

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/14/2014
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330
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W000000	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: January 8, 9, 10 and 14, 2014.</p> <p>Facility Number: 012632 Provider Number: 15G807 AIMS Number: 201065000</p> <p>Surveyors: Vickie Kolb, RN-TC Paula Chika, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/21/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2) and 4 additional clients (#3, #4, #5 and #6), the facility's governing body failed to exercise general policy and operating direction over the facility to ensure:</p>	W000104	<p>CORRECTION: The Governing body must exercise general policy, budget and operating direction over the facility. Specifically, the governing body has provided direction and oversight to assure that: All staff have been retrained on the need to report allegations immediately.</p>	02/13/2014

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>__ All allegations of abuse were reported immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) per 460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 in accordance with state law for client #3.</p> <p>__ All allegations of abuse and injuries of unknown origin were thoroughly investigated for clients #1, #2, #3, #4, #5 and #6.</p> <p>__ Client #1 was provided a legally sanctioned representative or health care representative to assist her in making informed decisions.</p> <p>Findings include:</p> <p>1. Please see W149. The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse were immediately reported for client #3 and all client to client abuse and injuries of unknown origin were thoroughly investigated for clients #1, #2, #3, #4, #5 and #6.</p> <p>2. Please see W153. The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse for client #3 were immediately reported to the administrator and to the Bureau of</p>		<p>Since the inservice no further late reporting has occurred. The QIDP has been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed and all relevant documents reviewed. Client 1's ability to give informed consent has been reassessed and the governing body is overseeing the facility in arranging to obtain a legal guardian for Client #1. PREVENTION:Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor responsible for Quality Assurance, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation, the governing body will administer written corrective action up to ad including termination of employment. The QIDP will turn in copies of completed investigations to the Clinical Supervisor responsible for Quality Assurance to allow for appropriate oversight and follow-up. The Clinical Supervisor will follow-up with the QIDP as needed but no less than weekly to</p>				

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W000125	<p>Developmental Disabilities Services and Adult Protective Services (APS) per state law.</p> <p>2. Please see W154. The governing body failed to exercise general policy and operating direction over the facility to ensure thorough investigations were conducted for clients #1, #2, #3, #4, #5 and #6 in regard to client to client abuse and injuries of unknown origin.</p> <p>9-3-1(a)</p> <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on interview and record review for 1 of 2 sample clients (#1), the facility failed to ensure the rights of the client by not ensuring representation by a legally sanctioned representative or health care representative to assist the client in making</p>	W000125	<p>review incident documentation and completed investigations to assure they have been completed thoroughly. Additionally, the governing body will submit a request to the Indiana State Department of Health for an inservice presentation to all agency professional staff regarding the components of a through investigation Professional staff will be retrained regarding the need to assure that all individuals have appropriate assistance making major life decision, based on their assessed ability to give informed consent. The interdisciplinary team with assistance from the Operations team is reviewing informed consent assessments for all clients and will obtain appropriate legal representation for clients as needed. RESPONSIBLE PARTIES:QIDP, Direct Support Staff, Operations Team</p> <p>CORRECTION: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</p>	02/13/2014	

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	<p>informed decisions.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 1/10/14 at 11 AM. Client #1's record indicated client #1 was a young emancipated female with diagnoses of, but not limited to, Schizo-affective Disorder, Depression, PTSD (Post Traumatic Stress Disorder), Borderline Personality Disorder, GERD (Gastric Esophageal Reflux Disease), Hypercholesterolemia (high cholesterol levels), Tachycardia (rapid heart rate), Edema (fluid retention) and Hypothyroidism.</p> <p>Client #1's physician's orders for 1/2014 indicated client #1 was taking the following psychotropic medications: Chlorpromazine 25 mg (milligrams) a day for Schizoaffective Disorder, Invega Sustenna 156 mg for PTSD (Post Traumatic Stress Disorder) and Borderline Personality Disorder, Depakote 1000 mg a day for PTSD and Borderline Personality Disorder, Ritalin 10 mg twice a day for decreased mood, energy and motivation, Effexor XR (extended release) 150 mg a day for depression and Chlorpromazine 50 mg as needed every four hours for severe agitation. Client #1's physician's orders indicated client #1 took Cogentin 0.5 mg a day for EPS (extrapyramidal symptoms - side effects associated with the use of antipsychotic medications).</p>		<p>right to file complaints, and the right to due process. Specifically, the facility has reassessed Client 1's ability to give informed consent and has arranged to obtain a legal guardian for Client #1. PREVENTION: Professional staff will be retrained regarding the need to assure that all individuals have appropriate assistance making major life decision, based on their assessed ability to give informed consent. The interdisciplinary team with assistance from the Operations team is reviewing informed consent assessments for all clients and will obtain appropriate legal representation for clients as needed.</p> <p>RESPONSIBLE PARTIES: QIDP, Operations Team</p>				

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W000149	<p>Client #1's record indicated an informed consent assessment of 8/5/13. The assessment indicated client #1 was not "likely to act responsibly" in regard to medical issues and following her program plans. The informed consent assessment indicated client #1 was in need of a health care representative. Client #1's record indicated no legally sanctioned representative or health care representative to assist client #1 in making informed decisions.</p> <p>During interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 1/10/14 at 5 PM the QIDPD indicated client #1 was emancipated and did not have a legally sanctioned representative or health care representative to assist client #1 in making informed decisions. The QIDPD indicated client #1 made her own decisions but would benefit from representation.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 2 sample clients (#1 and #2) and 4 additional clients (#3, #4, #5 and #6), the facility neglected to implement written policy and procedures ___To ensure all incidents of abuse were</p>	W000149	<p>CORRECTION: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically: The facility has retrained all staff on the need to report allegations immediately.</p>	02/13/2014			

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	<p>reported immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) per 460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 in accordance with state law.</p> <p>__To ensure all allegations of abuse and injuries of unknown origin were thoroughly investigated for clients #1, #2, #3, #4, #5 and #6.</p> <p>Findings include:</p> <p>The facility's policies and procedures were reviewed on 1/8/14 at 12 PM. The revised 2/26/11 facility policy entitled "Abuse, Neglect, and Exploitation" indicated "Adept staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, or mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of Adept, Rescare, and local, state and federal guidelines."</p> <p>Please see W153: For 1 of 28 allegations of abuse reviewed, the facility failed to ensure all allegations of abuse for client #3 were immediately reported to the administrator and to the Bureau of</p>		<p>Since the inservice no further late reporting has occurred. The QIDP has been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed and all relevant documents reviewed. PREVENTION:Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor responsible for Quality Assurance, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation, the governing body will administer written corrective action up to ad including termination of employment. The QIDP will turn in copies of completed investigations to the Clinical Supervisor responsible for Quality Assurance to allow for appropriate oversight and follow-up. The Clinical Supervisor will follow-up with the QIDP as needed but no less than weekly to review incident documentation and completed investigations to assure they have been completed thoroughly. Additionally, the governing body will submit a</p>				

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W000153	<p>Developmental Disabilities Services (BDDS) per 460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 in accordance with state law.</p> <p>Please see W154: For 42 of 49 allegations of abuse/neglect and/or injuries of unknown origin reviewed, the facility failed to conduct thorough investigations in regard to clients #1, #2, #3, #4, #5 and #6.</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 immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 28 allegations of abuse reviewed, the facility failed to ensure all allegations of abuse for client #3 were immediately reported to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) per 460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 in accordance with state law.</p> <p>Findings include:</p>	W000153	<p>request to the Indiana State Department of Health for an inservice presentation to all agency professional staff regarding the components of a through investigation RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Operations Team</p> <p>CORRECTION: The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Specifically, the facility has retrained all staff on the need to report allegations immediately. Since the inservice no further late reporting has occurred. PREVENTION: Supervisory staff will review all facility documentation to assure</p>	02/13/2014

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	<p>The facility's reportable records were reviewed on 1/8/14 at 11:30 AM. The BDDS (Bureau of Developmental Disabilities Services) reports indicated on 6/16/13 at 1:20 PM "One of [client #3's] staff reported to Clinical Supervisor that [staff #21] was verbally abusive towards [client #3] by cursing at [client #3]."</p> <p>The CWSF (Confidential Witness Statement Form) dated 6/15/13 and written by staff #7 to the QIDPD (Qualified Intellectual Disabilities Professional Designee) indicated "I think you should know a few things that were said on Thursday night, June 13, 2013, about 9:30 PM. [Staff #20] and I were discussing everything that was going on that night we remember some things that we had totally forgotten about. Our main concern that night was getting [client #3] calmed down from her behavior and making sure that she was physically safe. [Staff #21, staff #20] and I had gotten [client #3] into her bedroom so we could get her to calm down. That is when [staff #21] started screaming at her (client #3) saying that she was F-----g immature, she (client #3) was acting like a f-----g baby, the way she f-----g acts is no wonder she doesn't get to go anywhere, she is f-----g tired of her behaviors, f-----g tired of dealing</p>		<p>incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor responsible for Quality Assurance, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation, the governing body will administer written corrective action up to and including termination of employment. RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Operations Team</p>				

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	<p>with her and her behaviors, she was going to tell f-----g staff that she wasn't going to go anywhere. [Client #3] then went into another full blown behavior and while we had her in a hold on the floor [staff #21] gets her cell phone and starts talking on it while she is sitting on top of [client #3]. The she proceeds to fill out the IR (Incident Report) while still sitting on top of her with [client #3] going into another behavior in the bedroom. I had totally forgotten what [staff #21] said when in the bedroom. [Name of QIDPD], again my main concern at that time was keeping [client #3] physically safe from harming herself."</p> <p>Interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 1/8/14 at 11:30 AM indicated all allegations of abuse/neglect were to be reported immediately to the administrator and reported to BDDS and APS (Adult Protective Services) within 24 hours from the time of the allegation.</p> <p>Interview via email with the CS (Clinical Supervisor) was conducted on 1/13/14 at 11 AM. The CS indicated "The incident occurred on 6/13/13 and was not reported until 6/16/13. The allegations should have been reported immediately and the staff who were</p>						

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W000154	<p>present did not have an explanation for their delay in reporting."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 42 of 49 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct thorough investigations in regard to clients #1, #2, #3, #4, #5 and #6.</p> <p>Findings include:  The facility reportable and investigative records were reviewed on 1/8/14 at 11:30 AM. The records indicated:  5/12/13 at 6:30 PM "[Client #1] was standing in the dining room eating her chips when one of her housemates (client #5) asked her rudely to stop chomping in her ear. [Client #1] stated that she wasn't.... [Client #1] then hit [client #5] in the back of the head...." __The 5/12/13 investigative records indicated interviews from client #1, client #5 and two staff. The investigative records indicated no other client</p>	W000154	<p>CORRECTION:The facility must have evidence that all alleged violations are thoroughly investigated. Specifically, QIDP has been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed and all relevant documents reviewed. PREVENTION:The QIDP will turn in copies of completed investigations to the Clinical Supervisor responsible for Quality Assurance to allow for appropriate oversight and follow-up. The Clinical Supervisor will follow-up with the QIDP as needed but no less than weekly to review incident documentation and completed investigations to assure they have been completed thoroughly. Additionally, the governing body will submit a request to the Indiana State Department of Health for an inservice presentation to all agency professional staff regarding the components of a through</p>	02/13/2014

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	<p>interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>5/20/13 at 1:40 PM, client #3 was lying on the couch and sleeping. Client #5 attempted to hit client #3 multiple times with her hands but was blocked by the staff. Client #5 then ran outside the home, picked up a stick, ran back into the house and hit client #3 with the stick on the right side of client #3's abdomen. The report indicated client #3 continued to sleep through the incident and client #3 was not injured. When the staff conducted a body assessment the next morning, the staff found one dime size and one quarter size bruise on client #3 in the area where client #3 was hit with a stick. The 5/20/13 Incident report indicated four staff witnessed the incident.</p> <p>The 5/20/13 investigative records indicated interviews from clients #3 and #5. The investigative record indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p>		<p>investigation. RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Operations Team</p>		

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	<p>5/21/13 at 7 PM client #1 showed staff an 8 cm (centimeter) by 3 1/2 cm red purple splotchy bruise on the left side of her chest. The report indicated the client was not sure how she was injured. The investigative report of 5/21/13 indicated "It is possible that she (client #1) attempted to rub and scratch the temporary tattoo off instead of washing it off."            ___The 5/21/13 investigative records indicated an interview with client #1 and two statements from the staff indicating client #1 had shown the bruise to the staff. The investigative records indicated no client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>5/22/13 at 6 PM client #5 hit client #3 on the top of the head with a stick. The record indicated four staff and three clients were in the home at the time of the incident.            ___The 5/22/13 investigative records indicated interviews with clients #3 and #5 and witness statements from two of the four staff. The records indicated client #5 did not admit to hitting client #3 with a stick on her head and client #3 claimed the incident did not happen "but she was wearing her helmet and was not</p>				

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	<p>injured." The investigative record indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>5/28/13 at 9:21 AM client #1 showed the staff two bruises under her left armpit. The report indicated client #1 did not know how she was injured. The 5/28/13 investigative records indicated client #1 has a history of SIB (self injurious behaviors) and engaged in SIB on 5/25/13. The records indicated "It is likely that she received the bruises then." The investigative records indicated an interview with client #1 and two staff. The investigative record indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>5/30/13 at 8:35 AM the staff discovered three bruises on client #1. "One bruise is 2 cm by 1 cm above her left knee that is blue/purple. The second is 2 1/2 cm by 1 cm dark purple in color on back lower thigh above the back of the knee (the report did not distinguish right/left). The</p>			

