STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G555	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BI-COUNTY SERVICES INC	1139 BOLLMAN DECATUR, IN 46733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for an extended annual recertification and state licensure survey. Dates of Survey: August 5, 7, 8, 9, 14, 15 and 16, 2013. Facility number: 001069 Provider number: 15G555 AIM number: 100245430 Surveyor: Kathy Wanner, QIDP. The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/29/13 by Ruth Shackelford, QIDP.	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, the governing body failed to exercise operating direction over the facility for 8 of 8 clients living in the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8), by failing to maintain the kitchen cabinets in good repair. Findings include: Observations of the group home where clients #1, #2, #3, #4, #5, #6, #7 and #8 lived, were conducted on 8/5/13 at 2:50 P.M. The lower cabinet door fronts and drawer fronts of the kitchen cabinets had worn off varnish with areas of bare wood. An interview was conducted with client #3 at 3:46 P.M. on 8/7/13. When asked about the kitchen cabinets, client #3 stated, "Yes, they need new ones." An interview was conducted with Direct Care Staff (DCS) #2 on 8/15/13 at 1:08 P.M. When asked about the kitchen cabinets, DCS #2 stated, "Yes, I thought we were going to get some work done on the house, but it hasn't been completed. The varnish on the cabinets is worn off."	W000104	Bollman Annual Recertification & Licensure Survey Plan of Correction Survey Event ID ENHQ11 September 2013 W104- Governing Body Bi-County Services, Inc. (BCS) will assure that the governing body exercises general policy, budget and operating direction over the agency. The governing body provides, monitors and revises, as necessary, policies, procedures and operating directions, which ensure the necessary staffing, training resources, equipment and environment to provide consumers with active treatment and to provide for their health and safety. Operating direction as it relates to this survey plan of correction (POC) failed to maintain the kitchen cabinets in good repair. Corrective action and follow-up specific to Bollman Consumers: Work Order was submitted to Maintenance Department on 9/4/13. On 9/5/13 the cabinets and drawers were refinished/stained by the maintenance department with a 2nd coat to be added within six months. Cleaning instructions for cabinets include using warm soapy water rather than cleaning products with chemicals to assure that the cabinets stay in good	09/15/2013

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	An interview was conducted with the Residential Manager (RM) on 8/15/13 at 2:20 P.M. The RM stated, "Yes the cabinets are older, and showing some wear, especially on the bottom ones." An interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) on 8/15/13 at 2:12 P.M. The QIDP stated, "Yes, I guess they do need to be refinished." The QIDP indicated there were no work orders available for review. 9-3-1(a)		shape. The cabinets were not found to be unsanitary in anyway, there were positive results with cosmetic changes to the kitchen due to the refinishing.All staff working at Bollman will be retrained on proper cleaning of cabinets to assure that the kitchen cabinets, drawers are maintained in good shape by 9/15/13. Person's responsible: Residential Manager (RM) and Maintenance Department Target Completion Date: 9/15/13 Corrective action as it relates to monitoring practices for assuring operating directives relating to group home environment agency wide: The Residential Management Check Off Sheet was revised 6/2012 to include regular checks of environmental issues such as walls, doorways, furniture, carpeting, etc. are in good condition and if needs are noted, RM's will follow through and utilize the BCS Work Request process. All BCS Residential Management Team (RMT) members will be re-trained on the Governing Body standard in general and specifically utilizing the RM Check Off Sheet and completing work requests when environmental issues are identified by 9/15/13. Person's Responsible: Program Director (PD); Residential Administrator (RA) and RM's. Target completion date: 9/15/13	

