Medication Administration Record) was reviewed on 10/03/2011 at 5:15 p.m. The MAR, dated October 2011, indicated, "...GIVE 5 ml BY MOUTH TWICE DAILY...."</p> <p>During observations of medication administration on 10/04/2011 at 8:00 a.m., DSP #1 gave client #3 the following medications via g-tube: Daily Vitamin Liquid, Claritin, Calcium Carbonate, Carafate, and Reglan via g-tube. The MA R (Medication Administration Record) was reviewed on 10/04/2011 at 9:30 a.m. The MAR, dated October 2011, indicated, "...DAILY VITAMIN LQD (liquid) GIVE 5 ML BY MOUTH EVERY MORNING...LORATADINE (Claritin) GIVE 10 ML BY MOUTH ONCE</p>		<p>decided to get clarification from Client #3's Physician. Follow-up with the Physician resulted in the physician agreeing the liquid medications with the exception of her prn Robitussin should be administered via g-tube. New orders were obtained and the MAR was updated accordingly. In the future if there is a question about route of administration the House Manager or Nurse is to immediately contact the Physician for clarification. The medication is to be held until clarification can be obtained. All medications are to be administered per the MAR. Staff were provided training on 10-11-2011 see attached. Review of MAR Policy was provided again at the November 14, 2011 staff meeting. See November 14, 2011 Staff meeting agenda, minutes and signature page.</p>		

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	<p>DAILY... CALCIUM CARB 125 MG/5 ML GIVE 5 ML BY MOUTH...CARAFATE 1 GM/10 ML GIVE 10 ML TWICE DAILY BEFORE BREAKFAST AND BEDTIME...Metoclopramide take one teaspoonful (5 ml) by mouth three times qd (every day)...."</p> <p>During an interview on 10/03/2011 at 4:25 p.m., DSP # 6 indicated the nurse told her to give the liquid medications to client #3 via g-tube and the pills in applesauce by mouth.</p> <p>During an interview on 10/04/2011 at 9:30 a.m., DSP #1 indicated she had been instructed by the facility nurse to place liquid medications into the g-tube. She indicated she usually gave the carafate with the omeprazole (Prilosec) at 7 a.m. but gave it at 8 a.m. since the time printed on the MAR was 8:00 a.m.</p> <p>During an interview on 10/06/2011 at 1:00 p.m. the facility nurse stated she "overlooked the orders" for giving the medications orally.</p> <p>9-3-6(a)</p>				

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W0382	<p>The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, the facility failed to ensure the medication cabinet was locked when unattended by staff while 1 additional client (#4) was in the room where the medication cabinet was located.</p> <p>Findings include:</p> <p>During medication administration observations on 10/03/2011 at 3:50 p.m., DSP #6 left the medication cabinet unlocked and unattended for 5 minutes between passing medications to clients. Client #4 walked through the room where the medication cabinet was located.</p> <p>During an interview on 10/03/2011 at 4:25 p.m., DSP #6 indicated she should have locked the medication cabinet and placed keys in storage box by the office when she walked away from the medication cabinet.</p> <p>9-3-6(a)</p>	W0382	<p>Residential Director met with the House Manager, QDDP and Nurse to discuss the locking of medications. It was determined that ALL staff are advised during Core A and B training, orientation and at minimum annually thereafter to keep all medications and biologicals locked except when being prepared for administration. An employee warning has been issued to Direct Care Staff #6 as a result of her leaving the medication cabinet unlocked and unattended while client #4 walked through the room. As a further reminder a sign has been posted on the medication cabinet to keep locked at all times except when administering medication. Medication Storage Policy was reviewed at the Staff meeting on November 14, 2011.</p>	11/14/2011