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	<p>last one is 1 cm by 1 cm round dark purple in color on her left hip area." The report indicated client #1 did not know how she was injured.</p> <p>__The 5/30/13 investigative records indicated client #1 has a history of pinching herself which was addressed in her behavior plan. The report indicated it was "likely" client #1 pinched herself. The investigative records indicated an interview with client #1 and one staff. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>5/31/13 at 8:45 AM while doing client #3's body assessment, the staff discovered a dark purple bruise that was 2 1/2 centimeters (cm) by 1 cm long near client #3's right side above her hip. The report indicated client #3 did not know how she obtained the bruise.</p> <p>__The 5/31/13 investigative records indicated client #3 "often walks with her head down and often bumps into things and does not inform the staff. It is possible that [client #3] bumped into something, causing the bruise." The investigative records indicated an interview with client #3. The</p>						

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	<p>investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>6/2/13 at 5:30 PM client #6 hit client #3 on the top of the head. The I/A (Incident/Accident) report for 6/2/13 indicated three staff in the home at the time of the incident. ___The 6/2/13 investigative records indicated an interview with client #6. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>6/6/13 at 7 AM the staff found some bruises on client #3. The I/A report for 6/7/13 indicated "During weekly body assessment, injuries were found that are not currently being charted on: Pea size dark purple bruise under left breast, pea size bruise on inside of left elbow, small brown bruise on back of right knee, fading bruise in center of left shin, 3 pea size pink/red spots on outside left ankle, 2 bruises on upper left thigh on the outside - one is dime size with a faded</p>				

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	<p>one underneath about quarter size."          ___The 6/6/13 investigative records indicated an interview with client #3. The investigative records indicated client #3 did not know how she had received the bruises. The summary indicated client #3 had a history of SIB and has engaged in those behaviors over the past week. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>6/13/13 at 2:45 PM client #3 hit client #5 in the stomach. Client #5 then threw a piece of cookie at client #3 and hit her in the face.          ___The 6/13/13 investigative records indicated the staff interviewed client #5 but client #3 refused to be interviewed. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>6/18/13 at 10:45 AM client #1 showed the staff a knot underneath the skin on her outer left upper arm. The staff</p>				

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	<p>offered ice and client #1 refused. Client #1 indicated she did not know how she was injured.</p> <p>__The 6/18/13 investigative records indicated an interview with client #1. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The investigative summary indicated client # 1 "did receive her Invega injection on 5/30/13 in that location. It is likely that is how she received the knot." The facility records failed to indicate a thorough investigation was conducted.</p> <p>6/27/13 at 10:05 AM the staff noticed a 3 cm by 1 cm bruise on the back of client #1's left inner thigh and a 2 1/2 cm by 1 cm bruise on the back of her upper right thigh. The report indicated client #1 did not know how she was injured.</p> <p>__The investigative records of 6/27/13 indicated client #1 and one staff were interviewed. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The investigative summary indicated client #1 "thinks she may have run into a table at AWS." The facility records failed to indicate a thorough investigation was conducted.</p>				

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	<p>7/1/13 client #3 reported while at the day service program on 6/27/13 "...that a guy there was teasing her.... Client #3 reported to one of Res Care staff that [name of client] came up behind her, grabbed her breasts, hit her and she hit him. [Client #3] reported that she has not told the staff at AWS because [name of client] said that he would hurt her if she told anyone about it." The investigative report indicated the outcome as "CS (Clinical Supervisor) followed up with the AWS (day service program) staff. AWS stated that client [name of client] sleeps the entire time that he is there and constantly has to be prompted to wake up long enough to eat lunch and that they have never seen [client #3] and him close to each other." ___The 7/1/13 investigative records indicated an investigation was conducted. The investigative records indicated no records of interviews with staff and/or clients. The record did not indicate the records reviewed in regards to the investigation. The investigative summary indicated "AWS stated that client [name of client] sleeps the entire time that he is there and constantly has to be prompted to wake up long enough to eat lunch and that they have never seen [client #3] and him close to each other." The facility records failed to</p>			
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	<p>indicate a thorough investigation was conducted.</p> <p>7/4/13 at 7:45 AM client #5 was "taunting" client #3. Client #5 took her belt off and threatened to hit client #3 and threw a bowl at client #3. Client #3 then "retaliated" and hit client #5 in the chest and at the same time hit client #1 in the right cheek while trying to hit client #5 again. Client #5 then grabbed a fork, left the kitchen and began jabbing the walls with the fork.</p> <p>__The 7/4/13 investigative records indicated a witness statement from one staff. The I/A report dated 7/4/13 indicated 3 staff working in the group home. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>7/4/13 at 11:15 AM client #5 hit and kicked client #3 "before staff could block." Later, client #5 hit client #3 in the face/nose.</p> <p>__The 7/4/13 investigative records indicated an interview with client #3. The investigative records indicated no other client interviews, no staff interviews and did not indicate the</p>						

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	<p>documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>7/7/13 at 6:15 AM client #3 kicked client #5. Client #3 indicated client #5 was "taunting her." The 7/7/13 investigative records indicated clients #3 and #5 were interviewed by one of the direct care staff. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>7/8/13 at 4:10 PM client #3 was leaning on the arm of the couch in the living room when client #5 went to the couch and laid down on the couch. Client #3 continued to lean on the couch when client #5 kicked client #3 in the back. Client #3 hit client #5 on the right ankle. Staff intervened and redirected clients #3 and #5. Client #3 walked towards the dining room. Client #5 then began hitting client #3 in the upper back "multiple times." Staff got between the two clients and redirected client #3 to her bedroom. Client #3 then threw a pillow at client #1 and shouted, "You</p>						

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	<p>mother f---r!" Client #1 then ran at client #3 and grabbed client #3 by her left arm and began punching client #3 in the back.</p> <p>__The 7/8/13 investigative records indicated interviews with clients #1, #3 and #5. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>7/11/13 at 7:43 AM client #3 was standing in front of the kitchen table when client #5 came up "unexpectedly" and hit client #3 on her helmet (head). Client #5 proceeded to slap client #3 on the back.</p> <p>__The 7/11/13 investigative records indicated interviews from clients #3 and #5. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>7/11/13 at 8:45 AM client #5 was trying to provoke client #3. When client #5 tried to get at client #3, client #5 ended up shoving client #1.</p>			

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	<p>__ The 7/11/13 investigative records indicated interviews with clients #1 and #5. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>7/17/13 at 11:20 AM when client #3 knocked client #5's items off of a table, client #5 shoved client #3.</p> <p>__ The 7/17/13 investigative records indicated interviews from clients #3 and #5. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>7/19/13 at 5:55 AM client #5 began pounding on client #3's bedroom door to wake her up. Client #5 got through the staff's attempt to block her and client #5 smacked client #3 in the face.</p> <p>__ The 7/19/13 investigative records indicated client #3 refused to be interviewed. The records indicated client #5 was interviewed. The investigative records indicated no other client interviews, no staff interviews and did</p>			

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	<p>not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>7/20/13 at 7:15 AM client #3 pulled client #5's hair and client #3 alleged client #5 had pulled her leg while client #3 was climbing on the window sill. __The 7/20/13 investigative records indicated one of the direct care staff interviewed clients #3 and #5. The I/A report of 7/20/13 indicated 4 staff were in the home at the time the allegations were made. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>7/21/13 at 5 PM client #3 refused to leave client #6's bedroom when client #6 "punched" client #3 in the back. __The 7/21/13 investigative records indicated clients #3 and #6 were interviewed. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p>			

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	<p>7/23/13 at 7 PM staff noticed client #1 had a 1/4 inch scratch on her left foot. The report indicated client #1 did not know how she scratched her foot.</p> <p>___The 7/23/13 investigative records indicated an interview with client #1. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>7/27/13 at 2:15 PM client #5 knocked on client #6's bedroom door when client #6 became angry and shouted at client #5 to "get the f--k out of her room, that what she was doing was none of [client #5's] business and to leave her alone!" Client #5 then slammed client #6's bedroom door and called client #6 a 'f----g b---h.'" Client #6 threatened to slap client #5. Client #3 began yelling and went into client #6's bedroom while client #6 was not in her room and began destroying client #6's personal property. Client #3 hit client #6 and broke her eyeglasses.</p> <p>___The 7/27/13 investigative records indicated interviews with clients #3 and #6. The investigative records indicated no other client interviews, no staff interviews and did not indicate the</p>						

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	<p>documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>8/1/13 at 11:30 AM while conducting a weekly body assessment on client #3, staff found two green bruises. One was 5 1/2 cm long on the left side of her back along with a splotchy green one that was 7 cm by 2 cm long below it. Client #3 indicated she did not know how she got the bruises.</p> <p>__The 8/1/13 investigative records indicated client #3 was interviewed and one staff statement. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The investigative summary indicated "When asked [client #3] stated she didn't know how she got the bruises but then stated that housemate (client #5) hit her on Sunday. No staff witnessed any contact being made between the two and [client #3] was removed from the house 2 times on Sunday due to [client #5's] behaviors...." The facility records failed to indicate a thorough investigation was conducted.</p> <p>8/21/13 at 7:05 AM client #3 touched client #6's "butt." Client #6 asked client</p>				

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	<p>#3 to stop. Clients #3 and #6 "exchanged unnecessary words."            ___The 8/21/13 investigative record indicated interviews with client #3 and client #6. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>8/23/13 at 9:50 AM staff discovered a 2 cm by 1 1/2 cm bruise on client #1's left thigh. When client #1 was first asked how she got the bruise on her thigh she stated, "It might have come from doing boxes." When asked by another staff how she got the bruise on her leg, client #1 indicated she did not know.            ___The 8/23/13 investigative records indicated interviews with client #1 and one group home staff. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>8/29/13 at 7:45 AM "During her (client #1's) weekly body assessment staff found a bruise on [client #1's] right upper thigh, right upper bicep, and her</p>						

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	<p>left under part of her upper outer arm. Staff asked [client #1] if she knew how she received these bruises and she told staff that sometimes they tickle each other at AWS workshop. The investigation concluded that [client #1] received the bruises from other individuals tickling her while at AWS. Staff will encourage [client #1] to remind others to respect her personal space to prevent future incidents." The follow up BDDS report of 8/30/13 indicated "AWS clients were using their hands/fingers to tickle [client #1]. [Client #1] does bruise very easily. AWS staff report that the individuals joke and play around towards the end of the day before they leave and after all of the areas are cleaned up..."</p> <p>__ The 8/29/13 investigative records indicated an interview with client #1. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>9/5/13 at 7:50 AM "During her (client #1's) weekly body assessment, staff found 3 bruises and 1 scratch on [client #1] that was (sic) not currently being flowed on. Staff found a 1 cm by 1/2 cm</p>				

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	<p>dark purple bruise on her lower right thigh, a 1/2 cm long scratch on top of left thumb, a pea sized dark purple bruise on her outer right thigh, and a 2 cm by 1 cm purple bruise on her left outer forearm. [Client #1] claims that the bruises came from working on boxes at AWS. The QIDP (Qualified Intellectual Disabilities Professional) has been out at AWS the last 2 days and she (client #1) has not been working on boxes...."</p> <p>__The 9/5/13 investigative records indicated an interview with client #1 and one group home staff interview. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>9/12/13 at 6:45 AM the staff discovered a "cluster of purple colored bruises on the back of her (client #3's) right leg. There is also a longer purple bruise on top of the cluster that is 3 cm by 2 cm. [Client #3] thinks she got it from kicking the back of her leg with the walking boot.</p> <p>__The 9/12/13 investigative records indicated an interview with client #3 and one staff. The investigative record indicated no other client interviews, no</p>						

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	<p>staff interviews and did not indicate the documents reviewed in regard to the investigation. The investigative summary indicated client #3 "got the cluster of bruises due to hitting herself with the boot that she wears on her left foot due to a prior toe injury." The facility records failed to indicate a thorough investigation was conducted.</p> <p>9/30/13 at 6:20 AM "While assisting [client #2] back to her room after taking her medications, staff noticed blood on the back of her left foot. Upon observing her feet, staff noticed a 1 cm long slit on [client #2's] right heel. [Client #2] stated that she did not know what happened. Staff believe that it may have come from the plastic on her walker or her toenails.... Given the length of [client #2's] toenails, the investigation concluded that [client #2] cut the back of her heel with her toenails causing the injury...."</p> <p>__The 9/30/13 investigative records indicated an interview with client #2. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p>			
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	<p>10/14/13 at 3:30 PM "[Client #1] came home from AWS workshop and stated that she had hurt her right hand and that she had told AWS staff about this." __The 10/14/13 investigative records indicated interviews with client #1 and the workshop supervisor. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The investigative summary indicated client #1 had been working with "loaf boxes that are 12 inches by 12 inches and not heavy." The facility records failed to indicate a thorough investigation was conducted.</p> <p>10/18/13 at 8:45 PM "[Client #1] became upset when housemate [client #3] called her a 'dumb b---h.' [Client #1] then punched housemate in the back one time...." __The 10/18/13 investigative records indicated interviews from clients #1 and #3 and one staff interview. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>10/24/13 at 7:15 AM the staff noted a</p>						

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	<p>quarter sized blue/green bruise on client #1's outer left thigh. Client #1 did not know how she was injured.</p> <p>__The 10/24/13 investigative records indicated an interview with client #1 and one staff interview. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The investigative summary indicated client #1 had been engaging in SIB and had a history of pinching herself. The facility records failed to indicate a thorough investigation was conducted.</p> <p>10/24/13 at 8:25 AM the staff noted a pea sized abrasion on the knuckle of client #3's left index finger and a pea sized red area in the center of her left hand. The record indicated client #3 did not know how she was injured.</p> <p>__The 10/24/13 investigative records indicated an interview with client #3 and one staff. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>11/21/13 at 10:30 AM "During [client #2's] weekly body check staff found a 2</p>				