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W000125	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 record review and interview, the facility failed for 1 of 1 recently admitted clients (client #2) to ensure a legally sanctioned decision-maker had been identified to assist client #2 with exercising her individual rights. Findings include: Client #2's record was reviewed on 8/9/13 at 12:50 P.M. Client #2's record indicated she had been admitted to the group home from the home of her parent on 4/15/2013. Client #2's record indicated her parent advocated for her. Client #2's Physician's Order (PO) dated for 8/2013 indicated client #2 had diagnoses of, but not limited to, Profound Mental Retardation, Cerebral Palsy with resulting Quadriplegia, Scoliosis, Partial Trisomy 22, Mild Ataxia, Rod Placement in Spine, Dysphagia and Left Arm Contracture. Client #2 communicated primarily by gesture, smiles, body language and vocalizations (yelling, crying, etc.). Client #2 ambulated by using her right hand to move the wheel of her wheelchair, and	W000125	Bollman Annual Recertification & Licensure Survey Plan of Correction Survey Event ID ENHQ11 September 2013 W125-Protection of Client Rights The facility must assure the rights of all consumers. Therefore, the facility must allow and encourage individual consumers to exercise their rights as consumers of the facility, and as citizens of the United States, including the right to file complaints and the right to due process. BCS failed to ensure that consumer #2 had an identified legally sanctioned decision- maker to assist with exercising her individual rights. At the time of consumer #2's admission to the group home, the IST including the BDDS District 3 Service Coordinator & consumer #2's IPMG Case Manager discussed at length the need for a health care representative (HCR). Since consumer #2's mother is very involved in her life, but unable to make informed decisions about consumer #2's health care concerns, guardianship was deemed secondary to identifying a HCR. We had made initial contact with	09/15/2013

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	was currently being assessed to determine if a motorized wheelchair with a right toggle switch would increase her mobility independence. Client #2's record indicated after admission to the group home she was evaluated by a dentist and on 5/7/13 had 26 (twenty-six) teeth extracted due to "gross caries and non-restorable teeth." Client #2's record did not indicate if she had received dental care while living with her parent. Client #2's record indicated after admission to the group home client #2 experienced abdominal pain. Client #2 presented with a deformed shaped abdomen at admission to the group home. A KUB (abdominal x-ray), abdominal/pelvic CT scan, EGD (esophagogastroduenoscopy) and colonoscopy were completed in 6/2013 indicating a "Large 30 cm (thirty centimeter) cystic mass in the abdominopelvic region." On 6/24/13 client #2 underwent surgery to remove the cystic mass. A post-op appointment on 7/10/13 indicated "Ovarian cyst removal 18 cm x 12 cm (eighteen centimeters by 12 centimeters) cyst." There was no documentation in client #2's record to indicate she had received any medical tests/care regarding the "abdominal distension and behavior indicating pain," prior to her placement at the group home.		a potential HCR and then C2 had a health crisis requiring immediate medical attention/surgery. Her mother was involved during the medical crisis. BCS dropped the ball when no further follow-up (F/U) with potential HCR was made. We did fail to ensure that consumer #2 had a HCR to assist with advocacy, encouragement of expressing her individual rights and making informed health care decisions as part C2's team. Corrective Action and Follow-Up Specific to Consumer #2: The original person identified as a HCR for consumer #2 (C2) has since decided that she is unable to take on that responsibility. We have identified another individual who worked with C2 in the past when she was an emergency placement with BCS for approximately 3 months in 2009. The identified individual for HCR is an RN and has C2's best interests at heart and also has met C2's mother and has communicated with her in the past. She is no longer a BCS employee, but continues to be a wonderful consumer advocate. She has agreed to take on this responsibility and the QIDP will make contact with consulting attorney to get the representative status underway by 9/15/13. Corrective Action as it relates to protection of consumer rights agency wide: All BCS residential consumers have either a	

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	Client #2's Comprehensive Functional Assessment dated 5/8/13 and Informed Consent Assessment dated 5/2/13 indicated client #2 was "independent in appropriate interactions with peers and appropriate in public settings." Client #2 "with assistance could express comfort/discomfort, was willing to follow doctor's orders, understands what is expected of her (behavior and goals), exits during emergency drills, dresses appropriately for weather and uses good manners." Client #2 needed more assistance in all other areas. Client #2's record indicated her parent had a history of not being able to advocate for client #2's health and medical needs. An interview was conducted with Direct Care Staff (DCS) #2 on 8/15/13 at 1:08 P.M. When asked if client #2 would benefit from a legally sanctioned representative, DCS #2, "Yes, she (client #2) would. I know her mother wants to still be involved, but she hasn't been able to always make good choices for [client #2]." An interview was conducted with the Residential Manager (RM) on 8/15/13 at 2:20 P.M. The RM stated, "I think she is doing better now, and I don't foresee any more big medical issues for her (client #2). Her mother really wants to remain		guardian, power of attorney &/or HCR. Any new consumers admitted to BCS residential group homes will at the time of transition meeting discuss and assure that each individual has a legally sanctioned decision-maker identified to assist with exercising their individual rights. If there is no designated representative at the time of transition the IST will make assurance of setting the priority of seeking out someone who can assume that responsibility. All RMT members will be re-trained on the importance of assuring advocacy for consumers and protection of individual rights. QIDP's will assume the responsibility of meeting corrective action item B.2 above during transition &/or admission meetings and documenting such information as part of the ISP. Persons Responsible: Program Director (PD), Residential Administrator (RA), QIDP and RMT's. Target Completion Date: 9/15/13	