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	<p>1/2 cm by 1 cm purple bruise on her lower outer calf, 3 1/2 cm by 1 1/2 cm purple/brown bruise on her right lower thigh above the knee, a dime sized light brown bruise on her right wrist, right knee cap has a dime sized brownish purple bruise, right back of calf has a nicekl (sic) sized brown bruise, left knee cap has a pea sized light green bruise, left shin has a faint 2 cm by 1 1/2 cm purple bruise, left below the knee cap has a faint green pea sized bruise, left shoulder has a quarter sized light brown bruise, right elbow has 2 pea sized light brown bruises, top of left foot has a 6 cm purple bruise/light purple in color with small area in front of her fourth left pinky toe that is dark purple(left pinky toe appears swollen), and a pea sized dark purple bruise on her upper/inner thigh. [Client #2] was just released from [name of hospital] on Monday, 11/18/13, where she stayed in their emergency room due to being severely behavioral. [Client #2] was staffed with Rescare staff 24/7 while she was there. Staff witnessed [client #2] be put in restraints and put in holds due to her being combative and self injurious, resulting in the marks found above...."</p> <p>The Follow Up report dated 11/22/13 indicated staff assisted the hospital security staff with the holds.</p> <p>___The facility records indicated no</p>			

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	<p>investigation was conducted in regard to the multiple bruising found on client #2 after a hospital visit.</p> <p>12/6/13 at 10:05 AM while in the restroom, client #1 showed staff a dime sized purple bruise on her upper left calf below the knee. Client #1 indicated she woke up with it.</p> <p>__The 12/6/13 investigation records indicated an interview with client #1. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The investigative summary concluded client #1 had engaged in SIB of pinching herself which caused the bruising. The facility records failed to indicate a thorough investigation was conducted.</p> <p>12/9/13 at 10:30 PM client #1 requested a band-aid for her left foot. The staff applied ointment and wrapped her foot with gauze. The staff reported a two inch "crack and it was bleeding." Client #1 indicated she did not know how she injured her foot.</p> <p>__The 12/9/13 investigative records indicated interviews with two staff in the group home and an interview with client #1. The investigative records indicated no other client interviews, no staff</p>				

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	<p>interviews and did not indicate the documents reviewed in regard to the investigation. The investigation summary indicated client #1 had a history of SIB and the staff "found [client #1] picking at her foot about a week ago." The facility records failed to indicate a thorough investigation was conducted.</p> <p>12/12/13 at 4 PM staff noticed a bruise on client #1's right outer forearm. ___The 12/12/13 investigative records indicated "Given the location of the bruise, the investigation concluded that [client #1] did run into the door at AWS causing the injury." The investigative record indicated an interview with client #1. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>12/19/13 at 9:20 AM staff noticed a 6 1/2 cm by 5 cm dark purple bruise on the back of client #2's right bicep and a 2 cm and small pea sized bruise on her inner left bicep. The report indicated client #2 reported to the staff she did not know how she got the injury. The report indicated when the QIDPD spoke with</p>						

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	<p>client #2 about her injuries the client indicated she got the bruise on the back of her right bicep from standing in front of the door and the staff opened the door, hitting her on accident with the door. "Investigation concluded that [client #2] got the bruise on the back of her right bicep by being accidentally hit with the door. [Client #2] has a history of self injurious behaviors and has displayed these on multiple occasions since she moved into [group home street name]. The investigation concluded that [client #2] received the bruises on her inner left bicep due to self injurious behaviors."</p> <p>__The 12/19/13 investigative records indicated an interview with client #2. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The facility records failed to indicate a thorough investigation was conducted.</p> <p>12/22/13 at 1 PM client #3 kicked client #4.</p> <p>__The 12/22/13 investigative records indicated a staff witness statement. The investigative records indicated no other client interviews, no staff interviews and did not indicate the documents reviewed in regard to the investigation. The</p>			

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	<p>facility records failed to indicate a thorough investigation was conducted.</p> <p>Interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 1/8/14 at 11:30 AM and on 1/9/14 at 12:30 PM indicated all client to client abuse and all injuries of unknown origin were investigated. The QIDPD indicated she conducted the investigations for the client to client abuse and the injuries of unknown origin. The QIDPD indicated when there is an injury noted, the staff complete an I/A report and the staff or herself would interview the client or clients involved and then the QIDPD would then conclude the investigation given the information from the client's statement and/or the staff witness statements. The QIDPD indicated she did not record the documents reviewed on the investigative records. The QIDPD stated, "Most of our unknowns are from behaviors or SIB." When asked if she interviewed all the staff that worked in he home and/or the staff at the day program when investigating unknown injuries, the QIDPD stated, "No, not usually." The QIDPD indicated all allegations of staff to client abuse were formally conducted by the administrative staff.</p> <p>9-3-2(a)</p>			

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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, interview and record review for 1 of 2 sampled clients (#2), the facility failed to ensure all staff who worked with the client were trained in regard to the use of a gait belt for ambulation.</p> <p>Findings include:</p> <p>During the 1/8/14 observation period between 4:40 PM and 6:55 PM, at the group home, client #2 wore a gait belt. While sitting in a chair with arms at the dining room table, client #2 leaned over to the side of the chair. Client #2 asked to go to the bathroom. Staff #9 held the back of client #2's gait belt and physically assisted client #2 to stand and walk. Client #2 was unsteady on her feet as the client swayed from side to side. Staff #9 asked client #2 to stop, wait and walk slowly. Staff #9 assisted client #2 to walk by holding the back of the gait belt with one hand and hyper extending client #2's right arm up in the air and holding with staff's other hand.</p>	W000189	<p>CORRECTION: The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Specifically, the facility has completed retraining of all staff toward supporting Client #2's ambulation needs based on Client #2's updated Comprehensive High Risk Plan for falls. PREVENTION: All new staff will be trained on each client's high risk plans prior to completion of new-hire orientation. The QIDP will be expected to observe no less than two morning and two evening active treatment sessions per week to assess direct support staff interaction with clients and to provide hands on coaching and training toward proper implantation of high risk plans. Additionally members of the Operations Team will conduct active treatment observations at the facility on a weekly basis for the next 60 days and after two months, no less than monthly to assure risk plans are implemented as written. The</p>	02/13/2014
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	<p>Once client #2 was finished using the bathroom, staff #9 assisted client #2 to walk from the bathroom to her bedroom. Client #2 had an unsteady gait and the client's right arm was extended in the air. At 6:36 PM, two staff (staff #8 and #9) physically assisted client #2 to ambulate from her bedroom to the dining room table. A staff person was on each side of the client holding the back of the client's gait belt, not the handles/loops on the gait belt. Client #2's left and right arms were extended out and up in the air with each staff holding the client's hands as they assisted the client to ambulate/walk. Client #2 was unsteady while ambulating with 2 staff. When staff held the client's gait belt, client #2's gait belt would rise up the client's back.</p> <p>During the 1/9/14 observation period between 5:20 AM and 8:00 AM, at the group home, staff #4 physically assisted client #2 to go to the bathroom. Client #2's gait was unsteady as the client swayed from side to side. Staff #4 held client #2's gait belt on the side and held client #2's left arm at the shoulder area when ambulating with the client. The loops/handles on the gait belt were not used. At 7:22 AM, two staff (staff #3 and #5) went into client #2's bedroom to assist the client to get up and to go to the</p>		Nurse Manager and Program Manager will track facility training records to assure all staff receive documented training on risk plans as they are modified, but no less than annually. RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Health Services Team Operations Team				

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	<p>office area for her medications. Staff #3 and #5 held the back of client #2's gait belt (not the handles or the loops) while each staff held the hands of client #2. Client #2's arms were extended up and out. During both observation periods, a walker was present in client #2's bedroom with clothes and/or clothes hangers on the walker.</p> <p>Client #2's record was reviewed on 1/10/14 at 9:55 AM. Client #2's 9/27/13 ISP (Individualized Support Plan) indicated client #2 had an "unsteady gait."</p> <p>Client #2's 12/5/13 physician's orders indicated client #2's diagnosis included, but was not limited to, Cerebellar Ataxia (loss of muscle coordination in the brain).</p> <p>An undated typed form indicated the following:</p> <p>"1. Must be 1 to 1 staff at all times and this requires within arms reach except when in bed asleep. When asleep she is eyesight with door open.</p> <p>2. While ambulating with 1 person. Hold on to the back of gait belt and one hand on the walker.</p>						

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	<p>3. While ambulating with 2 people each person has a hold of the side of the gait belt and one hand on the walker...."</p> <p>Client #2's undated Gait Belt Training in the client's Individual Support Plan (ISP) book indicated "...Walking Techniques When helping a patient walk with a gait belt, stand to his side and slightly behind. This position allows you to keep a secure grip on the back of the gait belt without interrupting the patient's movement. In most cases, you will only need to grasp the belt with one hand while walking. However, if the patient's risk of falling is extremely high, you might choose to grasp the belt with both hands. If the patient begins to fall while you are walking, bring your body close to his and use the gait belt to slowly lower him to the ground."</p> <p>The facility's training records were reviewed on 1/10/14 at 9:50 AM. The facility's 10/4/13 Inservice Sign-in Sheet indicated the facility's nurse conducted gait belt training and ambulating with one to two staff on 10/4/13. The 10/4/13 inservice training indicated staff #2 and #8 had not received the gait belt/ambulation training.</p> <p>Interview with the LPN on 1/10/14 at 10:58 AM indicated facility staff should</p>			

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	<p>encourage client #2 to use her walker when ambulating as client #2 was a fall risk. The LPN indicated client #2 required one to two staff when ambulating with the client. The LPN stated "Staff should hold gait belt with both hands." The LPN indicated facility staff should not hold client #2's arms/up in the air when ambulating. The LPN stated they should "hold on to (client #2's) arm."</p> <p>Interview with the Qualified Intellectual Disability Professional-Designee (QIDP-D) on 1/10/14 at 2:00 PM indicated client #2 was to utilize a walker when ambulating. The QIDP-D indicated client #2 would refuse to use her walker. The QIDP-D indicated one staff and/or 2 staff would assist client #2 to ambulate due to the client's unsteady gait. The QIDP-D indicated the facility staff had been trained in regard to the gait belt and ambulating with client #2. The QIDP-D indicated she would need to retrain staff on using the gait belt correctly. The QIDP-D indicated staff #2 and #8 were hired after the original training on 10/4/13. The QIDP-D indicated she did not know if the facility's nurse had conducted training with the 2 new staff.</p> <p>9-3-3(a)</p>			

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, interview and record review for 1 of 2 sampled clients (#2), the facility failed to assess and/or obtain a re-assessment of the client's ambulation skills/ability and to obtain an occupational therapy assessment and a hearing assessment within 30 days of the client being admitted to the group home.</p> <p>Findings include:</p> <p>During the 1/8/14 observation period between 4:40 PM and 6:55 PM, at the group home, client #2 wore a gait belt. While sitting in a chair with arms at the dining room table, client #2 leaned over to the side of the chair. Client #2 asked to go to the bathroom. Staff #9 held the back of client #2's gait belt and physically assisted client #2 to stand and walk. Client #2 was unsteady on her feet as the client swayed from side to side. Staff #9 asked client #2 to stop, wait and walk slowly. Staff #9 assisted client #2 to walk by holding the back of the gait belt with one hand and hyper</p>	W000210	<p>CORRECTION: 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. Specifically, the team will assure that Client #2 has been re-assessed by Occupational Therapy and Physical Therapy on order to develop appropriate supports for Client #2's ambulation needs. PREVENTION: Professional staff will be retrained regarding assessment requirements for new admissions to the facility. The QIDP be provided with a tracking system to assure that all required assessments are completed within 30 days of admission. Members of the Operations and/or Health Services Teams will review assessment data during and after the initial assessment period to assure assessments occur as needed and required. RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Health Services Team, Operations Team</p>	02/13/2014

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	<p>extending client #2's right arm up in the air and holding with staff's other hand. Once client #2 was finished using the bathroom, staff #9 assisted client #2 to walk from the bathroom to her bedroom. Client #2 had an unsteady gait and the client's right arm was extended in the air. At 6:36 PM, two staff (staff #8 and #9) physically assisted client #2 to ambulate from her bedroom to the dining room table. A staff person was on each side of the client holding the back of the client's gait belt, not the handles/loops on the gait belt. Client #2's left and right arms were extended out and up in the air with each staff holding the client's hands as they assisted the client to ambulate/walk. Client #2 was unsteady while ambulating with 2 staff. When staff held the client's gait belt, client #2's gait belt would rise up the client's back.</p> <p>During the 1/9/14 observation period between 5:20 AM and 8:00 AM, at the group home, staff #4 physically assisted client #2 to go to the bathroom. Client #2's gait was unsteady as the client swayed from side to side. Staff #4 held client #2's gait belt on the side and held client #2's left arm at the shoulder area when ambulating with the client. The loops/handles on the gait belt were not used. At 7:22 AM, two staff (staff #3</p>			

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	<p>and #5) went into client #2's bedroom to assist the client to get up and to go to the office area for her medications. Staff #3 and #5 held the back of client #2's gait belt (not the handles or the loops) while each staff held the hands of client #2. Client #2's arms were extended up and out. During both observation periods, a walker was present in client #2's bedroom with clothes and/or clothes hangers on the walker.</p> <p>The facility's reportable incident reports, internal Incident/Accident Reports (IARs) and/or investigations were reviewed on 1/9/14 at 10:46 AM. The facility's 12/30/13 IAR indicated "[Client #2] was getting out of the van at doctors (sic) office with staff assistance. Staff prompted [client #2] to steady feet before starting to walk [client #2] ignored staff's prompts and continued to walk landing (sic) her feet together and fell to the right. Staff gently blocked [client #2] hitting the ground. [Client #2] hit her right knee and right palm of hand. Staff assisted [client #2] up and sat down in doctor's office." The IAR indicated 2 staff witnessed and/or were involved in the incident. The facility's 12/30/13 IAR indicated "Staff will continue to encourage [client #2] to walk slowly to prevent future occurrences."</p>			

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	<p>The attached 12/30/13 Fall Assessment indicated client #2 fell getting out of the van. The fall assessment indicated "...HOW COULD THIS BE PREVENTED IN THE FUTURE? Have 2 people assisting [client #2] when getting out of the van/walking."</p> <p>The facility's 12/18/13 reportable incident report indicated "While [client #2] was using the restroom, she leaned over to get the toilet paper and fell off of the toilet, landing on her right hip/thigh and right elbow. Before [client #2] began leaning, she did not let staff know what she was needing or staff would have gotten the toilet paper for her. Staff had a 1:1 (staff to client conversation) with [client #2] about her needing to ask for assistance so that accidents are less likely to happen. [Client #2] agreed to ask in the future."</p> <p>Client #2's record was reviewed on 1/10/14 at 9:55 AM. Client #2's 9/27/13 ISP (Individualized Support Plan) indicated client #2 had an "unsteady gait." The ISP indicated client #2 was admitted to the group home on 9/27/13.</p> <p>Client #2's 12/5/13 physician's orders indicated client #2's diagnosis included, but was not limited to, Cerebellar Ataxia</p>			

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	<p>(loss of muscle coordination in the brain).</p> <p>Client #2's 9/12/13 Comprehensive High Risk Health Plan indicated client #2 had a history of falls. The risk plan indicated the client was a fall risk due to the Cerebral Ataxia. The risk plan indicated the the following:</p> <p>"1. Use roller walker for gait safety.</p> <p>2. Utilize a gait belt.</p> <p>3. Provide nonskid footwear at all times.</p> <p>4. Use wheelchair when unsteady for extended community outings.</p> <p>5. Utilize shower chair or bath bench during ADL (adult daily living) care.</p> <p>6. Staff to provide at least standby assistance during showering (Do not submerge in bath tub unless otherwise indicated by IDT (interdisciplinary team)...."</p> <p>Client #2's 9/20/13 risk plan for Fractures indicated the client had a history of fractures due to the client's self injurious behaviors. The risk plan indicated the following (not all</p>			

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	<p>inclusive):</p> <ol style="list-style-type: none"> <li>"1. Keep area free of clutter.</li> <li>2. Avoid use of area/throw rugs.</li> <li>3. Provide nonskid footwear at all times.</li> <li>4. Staff to provide hands-on assistance when entering and exiting the van.</li> <li>5. Staff to provide standby assistance during in home ambulation exercises.</li> <li>6. Staff to provide at least standby assistance during showering/bathing...."</li> </ol> <p>Client #2's 9/27/13 ISP and/or above mentioned notes/risk plans did not specifically indicate when/how facility staff were to ambulate with the client to prevent falls, and/or indicate how facility staff were to supervise the client while toileting to prevent falls.</p> <p>Client #2's Record Of Visits (ROV) indicated the following:</p> <p>-10/17/13 A Physical Therapy (PT) evaluation was completed. The assessment indicated "Requires gait assistance for safety and core weakness noted. Lower extremity strength</p>				

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	<p>functional limits, decreased left ankle ROM Myalgia (per RX (prescription) from physician). PT diagnosis gait difficulty muscle weakness...." The assessment indicated client #2 would need PT 2 to 3 times a week for 8 weeks "...with follow up follow-up for gait training, therapeutic exercise, neuromuscular re-ed (re-education)."</p> <p>-10/24/13 PT appointment was canceled as client was admitted to hospital behavioral unit. The form indicated the PT was rescheduled for 11/13/13.</p> <p>-10/24/13 Client #2's appointment for Occupational Therapy (OT) was scheduled for 10/24/13. The 10/24/13 form indicated the OT appointment was canceled and rescheduled for 11/13/13 at 2:45 PM. The note indicated the appointment was canceled as client #2 was in the hospital.</p> <p>-11/13/13 Client #2 "participated in balance &amp; (and) mobility training...Continue balance &amp; mobility training. Will schedule Reval (re-evaluation) as pt. (patient) has been in hospital almost a month."</p> <p>Client #2's above mentioned ROV did not indicate client #2 had an OT evaluation within 30 days of the client</p>				

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	<p>being admitted to the group home. The above mentioned ROV also indicated the client's PT evaluation did not indicate/provide recommendations on how facility staff were to assist the client safely ambulate at the group home, getting on and off the van and/or in the community. The PT evaluation did not include the use of any adaptive equipment (walker, gait belt and/or wheelchair). Client #2's record did not indicate an OT evaluation was obtained with 30 days of the client being admitted to the group home.</p> <p>Client #2's 1/3/14 ROV indicated client #2 was scheduled for a hearing examination/evaluation on 1/3/14, but the appointment was rescheduled due to the weather. Client #2's 12/5/13 ROV indicated the client had a hearing appointment scheduled for 12/5/13 but was canceled and rescheduled for 1/3/14.</p> <p>Interview with the LPN on 1/10/14 at 10:58 AM indicated facility staff should encourage client #2 to use her walker when ambulating as client #2 was a fall risk. The LPN indicated client #2 would refuse to use her walker. The LPN indicated client #2 required one to two staff when ambulating with the client. The LPN indicated client #2 should have</p>						

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	<p>2 staff with her when in the community to ensure the client's safety. The LPN indicated client #2's hearing evaluation had been rescheduled for February 2014. The LPN indicated client #2 would be re-assessed by PT in regard to the client's ambulation. The LPN indicated client #2 had not attended the recommended PT sessions as the client had been in the hospital for her behaviors.</p> <p>Interview with the Qualified Intellectual Disability Professional-Designee (QIDP-D) on 1/10/14 at 2:00 PM indicated client #2 was to utilize a walker when ambulating. The QIDP-D indicated client #2 would refuse to use her walker. The QIDP-D indicated one staff and/or 2 staff would assist client #2 to ambulate due to the client's unsteady gait. The QIDP-D indicated 2 staff would go on the doctor's appointments with client #2 to assist the client to get off the van. The QIDP-D indicated client #2's ISP did not specifically indicate how/when client #2 required one staff versus two staff for ambulation. The QIDP-D indicated client #2's ISP did not specifically indicate how facility staff were to assist the client to ambulate when in the community. The QIDP indicated client #2 did not have an order for a</p>			

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W000227	<p>wheelchair and the client's doctor did not want client #2 in a wheelchair. The QIDP-D indicated client #2 had been re-scheduled for an OT assessment.</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 observation, interview and record review for 2 of 2 sampled clients (#1 and #2), the clients' Individual Support Plans (ISPs) failed to address client #2's refusals to use her walker and/or address client #1's need to maintain her bedroom and clothing.</p> <p>Findings include:</p> <p>1. During the 1/8/14 observation period between 4:40 PM and 6:55 PM and during the 1/9/14 observation period between 5:20 AM and 8:00 AM, at the group home, client #2 was physically assisted to ambulate with a gait belt by one to two staff persons during the above mentioned observation periods. Client #2 was unsteady on her feet in that the client would sway from side to</p>	W000227	<p>CORRECTION: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. Specifically for Client#2, an updated Comprehensive High Risk Plan for Falls has been developed that addresses how staff must support Client #2's ambulation needs including the use of a walker. Additionally, proactive and reactive strategies have been added to Client #2's Behavior Support Plan that address non-cooperation. Specifically for Client #1, the interdisciplinary team will develop a domestic skills objective that trains Client #1 toward maintaining a clean bedroom. PREVENTION:The agency will retrain QIDP and</p>	02/13/2014

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	<p>side when walking. Client #2 did not utilize a walker when ambulating. During the above mentioned observation periods, a walker was present in client #2's bedroom with clothes and/or clothes hangers on the walker.</p> <p>Client #2's record was reviewed on 1/10/14 at 9:55 AM. Client #2's 9/27/13 ISP indicated client #2 had a walker and an "unsteady gait."</p> <p>Client #2's 12/5/13 physician's orders indicated client #2's diagnosis included, but was not limited to, Cerebellar Ataxia (loss of muscle coordination in the brain).</p> <p>Client #2's 9/12/13 High Risk Health Plan for Falls indicated client #2 was to use a "rolling walker for gait safety" when ambulating.</p> <p>Client #2's undated typed instructions indicated "...2. While ambulating with 1 person. Hold on to the back of gait belt and one hand on the walker (sic). 3. While ambulating with 2 people each person has a hold of the side of the gait belt and hand on the walker...."</p> <p>Client #2's 12/16/13 revised Behavior Support Plan (BSP) indicated client #3 had a targeted behavior of</p>		<p>facility nurse regarding the need to develop necessary supports and measureable objectives to support clients toward independence. Members of the Operations Team will incorporate audits of support documents into weekly visits to the facility for the next 60 days and after two months, no less than monthly to assure appropriate supports are included in each client's support plan. RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Behavior Therapist, Health Services Team, Operations Team</p>	

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	<p>"Non-Compliance: Health any time [client #2] refuses and does not take her scheduled medications and medical treatments, refuses to eat meal or meal substitute or refuses to follow medical/health/safety directions (including appointments) as indicated on the physician's and dietary orders..."</p> <p>Client #2's 12/16/13 BSP and/or 9/27/13 ISP did not specifically address client #2's refusals to utilize her walker.</p> <p>Interview with the LPN on 1/10/14 at 10:58 AM indicated facility staff should encourage client #2 to use her walker when ambulating as client #2 was a fall risk. The LPN indicated client #2 would refuse to use her walker.</p> <p>Interview with the Qualified Intellectual Disability Professional-Designee (QIDP-D) on 1/10/14 at 2:00 PM indicated client #2 was to utilize a walker when ambulating. The QIDP-D indicated client #2 would refuse to use her walker. The QIDP-D indicated client #2's ISP did not specifically address the client's refusals to use her walker.</p> <p>2. An observation was conducted of client #1's bedroom on 1/8/14 at 1 PM and on 1/10/14 at 4 PM. On both observations the floor of client #1's</p>			

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	<p>bedroom was covered with various clothing, underwear, purses, shoes and personal items. Two laundry baskets and a laundry hamper were mixed with all the clothing on the floor and the hampers were over flowing with clothing. Two of the four drawers of the chest of drawers were pulled open and clothing was hanging from the drawers. The bed was unmade and clothes, including a winter coat, were on the bed.</p> <p>Client #1's record was reviewed on 1/10/14 at 11 AM. Client #1's CFA (Comprehensive Functional Assessment) of 8/5/13 indicated client #1 was not independent in putting her clothes in the drawer or chest or in hanging her clothing in a closet without staff supervision and prompting. Client #1's ISP (Individualized Support Plan) of 12/18/13 indicated no objectives to teach client #1 to maintain her bedroom and to care for her clothing.</p> <p>During interview with staff #2 on 1/10/14 at 4 PM, staff #2 stated, "Her room always looks like this." When asked if the clothes on the floor and in the laundry baskets were clean or dirty, staff #2 stated, "Clean, no dirty. I don't know."</p> <p>Interview with the QIDPD (Qualified</p>			

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W000240	<p>Intellectual Disabilities Professional Designee) on 1/10/14 at 5 PM indicated client #1 did not have any objectives in her ISP to assist her with maintaining and cleaning her bedroom and taking care of her clothing.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2) and for 2 additional clients (#3 and #4), the facility failed to ensure client #2's Individual Support Plan (ISP) specifically indicated how facility staff were to ambulate with the client while in the group home, out in the community, and/or how to monitor/supervise the client while on the toilet to ensure the client's safety and to prevent falls/injuries. The facility failed to ensure client #1, #2, #3 and #4's ISPs specifically indicated/included what kitchen and laundry room items would need to be locked when the clients demonstrated self-injurious and/or suicidal behavior.</p> <p>Findings include:</p>	W000240	<p>CORRECTION: The individual program plan must describe relevant interventions to support the individual toward independence. Specifically: For Client #2, an updated Comprehensive High Risk Plan for Falls has been developed that addresses how staff must support Client #2's ambulation needs including the use of a walker. Additionally, proactive and reactive strategies have been added to Client #2's Behavior Support Plan that address non-cooperation. For Clients #1 – #4, the interdisciplinary team will develop a comprehensive list of kitchen and laundry items that need to be secured during episodes of self-injurious and/or suicidal behaviors. These lists will be specific to each client. Behavior Support Plans will include specific criteria for when</p>	02/13/2014

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	<p>1. During the 1/8/14 observation period between 4:40 PM and 6:55 PM, at the group home, client #2 wore a gait belt. While sitting in a chair with arms at the dining room table, client #2 leaned over to the side of the chair. Client #2 asked to go to the bathroom. Staff #9 held the back of client #2's gait belt and physically assisted client #2 to stand and walk. Client #2 was unsteady on her feet as the client swayed from side to side. Staff #9 asked client #2 to stop, wait and walk slowly. Staff #9 assisted client #2 to walk by holding the back of the gait belt with one hand and hyper extending client #2's right arm up in the air and holding with staff's other hand. Once client #2 was finished using the bathroom, staff #9 assisted client #2 to walk from the bathroom to her bedroom. Client #2 had an unsteady gait and the client's right arm was extended in the air. At 6:36 PM, two staff (staff #8 and #9) physically assisted client #2 to ambulate from her bedroom to the dining room table. A staff person was on each side of the client holding the back of the client's gait belt, not the handles/loops on the gait belt. Client #2's left and right arms were extended out and up in the air with each staff holding the client's hands as they assisted the client to ambulate/walk.</p>		<p>the restrictions should be removed. PREVENTION: The QIDP will receive training regarding the need to develop specific supports to address safety and behavioral issues as assessed by the interdisciplinary team. Members of the Operations Team will conduct active treatment observations at the facility on a weekly basis for the next 60 days and after two months, no less than monthly to assure Behavior Support Plans are implemented as written. The observations will be designed to assure that training programs and interventions are in place to support health, safety and dignity. These observations will include interviews with direct support staff to assess and address as needed competency and knowledge of updated behavior supports. RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Behavior Therapist, Health Services Team, Operations Team</p>				