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	involved." An interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) on 8/15/13 at 2:12 P.M. The QIDP stated, "Yes, I think she would benefit from a guardian." The QIDP stated "She (client #2) needed a lot of medical care when she first moved in." The QIDP indicated the parent needed case management services. 9-3-2(a)			

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W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review, observation and interview, the facility failed to take sufficient corrective action to protect 1 of 4 sampled clients (client #3) from recurrent falls resulting in injury. Findings include: Facility records were reviewed on 8/5/13 at 3:40 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 8/5/12 and 8/5/13. The BDDS reports indicated the following: -A BDDS report dated 12/14/12 for an incident on 12/14/12 at 10:00 A.M. indicated "While at day services, [client #3] stood and moved to approach a staff member to speak with her and tripped over her chair leg in the process. She fell and landed with her right knee first and ended resting on her right hip. As a result of the fall, she has a 2 (two) inch by 1 (one) inch red area on her right knee with a bruise of 1/2 (one-half) inch in the middle...House manager will speak with [client #3] to remind her of importance of being aware of her surroundings and to slow down when attempting to stand and walk. [Client #3] and her support team	W000157	Bollman Annual Recertification & Licensure Survey Plan of Correction Survey Event ID ENHQ11 September 2013 W157-Staff Treatment of Consumers If an alleged violation is verified, appropriate corrective action must be taken. BCS failed to take sufficient corrective action to protect consumer #3 from recurrent falls resulting in injury. Six (6) Incident Reports were submitted to BDDS during the time frame of December 14th 2012 through August 5th of 2013, regarding falls with minor injury(s) for consumer #3. Of the six falls, four have occurred since May 2013. The trend/pattern was identified and Physical Therapy evaluation sought, however, falls have occurred since that time. Falls have occurred across all settings including home, Day Services (DS) and in the community. Fortunately none of the falls has caused serious injury, however the potential is there for that to occur should intervention strategies for safety not be available in risk plans/programming to be implemented consistently across all settings. In addition to the diagnosis of congenital weakness of the right side, Consumer #3 has other diagnoses which can affect her gait & balance when	09/15/2013

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	will continue to use her goal to walk safely while at day services." -A BDDS report dated 3/8/13 for an incident on 3/6/13 at 9:45 P.M. indicated "[Client #3] fell in the bedroom of her home, striking her forehead on a tray table and resulting in a one-half inch abrasion and slight swelling to the area. [Client #3] was alone in her room at the time of the incident and was unable to say exactly what caused her to fall. She could only say she lost her balance just before falling...neuro (neurological) checks were completed per agency protocol...reported experiencing a headache she was administered Acetaminophen (pain)...cleansing area twice daily...tray table that she struck her head upon while falling will be moved to another location for storage...does have history of falls and a fall risk plan is in place. She was following the plan at the time of the incident and is typically allowed as much personal time without supervision in her bedroom as she chooses because this has not been a location where she has experienced falls in the past...." -A BDDS report dated 5/7/13 for an incident on 5/7/13 at 4:25 A.M. indicated "While getting ready for the day [client #3] was walking too fast and fell to her left side, resulting in two abrasions. She		acute flare-ups occur, including, but not limited to bradycardia, urinary retention and osteoporosis. As such this POC will address corrective action is it relates to promoting consistent safe walking habits for prevention of further falls, monitoring of health status regularly (urinary retention care plan monitoring, bradycardia Risk Plan monitoring & osteoporosis monitoring following all falls) while still respecting her strong self-advocacy for personal independence. Corrective Action Specific to Consumer #3 (C3): From mid-December 2012 through early May 2013, a pattern of falls was identified and agency RN's contacted Dr. Jonna on 5/9/13 for referral to have a PT evaluation completed. The PT evaluation was completed by Teri Conrad, PT who has been a part of C3's team since admission to the group home in May of 2011. Recommendations from the evaluation included the addition of two more Home Exercise Plans (HEP) in conjunction with e FOUR exercisthe four exercises she already had to her plan. She works with the staff to complete her HEP's to assure that she is doing them correctly. Staff is following the directives provided by the PT for assuring HEP's are completed as directed. On August 15th 2013 C3 had cataract surgery which was successful. Increased vision will	