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	<p>Client #2 was unsteady while ambulating with 2 staff. When staff held the client's gait belt, client #2's gait belt would rise up the client's back.</p> <p>During the 1/9/14 observation period between 5:20 AM and 8:00 AM, at the group home, staff #4 physically assisted client #2 to go to the bathroom. Client #2's gait was unsteady as the client swayed from side to side. Staff #4 held client #2's gait belt on the side and held client #2's left arm at the shoulder area when ambulating with the client. The loops/handles on the gait belt were not used. At 7:22 AM, two staff (staff #3 and #5) went into client #2's bedroom to assist the client to get up and to go to the office area for her medications. Staff #3 and #5 held the back of client #2's gait belt (not the handles or the loops) while each staff held the hands of client #2. Client #2's arms were extended up and out. During both observation periods, a walker was present in client #2's bedroom with clothes and/or clothes hangers on the walker.</p> <p>The facility's reportable incident reports, internal Incident/Accident Reports (IARs) and/or investigations were reviewed on 1/9/14 at 10:46 AM. The facility's 12/30/13 IAR indicated "[Client #2] was getting out of the van at</p>			

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	<p>doctors (sic) office with staff assistance. Staff prompted [client #2] to steady feet before starting to walk [client #2] ignored staff's prompts and continued to walk landing (sic) her feet together and fell to the right. Staff gently blocked [client #2] hitting the ground. [Client #2] hit her right knee and right palm of hand. Staff assisted [client #2] up and sat down in doctor's office." The IAR indicated 2 staff witnessed and/or were involved in the incident. The facility's 12/30/13 IAR indicated "Staff will continue to encourage [client #2] to walk slowly to prevent future occurrences."</p> <p>The facility's attached 12/20/13 Injury Follow-Up Flow Chart indicated client #2 was not injured.</p> <p>The attached 12/30/13 Fall Assessment indicated client #2 fell getting out of the van. The fall assessment indicated "...HOW COULD THIS BE PREVENTED IN THE FUTURE? Have 2 people assisting [client #2] when getting out of the van/walking." The 12/30/13 fall assessment was completed by staff #5 who was present when client #2 fell.</p> <p>The facility's 12/18/13 reportable incident report indicated "While [client</p>			

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	<p>#2] was using the restroom, she leaned over to get the toilet paper and fell off of the toilet, landing on her right hip/thigh and right elbow. Before [client #2] began leaning, she did not let staff know what she was needing or staff would have gotten the toilet paper for her. Staff had a 1:1 (staff to client conversation) with [client #2] about her needing to ask for assistance so that accidents are less likely to happen. [Client #2] agreed to ask in the future."</p> <p>Client #2's record was reviewed on 1/10/14 at 9:55 AM. Client #2's 9/27/13 ISP indicated client #2 had an "unsteady gait."</p> <p>Client #2's 12/5/13 physician's orders indicated client #2's diagnosis included, but was not limited to, Cerebellar Ataxia (loss of muscle coordination in the brain).</p> <p>Client #2's Record Of Visits (ROV) indicated the following:</p> <p>-10/17/13 A Physical Therapy (PT) evaluation was completed. The assessment indicated "Requires gait assistance for safety and core weakness noted. Lower extremity strength functional limits, decreased left ankle ROM Myalgia (per RX (prescription)</p>						

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	<p>from physician). PT diagnosis gait difficulty muscle weakness...." The assessment indicated client #2 would need PT 2 to 3 times a week for 8 weeks "...with follow up follow-up for gait training, therapeutic exercise, neuromuscular re-ed (re-education)."</p> <p>-10/24/13 PT appointment was canceled as client was admitted to hospital behavioral unit. The form indicated the PT was rescheduled for 11/13/13.</p> <p>-11/13/13 Client #2 "participated in balance &amp; (and) mobility training...Continue balance &amp; mobility training. Will schedule Reval (re-evaluation) as pt. (patient) has been in hospital almost a month."</p> <p>An undated typed form indicated the following:</p> <p>"1. Must be 1 to 1 staff at all times and this requires within arms reach except when in bed asleep. When asleep she is eyesight with door open.</p> <p>2. While ambulating with 1 person. Hold on to the back of gait belt and one hand on the walker.</p> <p>3. While ambulating with 2 people each person has a hold of the side of the gait</p>						

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	<p>belt and one hand on the walker...."</p> <p>Client #2's 9/12/13 Comprehensive High Risk Health Plan indicated client #2 had a history of falls. The risk plan indicated was a fall risk due to the Cerebral Ataxia. The risk plan indicated the the following:</p> <ol style="list-style-type: none"> <li>"1. Use roller walker for gait safety.</li> <li>2. Utilize a gait belt.</li> <li>3. Provide nonskid footwear at all times.</li> <li>4. Use wheelchair when unsteady for extended community outings.</li> <li>5. Utilize shower chair or bath bench during ADL (adult daily living) care.</li> <li>6. Staff to provide at least standby assistance during showering (Do not submerge in bath tub unless otherwise indicated by IDT (interdisciplinary team).</li> <li>7. Should fall occur NOTIFY the nurse Immediately-with or without injury.</li> <li>8. Nurse will assess [client #2] within 24 hours of all reported falls- with or without injury...."</li> </ol>			

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	<p>Client #2's 9/20/13 risk plan for Fractures indicated the client had a history of fractures due to the client's self injurious behaviors. The risk plan indicated the following (not all inclusive):</p> <ol style="list-style-type: none"> <li>"1. Keep area free of clutter.</li> <li>2. Avoid use of area/throw rugs.</li> <li>3. Provide nonskid footwear at all times.</li> <li>4. Staff to provide hands-on assistance when entering and exiting the van.</li> <li>5. Staff to provide standby assistance during in home ambulation exercises.</li> <li>6. Staff to provide at least standby assistance during showering/bathing...."</li> </ol> <p>Client #2's 9/27/13 ISP and/or above mentioned notes/risk plans did not specifically indicate when/how facility staff were to ambulate with the client to prevent falls, and/or indicate how facility staff were to supervise the client while toileting to prevent falls.</p> <p>Interview with the LPN on 1/10/14 at 10:58 AM indicated facility staff should</p>			
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	<p>encourage client #2 to use her walker when ambulating as client #2 was a fall risk. The LPN indicated client #2 would refuse to use her walker. The LPN indicated client #2 required one to two staff when ambulating with the client. The LPN indicated client #2 should have 2 staff with her when in the community to ensure the client's safety.</p> <p>Interview with the Qualified Intellectual Disability Professional-Designee (QIDP-D) on 1/10/14 at 2:00 PM indicated client #2 was to utilize a walker when ambulating. The QIDP-D indicated client #2 would refuse to use her walker. The QIDP-D indicated one staff and/or 2 staff would assist client #2 to ambulate due to the client's unsteady gait. The QIDP-D indicated 2 staff would go on the doctor's appointments with client #2 to assist the client to get off the van. The QIDP-D indicated client #2's ISP did not specifically indicate how/when client #2 required one staff versus two staff for ambulation. The QIDP-D indicated client #2's ISP did not specifically indicate how facility staff were to assist the client to ambulate when in the community. The QIDP indicated client #2 did not have an order for a wheelchair and the client's doctor did not want client #2 in a wheelchair.</p>			

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	<p>2. During the 1/8/14 observation period between 4:40 PM and 6:55 PM, at the group home, client #4 was in the kitchen helping staff #6 cook the dinner meal. At one point, client #4 placed forks on plates. Client #4 turned to staff #6 and told the staff she needed two more forks. Staff #6 retrieved keys and unlocked a cabinet located underneath the kitchen sink. Client #4 walked over and removed two forks from the silverware container. Staff #6 locked the cabinet again. The locked cabinet contained eating utensils, cooking utensils (spatulas, cooking spoons, measuring cups, whip and etc.). The locked cabinet also contained cleaning supplies. During the above mentioned observation period, clients #1, #2, #3 and #4 did not display any maladaptive behaviors and/or require supervision due to behaviors of self injury and/or suicide.</p> <p>Client #2's record was reviewed on 1/10/14 at 9:55 AM. Client #2's revised 12/16/13 Behavior Support Plan (BSP) indicated when client #2 was on Modified Enhanced Supervision (MES) for threats to herself/others in the home and/or community, the facility would lock "...Items that she could use to harm or kill herself, to include sharps and all household cleaning chemicals, or other</p>			
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	<p>potentially dangerous items in the kitchen or laundry room...." Client #2's BSP did not specifically indicate and/or define what could be locked from the kitchen and/or laundry room areas.</p> <p>Client #1's record was reviewed on 1/10/14 at 11:00 AM. Client #1's 12/17/13 BSP indicated "...When on MES, [client #1] will not have any access to ...Working on goals that allow her access to items that she could use to harm or kill herself, to include sharps and all household cleaning chemicals or others in the kitchen R laundry room. All potentially dangerous items will be locked until [client #1] of off 1:1 (one staff to one client) and MES and the team has assessed her as being in control and not a danger to herself and/or others..." Client #1's BSP and/or 12/18/13 ISP did not specifically indicate what kitchen and/or laundry items were to be locked.</p> <p>Client #3's record was reviewed on 1/10/14 at 12:45 PM. Client #3's 11/13/13 BSP indicated if client #3 demonstrated self-injurious behavior and/or suicide, client #3 would be placed on enhanced supervision. The BMP indicated cleaning supplies/chemicals, sharps and any "potentially dangerous items in the</p>						

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	<p>kitchen or laundry room" would be locked. Client #3's BSP did not specifically indicate what items should be locked in the kitchen and/or in the laundry room.</p> <p>Client #4's record was reviewed on 1/10/14 at 1:10 PM. Client #4's 12/13/13 BSP indicated when the client was on MES due to self injury and/or suicidal behaviors, cleaning supplies, sharps and other "potentially dangerous items in the kitchen or laundry room" would be locked when the client was placed on one to one supervision. Client #4's BSP indicated the client would not have access to these items until she was off one on one. Client #4's BSP did not specifically indicate what items from the kitchen and laundry would need to be locked.</p> <p>Interview with the Qualified Intellectual Disabilities Professional-Designee (QIDP-D) on 1/10/14 at 2:00 PM indicated the silverware/cabinet under the sink should not be locked unless the clients were having behaviors or placed on one to one supervision due to their behaviors. The QIDP-D indicated the clients' ISPs did not include what items were to be locked.</p> <p>9-3-4(a)</p>				

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W000242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based on record review and interview for 1 of 2 sample clients (#1), the facility failed to address client #1's identified training need in regard to understanding dental hygiene and oral health.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 1/10/14 at 11 AM.</p> <p>__ Client #1's Dental Summary Progress Report of 9/5/13 indicated client #1 required fillings in six of her teeth. The report indicated dental decay and restoration needed.</p> <p>__ Client #1's undated Healthcare Addendum indicated "[Name of doctor] recommends that [client #1] brush her teeth at least twice daily."</p> <p>__ Client #1's CFA (Comprehensive Functional Assessment) of 8/5/13 indicated client #1 required supervision</p>	W000242	<p>CORRECTION:As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Specifically, Staff have been trained on Client #2's revised Comprehensive High Risk Plan for falls –including appropriate use of Client #2's walker and gait belt.Direct support staff will be retrained on implementation of Client #3's medication education strategies. Staff will be trained on revised Behavior Support plans for each client that include specific criteria for when items may be secured due to self-injurious and/or suicidal behaviors. PREVENTION:The QIDP will be expected to observe</p>	02/13/2014
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	<p>to brush her teeth.</p> <p>__ Client #1's 12/2013 MARs (Medication Administration Records) indicated staff were to observe client #1 brush her teeth in the AM and at HS (bedtime). The MAR indicated client #1 refused to brush her teeth 6 out of 31 times in the AM and 31 out of 31 times at HS.</p> <p>__ Client #1's ISP (Individualized Support Plan) of 12/18/13 indicated no objectives to assist client #1 with understanding oral hygiene and tooth brushing.</p> <p>Interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 1/10/14 at 5 PM stated client #1 "frequently refused" to brush her teeth." The QIDPD stated, "I know she had to have several fillings and it's not that she can't brush her teeth, she just won't." The QIDPD indicated there were no objectives to assist client #1 with understanding dental hygiene and oral health.</p> <p>9-3-4(a)</p>		<p>no less than two morning and two evening active treatment sessions per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff implement medication education objectives and implement behavior supports and risk plans as written A QIDP from a separate facility providing supports to individuals with similar developmental and behavioral needs will perform periodic cross reviews of active treatment, providing coaching and training as needed. Additionally, members of the Operations Team will conduct active treatment observations on a weekly basis for the next 60 days and after two months, no less than monthly to assure staff implement medication education objectives and implement behavior supports and risk plans as written. RESPONSIBLE PARTIES:QIDP, Direct Support Staff, Health Services Team, Behavior Therapist, Operations Team</p>		