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	has an abrasion on her left elbow measuring 1-1/4 (one and one-fourth) inches by 1/2 (one-half) inch, and an abrasion on her left knee measuring 1/2 inch by 1/2 inch. Both required basic first aid. [Client #3] refused ice and states that there is no pain in either area...Staff will continue to encourage [client #3] to slow down while walking independently, and continue to work on her goal to walk safely." -A BDDS report dated 6/7/13 for an incident on 6/6/13 at 12:35 P.M. indicated "[Client #3] fell while at workshop on 6/6/13, causing minor abrasions to her elbow, knee, and right side of her head. [Client #3] is reported to have lost her balance and may have been walking at an unsafe pace prior to falling...RN evaluated her injuries and applied basic first aid to her abrasions. Neuro (neurological) checks were completed and found to be within normal limits....[Client #3] was assessed by a physical therapist on 5/31/13 for review of her mobility skills. The therapy report has not yet been received. When received, any further instructions for treatment or recommendations to improve her mobility skills will be implemented across all settings." -A BDDS report dated 7/22/13 for an		allow for better navigation throughout her environments. C3's Fall Risk Plan is being revised by QIDP to address consistent strategies across all settings that can be implemented with the focus on walking safely while using fall prevention techniques/practices. The QIDP is revising C3's Consumer Specific Training (CST) to include identified strategies for safe walking/fall prevention practices. C3's residential goals targeting remaining safe while walking, pedestrian safety skills and walking at a safe pace will be reviewed by the QIDP to identify if any revisions are needed to strategies and/or outcomes. DS goal for safe walking/fall prevention will be added to C3's DS ISP programming. Her current DS goal(s) of participating in community activities and increasing self-esteem by participating in things she likes to do will be revised to include strategies directed to being safe in the community & at DS by walking safely & practicing fall prevention techniques. Four DCS working with C3 across all settings will participate in a "Preventing Falls in Adults with Disabilities & Chronic Health Conditions-What Works?" webinar on 9/17/13. All DCS working with C3 across all settings will be trained on the revisions to her Fall Risk Plan, CST and ISP goals/strategies by	

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	incident on 7/22/13 at 11:45 A.M. indicated "...[client #3] fell while exiting her advocate's personal vehicle resulting in an injury to her left forearm. She has two small scratches measuring 1/2 (one-half) centimeter and 3/4 (three-fourths) centimeter with an abrasion near the area measuring 1-1/2 (one and one-half) centimeters by 2 (two) centimeters just below her elbow...[Client #3's] risk plan was being followed, and she has been encouraged to wait for assistance when exiting/entering a vehicle...." -A BDDS report dated 7/24/13 for an incident on 7/23/13 at 6:00 P.M. indicated "[Client #3] fell at home in her bedroom, causing bruising to her left elbow measuring approximately one inch in diameter. [Client #3] reported that she apparently fell due to simply losing her balance as she turned around in her bedroom. Her fall risk plan was being followed at the time of her fall. [Client #3] was provided a gait belt following the fall, as directed in her fall risk plan...." Observations were conducted at the group home where client #3 lived on 8/5/13 from 4:10 P.M. until 6:35 P.M. Client #3 walked with an unsteady gait and her right leg/foot turning outward. Client #3 walked at a fast pace, requiring direct care		9/15/13. Persons' responsible: QIDP, RM, Medical Department and Administrative Team Target Completion Date: 9/15/13 Corrective Action as it relates to follow through with appropriate corrective action when problems are identified: All RMT members, Supported Living Management Teams and supervisory staff will be re-trained on the importance of following through with corrective action once trends, problems &/or needs are identified. In addition, this group will also receive re-training on lack of follow through with corrective action identified IS NEGLECT by 9/15/13. Several QIDP & management team members will be participating in the "Preventing Falls" webinar on 9/17/13. Persons' responsible: PD, RA, QIDP's and management teams. Target Completion Date: 9/15/13	