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2) and for 2 additional clients (#3 and #4), the facility failed to ensure the clients' Individual Support Plans (ISPs) objectives and/or risk plans were implemented as written when formal and/or informal training opportunities existed.</p> <p>Findings include:</p> <p>1. During the 1/8/14 observation period between 4:40 PM and 6:55 PM and during the 1/9/14 observation period between 5:20 AM and 8:00 AM, at the group home, client #2 was physically assisted to ambulate with a gait belt by one to two staff persons during the above mentioned observation periods. Client #2 was unsteady on her feet in that the client would sway from side to side when walking. Client #2 did not utilize a walker when ambulating. During the above mentioned observation periods, a walker was present in client</p>	W000249	<p>CORRECTION:As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Specifically, Staff have been trained on Client #2's revised Comprehensive High Risk Plan for falls –including appropriate use of Client #2's walker and gait belt. Direct support staff will be retrained on implementation of Client #3's medication education strategies. Staff will be trained on revised Behavior Support plans for each client that include specific criteria for when items may be secured due to self-injurious and/or suicidal behaviors. PREVENTION:The QIDP will be expected to observe no less than two morning and two evening active treatment sessions per week to assess direct support staff interaction with clients and to</p>	02/13/2014

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	<p>#2's bedroom with clothes and/or clothes hangers on the walker.</p> <p>Client #2's record was reviewed on 1/10/14 at 9:55 AM. Client #2's 9/27/13 ISP indicated client #2 had a walker.</p> <p>Client #2's 9/12/13 High Risk Health Plan for Falls indicated client #2 was to use a "rolling walker for gait safety" when ambulating.</p> <p>Client #2's undated typed instructions indicated "...2. While ambulating with 1 person. Hold on to the back of gait belt and one hand on the walker (sic). 3. While ambulating with 2 people each person has a hold of the side of the gait belt and hand on the walker...."</p> <p>Interview with the LPN on 1/10/14 at 10:58 AM indicated facility staff should encourage client #2 to use her walker when ambulating as client #2 was a fall risk.</p> <p>Interview with the Qualified Intellectual Disability Professional-Designee (QIDP-D) on 1/10/14 at 2:00 PM indicated client #2 was to utilize a walker when ambulating.</p> <p>2. During the 1/9/14 observation period between 5:20 AM and 8:00 AM, at the</p>		<p>provide hands on coaching and training including but not limited assuring staff implement medication education objectives and implement behavior supports and risk plans as written A QIDP from a separate facility providing supports to individuals with similar developmental and behavioral needs will perform periodic cross reviews of active treatment, providing coaching and training as needed. Additionally, members of the Operations Team will conduct active treatment observations on a weekly basis for the next 60 days and after two months, no less than monthly to assure staff implement medication education objectives and implement behavior supports and risk plans as written. RESPONSIBLE PARTIES:QIDP, Direct Support Staff, Health Services Team, Behavior Therapist, Operations Team</p>				

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	<p>group home, staff #4 administered client #3 her morning medications which included Chlorpromazine (antipsychotic) 150 milligrams. Staff #4 did not provide any medication training with client #3.</p> <p>Client #3's record was reviewed on 1/10/14 at 12:45 PM. Client #3's 11/13/13 ISP indicated client #3 was to state 3 side effects of her (Thorazine) Chlorpromazine with 3 verbal prompts.</p> <p>Interview with the QIDP-D on 1/10/14 at 10:58 AM indicated client #3's medication training objective should be implemented at the medication pass.</p> <p>3. During the 1/8/14 observation period between 4:40 PM and 6:55 PM, at the group home, client #4 was in the kitchen helping staff #6 cook the dinner meal. At one point, client #4 placed forks on plates. Client #4 turned to staff #6 and told the staff she needed two more forks. Staff #6 retrieved keys and unlocked a cabinet located underneath the kitchen sink. Client #4 walked over and removed two forks from the silverware container. Staff #6 locked the cabinet again. The locked cabinet contained eating utensils, cooking utensils (spatulas, cooking spoons, measuring cups, whip and etc.). The locked cabinet</p>			

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	<p>also contained cleaning supplies. During the above mentioned observation period, clients #1, #2, #3 and #4 did not display any maladaptive behaviors and/or require supervision due to behaviors of self injury and/or suicide.</p> <p>Client #1's record was reviewed on 1/10/14 at 11:00 AM. Client #1's 12/17/13 BSP indicated "...When on MES, [client #1] will not have any access to ...Working on goals that allow her access to items that she could use to harm or kill herself, to include sharps and all household cleaning chemicals or others in the kitchen R laundry room. All potentially dangerous items will be locked until [client #1] of off 1:1 (one staff to one client) and MES and the team has assessed her as being in control and not a danger to herself and/or others...."</p> <p>Client #2's record was reviewed on 1/10/14 at 9:55 AM. Client #2's revised 12/16/13 Behavior Support Plan (BSP) indicated when client #2 was on Modified Enhanced Supervision (MES) for threats to herself/others in the home and/or community, the facility would lock "...Items that she could use to harm or kill herself, to include sharps and all household cleaning chemicals, or other potentially dangerous items in the</p>						

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	<p>kitchen or laundry room...."</p> <p>Client #3's record was reviewed on 1/10/14 at 12:45 PM. Client #3's 11/13/13 BSP indicated if client #3 demonstrated self-injurious behavior and/or suicide, client #3 would be placed on enhanced supervision. The BMP indicated cleaning supplies/chemicals, sharps and any "potentially dangerous items in the kitchen or laundry room" would be locked.</p> <p>Client #4's record was reviewed on 1/10/14 at 1:10 PM. Client #4's 12/13/13 BSP indicated when the client was on MES due to self injury and/or suicidal behaviors, cleaning supplies, sharps and other "potentially dangerous items in the kitchen or laundry room" would be locked when the client was placed on one to one supervision. Client #4's BSP indicated the client would not have access to these items until she was off one on one.</p> <p>Interview with the Qualified Intellectual Disabilities Professional-Designee (QIDP-D) on 1/10/14 at 2:00 PM indicated the silverware/cabinet under the sink should not be locked unless the clients were having behaviors or placed on one to one supervision due to their</p>				

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	<p>behaviors. The QIDP-D indicated clients #1, #2, #3 and #4 were not on increased supervision due to their behaviors on 1/9/14.</p> <p>Observations were conducted at the group home of the evening medication pass on 1/8/14 between 4:10 PM and 4:25 PM. During this time staff #6 was observed to give client #3 the following medications:</p> <p>__ Cogentin 1 mg (milligram) for side effects from the behavior medications          __ Thorazine 100 mg for IED (Intermittent Explosive Disorder) and Borderline Personality Disorder          __ Claritin 10 mg for Asthma          __ Ativan 2 mg for agitation          __ Remeron 15 mg for anxiety          __ Prilosec 20 mg for GERD (Gastric Esophageal Reflux Disease)          __ Oxaprozin 600 mg for inflammation          __ Topamax 100 mg for mood disorder</p> <p>During this observation staff #6 did not provide client #3 any medication training as to the medications the client took and/or the side effects of the medications that were given.</p> <p>Interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 1/10/14 at 4:00 PM indicated staff are to provide the clients</p>				

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W000262	<p>training at every opportunity available.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE 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 interview and record review for 2 of 2 sampled clients (#1 and #2), the facility failed to develop a system to ensure its Human Rights Committee (HRC) deliberated and discussed plans that included restrictive interventions and/or behavioral medications as the facility was calling each HRC member individually for approvals.</p> <p>Findings include:</p> <p>1. Client #2's record was reviewed on 1/10/14 at 9:55 AM. Client #2's HRC Conference Calling forms indicated the following (not all inclusive):</p> <p>-9/23/13 Four of seven HRC members were called separately to obtain approval for client #2's new Behavior Support Plan (BSP) as the client was a new admission to the group home. The HRC form also indicated approval was</p>	W000262	<p>CORRECTION: 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. Specifically, the governing body has developed a collaborative Human Rights Committee Process which will be used to assure that the committee reviews and consensually approves Client #1 and Client #2's current restrictive programs. PREVENTION: The QIDP will be retrained regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent.</p>	02/13/2014			

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	<p>obtained for client #2's restrictive psychotropic medications. A separate 9/23/13 form indicated 4 members approved the use of You're Safe, I'm Safe restraint techniques.</p> <p>-10/1/13 HRC members were called separately to approve the use of a soft helmet for client #2's self-injurious behavior of head banging. The form indicated 4 members were called and approved the restrictive technique.</p> <p>-10/8/13 HRC members were called separately to approve the use of a face shield when client #2 demonstrated the behavior of spitting. One member's comments indicated "As long as guardian is OK with it."</p> <p>-11/18/13 HRC members were called separately to obtain approval for the use of Ativan and Haldol PRN (as needed) injections used to control client #2's behaviors. The form indicated 4 of 7 members were called.</p> <p>-12/16/13 HRC members were called separately to obtain approval for the use of Invega 156 milligrams Intramuscular (IM) shot due to an increase in client #2's behaviors. The form indicated 3 of 7 members were contacted for approval.</p>		<p>Administrative staff will conduct visits to the facility on a weekly basis for the next 60 days and after two months, no less than monthly The Program Manager will incorporate monitoring of annual HRC approvals of restrictive programs into the current tracking process. RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Operations Team</p>				

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	<p>Interview with the Qualified Intellectual Disabilities Professional-Designee (QIDP-D) on 1/10/14 at 2:00 PM indicated the facility's HRC members were called to initially approve the above mentioned rights restrictions. The QIDP-D indicated she called each member separately for approval. The QIDP indicated the members called were not able to hold a discussion in regard to the restrictive techniques and/or medications.</p> <p>2. Client #1's record was reviewed on 1/10/14 at 11 AM. Client #1's 12/17/13 Behavior Support Plan (BSP) indicated the client received the following psychotropic medications:          ___ Chlorpromazine 25 milligrams a day for Schizoffective Disorder.          ___ Invega Sustenna 156 mg for PTSD (Post Traumatic Stress Disorder) and Borderline Personality Disorder.          ___ Depakote 1000 mg a day for PTSD and Borderline Personality Disorder.          ___ Ritalin 10 mg twice a day for decreased mood, energy and motivation.          ___ Effexor XR (extended release) 150 mg a day for depression.          ___ Chlorpromazine 50 mg as needed every four hours for severe agitation.</p> <p>Client #1's physician's orders for 1/2014 indicated client #1 was taking Cogentin</p>						

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	<p>0.5 milligrams (mg) once a day for EPS (extrapyramidal symptoms - side effects associated with antipsychotic medications).</p> <p>Client #1's BSP also indicated client #1 had the following restrictive interventions in her BSP:</p> <p>__ You're Safe, I'm Safe (physical intervention/restraint techniques) for physical aggression, property destruction and suicidal threats which included, blocking, one person hold and two person hold.</p> <p>__ Calling 911 when client #1's behavior "...jeopardizes the safety and well-being of peers, community members and staff..."</p> <p>__ Restrictions from the community while on modified enhanced supervision due to behaviors.</p> <p>__ During enhanced supervision techniques the staff "will conduct a room sweep and all items that [client #1] could potentially use to harm herself or others will be removed from her room."</p> <p>The facility's Human Rights Committee (HRC) notes for 2013 were reviewed on 1/10/14 at 3 PM. The facility's 2013 HRC notes for the approval of client #1's restrictions indicated the facility called each HRC member individually to obtain approval for client #1's</p>			

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W000268	<p>medications/restrictions/BSP approval and updates.</p> <p>Interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 1/10/14 at 5 PM indicated the facility's HRC was called individually by telephone to approve each of client #1's restrictions, behavior medication changes and approval for the client's BSP. The QIDPD indicated the HRC did not meet in person and/or via conference call to review and/or approve restrictions. The QIDPD stated, "I just call everyone one by one to get approval." The facility failed to allow for dialogue between the HRC members and/or a consensus of opinion.</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. Based on observation and interview for 1 additional client (#4), the facility failed to encourage and/or prompt the client to wear a coat on a cold winter day where the temperatures were in the low 20's to ensure the client's safety and dignity when going out into the</p>	W000268	CORRECTION: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. Specifically: The use	02/13/2014

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	<p>community.</p> <p>Findings include:</p> <p>During the 1/8/14 observation period between 4:40 PM and 6:55 PM, at the group home, client #4 left the group home with staff #2 to go shopping in the community. Client #4 had a light jacket on when she left the group home. Staff #2 did not encourage and/or prompt client #4 to wear and/or put on winter coat as it was cold outside (temperatures in the lower 20s).</p> <p>Interview with staff #8 on 1/9/14 at 5:45 AM indicated client #4 had a coat. When asked if client #4 should wear a coat when going outside, staff #8 stated "Yes."</p> <p>Interview with the Qualified Intellectual Disabilities Professional-Designee (QIDP-D) on 1/10/14 at 2:00 PM indicated client #4 had a coat. QIDP-D indicated the facility purchased a coat for the client as the client came to the group home with no coat. The QIDP-D indicated client #4 was admitted to the group home in the past month. The QIDP-D indicated facility staff should have encouraged client #4 to put on her winter coat when going out into the community on 1/8/14.</p>		<p>of Cogentin has been incorporated into Client #1's Behavior Support Plan. The use of Ambien has been incorporated into Client #2's Behavior Support Plan. Client #2's Behavior Support Plan has been revised to address strategies to develop good sleeping habits. PREVENTION:Revisions of behavior supports to reflect current assessed needs will be developed and revised as needed. Members of the Operations Team will review Behavior Support Plans as part of an ongoing internal audit process that will include assuring that behavior controlling drugs are used only as an integral part of each individual program. The Operations Team will conduct site visits that incorporate BSP reviews on a weekly basis for the next 60 days and after two months, no less than monthly. RESPONSIBLE PARTIES:QIDP, Direct Support Staff, Behavior Therapist, Health Services Team, Operations Team</p>				

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W000312	<p>9-3-5(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 2 of 2 sampled clients receiving medications to control behaviors (#1 and #2), the facility failed to ensure the use of all psychoactive/behavior modification medications were included in the clients' BSPs (Behavior Support Plans).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 1/10/14 at 11 AM. Client #1's quarterly physician's orders for January 2014 indicated client #1 received Cogentin one milligram twice daily for extrapyramidal symptoms (side effects associated with taking antipsychotic medications). Client #1's BSP dated 12/17/13 did not include the use of Cogentin.</p> <p>Interview via email dated 1/14/14 at 2:30 PM from the Behavior Clinician</p>	W000312	<p>CORRECTION: 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. Specifically: The use of Cogentin has been incorporated into Client #1's Behavior Support Plan. The use of Ambien has been incorporated into Client #2's Behavior Support Plan. Client #2's Behavior Support Plan has been revised to address strategies to develop good sleeping habits. PREVENTION: Revisions of behavior supports to reflect current assessed needs will be developed and revised as needed. Members of the Operations Team will review Behavior Support Plans as part of an ongoing internal audit process that will include assuring that behavior controlling drugs are used only as an integral part of</p>	02/13/2014			

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	<p>reviewed on 1/14/14 at 2:35 PM indicated client #1's "Cogentin was to be listed in the med (medicine) section on her annual BSP that I revised and updated (sic) after [client #1's] December 2013 annual. When updating her (client #1's) plan, I did not insure the Cogentin was listed."</p> <p>2. Client #2's record was reviewed on 1/10/14 at 9:55 AM. Client #2's December 2013 physician's orders indicated client #2 received the following (not all inclusive) medications:</p> <p>-Invega 156 milligrams (IM) (Intramuscular injection) once a month for IED (Intermittent Explosive Disorder).</p> <p>-Methocarbamol 750 milligrams 2 tablets three times a day for IED.</p> <p>-Zolpidem (Ambien) 5 milligrams at bedtime as needed (PRN) for sleeplessness.</p> <p>Client #2's revised 12/16/13 Behavior Support Plan (BSP) indicated the client demonstrated the targeted behaviors of physical aggression, verbal aggression, leaving assigned areas, non-compliance with health, non-compliance with</p>		<p>each individual program. The Operations Team will conduct site visits that incorporate BSP reviews on a weekly basis for the next 60 days and after two months, no less than monthly. RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Behavior Therapist, Health Services Team, Operations Team</p>				

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	<p>programs and emotional manipulation. Client #2's BSP indicated client #2's above mentioned medications were not part of/included in the list of behavioral medications in the client's BSP. The BSP did not include the use of Ambien for sleeplessness, and/or include an active treatment program which addressed the use of the Ambien for which it was prescribed. Client #2's BSP also did not include a plan of reduction based on the behavior (sleeplessness) for the use of the Ambien.</p> <p>Interview with the Qualified Developmental Intellectual Disabilities Professional-Designee (QIDP-D) on 1/10/14 at 2:00 PM indicated client #2's behavioral medications should be listed in the client's behavior plan. The QIDP-D indicated client #2 received the Ambien for sleeplessness and the facility was tracking how the client slept at night. The QIDP-D indicated she could not locate an active treatment plan for the use of the Ambien with a plan of reduction.</p> <p>9-3-5(a)</p>				

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W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 1 of 2 sampled clients (#1), the facility failed to ensure the client's vision was evaluated annually.</p> <p>Findings Include:</p> <p>Client #1's record was reviewed on 1/10/14 at 11 AM. Client #1's record indicated client #1 was to wear eye glasses "during all waking hours." Client #1's annual physical examination of 10/11/13 did not indicate a thorough evaluation of the client's vision.</p> <p>Client #1's record indicated client #1's most current vision evaluation was conducted on 11/13/12.</p> <p>Review of an email dated 1/14/14 from the facility Licensed Practical Nurse (LPN) reviewed on 1/14/14 at 9:15 AM indicated the most current vision evaluation for client #1 was 11/2012.</p> <p>9-3-6(a)</p>	W000323	<p>CORRECTION: The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Specifically, client #1 will receive a visual examination. PREVENTION: The Health Services Team will work with the Medical Director to develop a plan to assure the visual examination component of the Annual Physical is documented in a clear, understandable and accurate manner. Members of the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than quarterly to assure that examinations including but not limited to visual evaluations take place as required. RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Health Services Team, Operations Team</p>	02/13/2014

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, interview and record review for 1 of 2 sampled clients (#2) and for 1 additional client (#3), the facility's nursing services failed to revise and/or develop risk plans for falls and/or ambulation for client #2. The facility's nursing services failed to implement/follow a client's risk plan to assess the client after fall incidents. The facility's nursing services failed to ensure facility staff notified nursing services in regard to client #3's toe.</p> <p>Findings include:</p> <p>1. During the 1/8/14 observation period between 4:40 PM and 6:55 PM, at the group home, client #2 wore a gait belt. While sitting in a chair with arms at the dining room table, client #2 leaned over to the side of the chair. Client #2 asked to go to the bathroom. Staff #9 held the back of client #2's gait belt and physically assisted client #2 to stand and walk. Client #2 was unsteady on her feet as the client swayed from side to side. Staff #9 asked client #2 to stop, wait and walk slowly. Staff #9 assisted client #2 to walk by holding the back of the gait belt with one hand and hyper</p>	W000331	<p>CORRECTION: The facility must provide clients with nursing services in accordance with their needs. Specifically, the facility nurse has developed a risk plan to address Client 2's ambulation needs, based on recommendations from Client #2's physical Therapist. Additionally, the QIDP and nurse have retrained all staff to notify the nurse of all injuries and any changes in injury status. PREVENTION: The facility nurse will be retrained regarding the need to include specific care procedures as appropriate when developing comprehensive high risk and care plans. The Nurse Manager will review all revisions to facility nursing care plans for the next ninety days and thereafter will perform spot checks of facility nursing care plans as needed but no less than quarterly. Additionally, Operations Team members will review medical documentation while auditing active treatment sessions, no less than monthly, and make recommendations to the Health Services Team as appropriate. RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Health Services Team, Operations Team</p>	02/13/2014			

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	<p>extending client #2's right arm up in the air and holding with staff's other hand. Once client #2 was finished using the bathroom, staff #9 assisted client #2 to walk from the bathroom to her bedroom. Client #2 had an unsteady gait and the client's right arm was extended in the air. At 6:36 PM, two staff (staff #8 and #9) physically assisted client #2 to ambulate from her bedroom to the dining room table. A staff person was on each side of the client holding the back of the client's gait belt, not the handles/loops on the gait belt. Client #2's left and right arms were extended out and up in the air with each staff holding the client's hands as they assisted the client to ambulate/walk. Client #2 was unsteady while ambulating with 2 staff. When staff held the client's gait belt, client #2's gait belt would rise up the client's back.</p> <p>During the 1/9/14 observation period between 5:20 AM and 8:00 AM, at the group home, staff #4 physically assisted client #2 to go to the bathroom. Client #2's gait was unsteady as the client swayed from side to side. Staff #4 held client #2's gait belt on the side and held client #2's left arm at the shoulder area when ambulating with the client. The loops/handles on the gait belt were not used. At 7:22 AM, two staff (staff #3</p>			

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	<p>and #5) went into client #2's bedroom to assist the client to get up and to go to the office area for her medications. Staff #3 and #5 held the back of client #2's gait belt (not the handles or the loops) while each staff held the hands of client #2. Client #2's arms were extended up and out. During both observation periods, a walker was present in client #2's bedroom with clothes and/or clothes hangers on the walker.</p> <p>The facility's reportable incident reports, investigations and internal Incident/Accident Reports (IARs) were reviewed on 1/9/14 at 10:46 AM. The facility's reportable incident reports, IARs and/or investigations indicated the following:</p> <p>-12/30/13 "[Client #2] was getting out of the van at doctors (sic) office with staff assistance. Staff prompted [client #2] to steady feet before starting to walk [client #2] ignored staff's prompts and continued to walk landing (sic) her feet together and fell to the right. Staff gently blocked [client #2] hitting the ground. [Client #2] hit her right knee and right palm of hand. Staff assisted [client #2] up and sat down in doctor's office." The IAR indicated the nurse was notified 12/30/13 "onsite."</p>			

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	<p>The facility's attached 12/20/13 Injury Follow-Up Flow Chart indicated client #2 was not injured.</p> <p>The attached 12/30/13 Fall Assessment indicated client #2 fell getting out of the van. The fall assessment indicated "...HOW COULD THIS BE PREVENTED IN THE FUTURE? Have 2 people assisting [client #2] when getting out of the van/walking." The 12/30/13 fall assessment was completed by staff #5 (direct care staff).</p> <p>-12/18/13 "While [client #2] was using the restroom, she leaned over to get the toilet paper and fell off of the toilet, landing on her right hip/thigh and right elbow. Before [client #2] began leaning, she did not let staff know what she was needing or staff would have gotten the toilet paper for her. Staff had a 1:1 (staff to client conversation) with [client #2] about her needing to ask for assistance so that accidents are less likely to happen. [Client #2] agreed to ask in the future."</p> <p>-11/24/13 "[Client #2] (individual supported by ResCare) got of her chair and was attempting to walk without assistance from staff. As a result [client #2] fell and caught herself on the floor with her right hand. Staff assisted her</p>			

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	<p>from the floor and completed a body check. [Client #2] complained of pain in her right hand and her right palm was red. [Client #2] refused first aid....Additionally, staff will continue to monitor [client #2] while she is ambulating and continue to encourage [client #2] to ask for staff assistance while ambulating."</p> <p>The facility's 11/24/13 IAR indicated the facility's nurse was notified of the fall on 11/24/13 at 9:11 PM.</p> <p>The facility's 11/24/13 Fall Assessment was completed by direct care staff.</p> <p>-10/24/13 Client #2 was having a behavior at the group home. The reportable incident report indicated "...She ran out the back door and fell to the ground and sustained and (sic) abrasion on her knee. Staff performed first aid and remained with her for the remainder of the morning and early afternoon...."</p> <p>-10/23/13 "[Client #2] fell onto the floor from leaping up, her knees buckled and she landed on her knees. Staff was in eyesight but not arms reach to prevent fall...No injuries found." The IAR indicated a facility's nurse was notified at 3:35 PM on 10/23/13.</p>			

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	<p>The facility's 10/23/13 Fall Assessment indicated direct care staff completed the assessment.</p> <p>-10/18/13 "[Client #2] was ready to leave the med room. She ignored [staff #6's] prompt to wait a second because [staff #6] had to hold onto her gait belt to assist her out of the med room. [Client #2] leaped up and out of the chair. When she did her knees automatically buckled and she slumped forward or kinda (sic) fell on her left side. Staff assisted her to chair." The IAR indicated the facility's nurse was notified of the fall on 10/18/13 at 12:13 PM. The IAR indicated client #2 was not injured.</p> <p>The 10/18/13 Fall Assessment indicate direct care staff completed the assessment.</p> <p>-10/15/13 "[Client #2] dropped a piece of popcorn on the floor. As [client #2] was trying to grab it, [client #2] slid down to the floor with staff assistance and hit her big toe knuckle on her right foot on the chair leg. [Client #2] has a small dark bruise on her toe. Staff had ahold (sic) of [client #2's] gait belt, preventing the fall. Staff will continue to be within arm's reach of her to</p>			

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	<p>prevent future occurrences."</p> <p>Client #2's record was reviewed on 1/10/14 at 9:55 AM. Client #2's 9/27/13 ISP (Individualized Support Plan) indicated client #2 had an "unsteady gait."</p> <p>Client #2's 12/5/13 physician's orders indicated client #2's diagnosis included, but was not limited to, Cerebellar Ataxia (loss of muscle coordination in the brain). Client #2's physician's order did not indicate client #2 had an order to use a wheelchair.</p> <p>Client #2's Nursing Monthly Summaries indicated the following (not all inclusive):</p> <p>-12/30/13 Saw doctor for loose stool. The note indicated client #2's Miralax (stool softener mix) was discontinued and the client's Docusate Sodium (stool softener) was held for 3 doses.</p> <p>-12/18/13 "Fell onto floor and hit (L) (left) foot on corner of bed. No C/O (complaints of) pain."</p> <p>-11/26/13 Client #2 was admitted to a hospital's behavioral unit.</p> <p>-10/24/13 Client #2's Occupational</p>			

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	<p>Therapy appointment was canceled as the client was admitted to a hospital's behavioral health unit.</p> <p>-10/17/13 Client #2 had a PT (Physical Therapy) evaluation. The note indicated client #2 would attend PT 2 to 3 times a week.</p> <p>-10/16/13 Client #2 had an intake done for a psychiatric evaluation.</p> <p>-10/14/13 "Behaviors of hitting &amp; (and) kicking staff, throwing self on floor and biting self noted. Was out in YSIS (You're Safe, I'm Safe-physical restraint) hold."</p> <p>An undated typed form indicated the following:</p> <p>"1. Must be 1 to 1 staff at all times and this requires within arms reach except when in bed asleep. When asleep she is eyesight with door open.</p> <p>2. While ambulating with 1 person. Hold on to the back of gait belt and one hand on the walker.</p> <p>3. While ambulating with 2 people each person has a hold of the side of the gait belt and one hand on the walker...."</p>			

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	<p>Client #2's 9/12/13 Comprehensive High Risk Health Plan indicated client #2 had a history of falls. The risk plan indicated was a fall risk due to the Cerebral Ataxia. The risk plan indicated the the following:</p> <p>"1. Use roller walker for gait safety.</p> <p>2. Utilize a gait belt.</p> <p>3. Provide nonskid footwear at all times.</p> <p>4. Use wheelchair when unsteady for extended community outings.</p> <p>5. Utilize shower chair or bath bench during ADL (adult daily living) care.</p> <p>6. Staff to provide at least standby assistance during showering (Do not submerge in bath tub unless otherwise indicated by IDT (interdisciplinary team).</p> <p>7. Should fall occur NOTIFY the nurse Immediately-with or without injury.</p> <p>8. Nurse will assess [client #2] within 24 hours of all reported falls- with or without injury...."</p> <p>Client #2's monthly nursing notes and/or</p>			

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	<p>record indicated the facility's nurse did not assess/monitor client #2 after each fall as indicated by the above mentioned incidents.</p> <p>Client #2's 9/20/13 risk plan for Fractures indicated the client had a history of fractures due to the client's self injurious behaviors. The risk plan indicated the following (not all inclusive):</p> <ol style="list-style-type: none"> <li>"1. Keep area free of clutter.</li> <li>2. Avoid use of area/throw rugs.</li> <li>3. Provide nonskid footwear at all times.</li> <li>4. Staff to provide hands-on assistance when entering and exiting the van.</li> <li>5. Staff to provide standby assistance during in home ambulation exercises.</li> <li>6. Staff to provide at least standby assistance during showering/bathing...."</li> </ol> <p>Client #2's 9/27/13 ISP and/or above mentioned notes/risk plans did not specifically indicate when/how facility staff were to ambulate with the client to prevent falls, and/or indicate how facility staff were to supervise the client</p>			

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	<p>while toileting to prevent falls. Client #2's risk plans indicated the facility's nursing services had not reviewed and/or revised the risk plans as client #2 did not have an order for a wheelchair and was not utilizing the client's walker.</p> <p>Interview with the LPN on 1/10/14 at 10:58 AM indicated facility staff should encourage client #2 to use her walker when ambulating as client #2 was a fall risk. The LPN indicated client #2 would refuse to use her walker. The LPN indicated client #2 required one to two staff when ambulating with the client. The LPN indicated client #2 should have 2 staff with her when in the community to ensure the client's safety. The LPN indicated client #2's doctor did not want the client to utilize a wheelchair as the client had ambulated with a wheelchair in the past prior to coming to the group home. The LPN indicated client #2 did not have a wheelchair in the group home. The LPN indicated the use of a wheelchair should not be in the client's risk plan. The LPN indicated facility staff conducted fall assessments when client #2 had a fall. The LPN indicated she did not always do an assessment of client #2 after each a fall. The LPN stated "Not each time. If I do an assessment, it will be in the nursing notes." The LPN stated client #2 had a</p>			

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	<p>history of wrist and ankle fractures and that the LPN monitored "the hardware in (client #2's) legs."</p> <p>Interview with the Qualified Intellectual Disability Professional-Designee (QIDP-D) on 1/10/14 at 2:00 PM indicated client #2 was to utilize a walker when ambulating. The QIDP-D indicated client #2 would refuse to use her walker. The QIDP-D indicated one staff and/or 2 staff would assist client #2 to ambulate due to the client's unsteady gait. The QIDP-D indicated 2 staff would go on the doctor's appointments with client #2 to assist the client to get off the van. The QIDP-D indicated client #2's ISP did not specifically indicate how/when client #2 required one staff versus two staff for ambulation. The QIDP-D indicated client #2's ISP did not specifically indicate how facility staff were to assist the client to ambulate when in the community and/or at the group home. The QIDP indicated client #2 did not have an order for a wheelchair and the client's doctor did not want client #2 in a wheelchair.</p> <p>2. During the 1/9/14 observation period between 5:20 AM and 8:00 AM, at the group home, client #3 came into the medication room for her morning</p>						

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	<p>medications and indicated her toes were hurting. Client #3 had a small area on the back of her Left big toe which was bleeding. Once staff #4 cleaned the area, client #3's toe had a top layer of skin missing. Client #3 then showed staff #4 her big toe on her left foot. The client had an open like red area on the side of the nail bed of the big toe. The big toe looked swollen and had some drainage. While staff #4 was trying to put clean gloves on to assess client #3's left big toe, client #3 pushed on the area and stated "It's oozing." Staff #4 asked client #3 not to press on the toe and let the staff look at the area. Staff #4 cleaned the area with water and placed a Band-Aid on client #3's toe.</p> <p>The facility BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 1/8/14 at 11:30 AM indicated a report dated 1/8/14 at 8:20 AM. The report indicated client #3 "became physically aggressive towards staff. Staff gently blocked but had to initiate a 1 person YSIS (You're Safe I'm Safe) hold for safety. While in the hold [client #3] kicked the wall, injuring her toe. Once she was calm the hold was released. Staff asked [client #3] to exit the kitchen due to her toe bleeding, [client #3] complied and crawled into the dining room and sat</p>						

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	<p>under the dining room table picking at her injured toe.... [Client #3] pulled off her toenail on her right big toe and received scrapes on the bottom of her left big toe as a result of her behavior...."</p> <p>Review of the I/A (Incident/Accident) report of 1/8/14 at 8:20 AM indicated staff #1 notified the facility LPN (Licensed Practical Nurse) of client #3's injured toe on 1/8/14 at 9:50 AM.</p> <p>Review of the nursing "On Call Log Sheets" for January 2014 on 1/13/14 at 2 PM indicated no calls in regard to injury of client #3's right great toe from 1/8/13 through 1/10/13.</p> <p>Client #3's record was reviewed on 1/10/14 at 2 PM.</p> <p>__ Client #3's Injury Follow Up Flow Chart dated 1/8/14 at 8:20 AM indicated "behavior - kicked wall. Injury to right big toe. Bleeding and nail lifting." The form indicated client #3 refused twice to allow the staff to assess her toe. Staff #3 documented on the form on 1/10/14 (no time documented) "Right big toe has raw tip on end of toe approximate 1/2 pea size. Red/pink in color inside toenail along edge has dried blood."</p> <p>__ Client #3's "Record of Visit" dated 1/10/14 indicated client #3 was seen at a local walk in urgent care clinic at 4:52 PM to have her right great toe examined.</p>			

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	<p>The record indicated diagnoses of, but not limited to, "wound infection" and "cellulitis." Client #3's record indicated client #3 was to take an antibiotic and to soak her foot in Epsom Salts.</p> <p>__ Client #3's nursing notes indicated a note on 12/30/13 "Soaked rt (right) great toe in Epsom salts and warm water d/t (due to) scaly area and scabbed area..." Client #3's record indicated no other nursing notes in regard to client #3's toe after the note of 12/30/13. Client #3's record did not indicate nursing services had assessed client #3's right great toe after her injury of 1/8/13.</p> <p>Interview with the LPN (Licensed Practical Nurse) on 1/9/14 at 2 PM indicated she had no knowledge of an injured toe in regard to client #3. The LPN stated, "I know she had an issue with her toe when she dropped something on her foot but that's healed up." When the LPN was asked to provide her nursing notes for January 2014, the LPN indicated she was working on January notes and did not have them completed or available for review. The LPN stated the staff "should have" called and reported the injury to the toe.</p> <p>During interview with the QIDPD (Qualified Intellectual Disabilities</p>				

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W000436	<p>Professional Designee) on 1/10/14 at 5 PM, the QIDPD indicated whenever a client was injured due to behaviors or unknown injuries were discovered, the staff were to assess the client and report all new injuries to the nurse on call and to the QIDPD. Then once a shift, the staff were to document their findings on the Injury Follow Up Flow Charts. When the QIDPD was asked if she had assessed client #3's right great toe after reporting the client had pulled her toenail off, the QIDPD stated, "No, I was just reporting what they told me and that is what they said. They said she pulled her toenail off." The QIDPD stated, "I was told they (the staff) called the nurse."</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 2 of 2 sampled clients with adaptive equipment, the facility failed to to teach and encourage client #1 to wear and care for her prescribed</p>	W000436	CORRECTION:The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other	02/13/2014

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	<p>eye glasses and failed to provide client #2 with a posey vest.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 1/10/14 at 11 AM. Client #1's 11/13/12 vision assessment indicated client #1 was prescribed eye glasses. Client #1's undated Healthcare Addendum indicated "[Name of doctor] recommends that [client #1] wear her glasses during all waking hours." Client #1's 12/18/13 ISP (Individualized Support Plan) did not indicate a goal/objective to assist client #1 with taking care of her eye glasses and to wear her eye glasses.</p> <p>Interview with client #1 on 1/9/14 at 8:45 AM indicated her eye glasses were broken and being repaired.</p> <p>During interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 1/10/14 at 5 PM the QIDPD indicated client #1 had two pairs of eyeglasses. The QIDPD stated, one pair of client #1's eye glasses was broken and being repaired and "I'm not sure where the other pair is. She probably has them hidden somewhere." The QIDPD indicated client #1 did not like to wear her eye glasses and would hide them and tell the staff that she had</p>		<p>communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Specifically, the team has provided Client #2 with a Posey vest and trained staff on its appropriate use. Additionally, the will develop a learning objective to support Client #1 in learning to wear and care fore her eyeglasses. PREVENTION:Facilit y professional staff will be expected to observe no less than two morning and two evening active treatment sessions per week to assess direct support staff interaction with clients and to provide hands on coaching and training toward proper implementation of learning objectives including but not limited to adaptive equipment goals. Additionally, members of the Operations Team will conduct active treatment observations on a weekly basis for the next 60 days and after two months, no less than monthly to assure that clients are utilizing adaptive equipment as recommended.</p> <p>RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Operations Team</p>				

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	<p>lost them. The QIDPD indicated client #1 did not have a formal goal to wear her eye glasses.</p> <p>2. Client #2's record was reviewed on 1/10/14 at 9:55 AM. Client #2's 10/11/13 physician's order indicated "Posey vest while up in chair for protection d/t (due to) slumping, falling over and falling out of chair."</p> <p>During the 1/8/14 observation period between 4:40 PM and 6:55 PM and the 1/9/14 observation period between 5:20 AM and 8:00 AM, at the group home, client #2 did not wear a posey vest restraint while sitting in a chair. Client #2 sat in a chair with arms at the dining room table. Specifically during the 1/8/14 observation period, client #2 leaned over the side of the chair.</p> <p>Client #2's 12/16/13 revised Behavior Support Plan (BSP) and/or 9/27/13 Individual Support Plan (ISP) indicated client #2 had a history of throwing herself to the floor, out of the bed and/or chairs.</p> <p>Interview with the LPN on 1/10/14 at 10:58 AM indicated client #2 had an order for a posey vest. The LPN indicated client #2 did not have a posey vest at this time as the facility had not</p>						

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	<p>obtained the ordered posey vest for the client as the facility was trying to find one that fit the client.</p> <p>Interview with the Qualified Intellectual Disabilities Professional-Designee (QIDP-D) on 1/10/14 at 2:00 PM and on 1/14/14 at 10:45 AM, by phone, indicated client #2 had an order to obtain a Posey Vest restraint to assist the client to sit up in her chair without leaning over to the side and/to prevent the client from falling out of her chair. The QIDP-D indicated the client's interdisciplinary team had approved/agreed with the client's doctor in regard to obtaining a posey vest. The QIDP-D indicated facility staff were prompting the client to sit up straight until they found a vest. The QIDP-D indicated the workshop wanted the client to have a vest to assist the client to sit up straight and to prevent the client from falling out of her chair to the workshop floor. The QIDP-D indicated the posey vest would be used at the group home and the workshop. The QIDP-D indicated they were still looking online for stores that sold/had posey vest restraints.</p> <p>9-3-7(a)</p>			

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W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 2 of 2 sampled clients (#1 and #2) and for 1 additional client (#4), the facility failed to ensure clients participated in all aspects of meal preparation and service.</p> <p>Findings include:</p> <p>During the 1/8/14 observation period between 4:40 PM and 6:55 PM, at the group home, client #4 assisted staff #6 to prepare the dinner meal. Client #4 was able to open packages, place vegetables in the pot, stir items and handle hot items as client #4 drained vegetables in strainer and placed them in a serving bowl. Client #4 set the stove and oven temperature dials with verbal assistance. Once the dinner meal was finished cooking, staff #6 placed food (hashbrown casserole and mixed vegetables on client #1, #2 and #4's plates in the kitchen (client #3 refused to eat). Client #4 then carried the prepared plates to the table in the dining room area. Client #4 also carried Jello and</p>	W000488	<p>CORRECTION: The facility must assure that each client eats in a manner consistent with his or her developmental level. Specifically, all staff have been retrained to assist Clients 1, 2 and 4 with preparing and serving their food.</p> <p>PREVENTION: The QIDP will conduct mealtime observations no less than twice weekly for each meal, providing coaching and training to direct support staff as needed. Members of the Operations Team will conduct active treatment observations, including meals weekly for the next 60 days and after two months, no less than monthly to assure appropriate meal time training occurs. RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Operations Team</p>	02/13/2014

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	<p>watermelon to the table without staff assistance. Staff placed paper towels on the table for napkins and placed bowls on the table without involving clients #1, #2 and #4. Staff did not encourage clients #1, #2 and #4 to serve themselves and/or assist to set the table. Staff #9 poured client #2's drink without encouraging and/or assisting client #2 to do hand over hand. Client #4 was able to feed herself independently.</p> <p>Interview with the Qualified Intellectual Disabilities Professional-Designee (QIDP-D) on 1/10/14 at 2:00 PM indicated clients #1, #2 and #4 had the skills to serve themselves.</p> <p>9-3-8(a)</p>			