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	staff to verbally prompt her to "[Client #3] slow down when you are walking so you will not fall." Client #3 independently walked back and forth in the hallway from 4:48 P.M. until 5:18 P.M. as part of her exercise and therapy. Client #3 was not wearing a gait belt. Client #3 was independent in all of her activities, asking staff to take a walk with her outside before dinner. Client #3's record was reviewed on 8/9/13 at 2:30 P.M. Client #3's record indicated she had a diagnosis of "congenital weakness of right side." Client #3's record indicated she had a Physical Therapy evaluation on 5/31/13 with recommendations to continue her home exercise program and two new exercises were added. There were goals to 1. decrease falls, 2. maintain safe and independent walking. Client #3's record included a fall risk plan dated 4/7/13 indicating: "staff will monitor environment and provide reminders and verbal cues as necessary to navigate and maneuver, [client #3] will wear well fitting shoes which have been specially fitted to her feet at all times, staff will provide verbal cues to 'slow down please,' when she is hurrying or walking at too fast a pace staff will walk with her if she refuses to comply, working on her goal for safe walking, staff will provide			

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	assistance when she exits a vehicle, staff will provide assistance during inclement weather and uneven terrain and if she does fall she will wear gait belt post fall for 1-2 hours to assess her stability removing once assessed to be walking steady and safely again." Client #3's Individual Support Plan (ISP) dated 4/1/13 included the following goals: "I will remain safe while walking, I will improve my pedestrian safety skills (including looking for cracks in sidewalks, uneven terrain and environmental risks), I will walk at a safe pace." Client #3 was interviewed on 8/7/13 at 6:02 P.M. When asked how she can keep from falling down and hurting herself, client #3 stated, "I can slow down, look where I'm going, ask staff for help. I do my exercises." The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 8/9/13 at 10:55 A.M. When asked about client #3 falling, the QIDP stated, "Yes, she has continued to fall. It has decreased over time, but she has fallen and had subsequent injuries. We have not had an IDT (interdisciplinary team meeting) unless we see a change in skill level. We talked with the Physical Therapist (PT) and if we do anything more it would			

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	decrease her independence. We use the gait belt for contact spotting, when she is unsteady. I don't want to decrease her independence. I would say she is falling less than when she first came. I think she does know she needs to slow down." The Program Director (PD) was interviewed on 8/9/13 at 10:47 A.M. The PD stated, "Yes, she has fallen three times since she had her PT evaluation. She is so independent. It is a fine line between allowing her independence and keeping her from injuring herself. Maybe we could try knee and elbow pads." 9-3-2(a)			

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W000209	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. Based on record review and interview, the facility failed to assure the client and/or parent participated in the Individual Support Plan (ISP) development process for 1 of 1 new admissions (client #2) to the group home. Findings include: Client #2's record was reviewed on 8/9/13 at 12:50 P.M. Client #2's record indicated she had been admitted to the group home from the home of her parent on 4/15/2013. Client #2's record indicated her parent advocated for her. Client #2's record included an initial ISP dated 5/5/13. There was no documentation available for review to indicate client #2 and/or her parent were involved in the development process of client #2's 5/5/13 ISP. The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 8/9/13 at 1:25 P.M. The QIDP indicated he was not able to locate documentation to show client #2 and her parent had participated in the ISP process.	W000209	Bollman Annual Recertification & Licensure Survey Plan of Correction Survey Event ID ENHQ11 September 2013 W209-Individual Program Plan Participation by the consumer, parent (if consumer is a minor) or consumers' legal guardian/representative is required unless the participation is unobtainable or inappropriate. BCS was found to be deficient in this standard as evidenced by failure to assure documentation that consumer #2 & her mother participated in the ISP development process. It is the intent of BCS that all program planning meetings are scheduled & conducted to facilitate participation of all members of the team. Corrective Action and Follow-up specific to consumer #2 (C2):The QIDP will provide documentation of the admission meeting and program development process for 5/5/13 ISP indicating that C2's mother was involved and had input in the process and that C2 was also in attendance. This will be provided in a narrative summary of the ISP planning meeting by 9/15/13. The QIDP and/or RM will also review the ISP material once again with C2's mother and get her	09/15/2013

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	Client #2's parent was unavailable for interview. 9-3-4(a)		signature for the ISP by 9/15/13 if at all possible, as C2's mother is not always readily available. The Decatur RMT has a good working relationship with C2's mother and make every effort to involve her and keep her up to date regularly. They also have been able to incorporate her wishes into planning. Corrective Action as it relates to BCS practices agency wide: All Residential Management Team members, supervisory staff and medical team will be retrained on the priority of facilitating the participation of all IST members in the ISP development process. Training will also include documentation of the ISP development process and signatures of those participating, as well as indication of those who are unable to attend but offered input. Training will include the SDOH Guidelines & Probes related to the ISP standard, especially the W206-209 regulations. Training will occur by 9/15/13. Supported Living Management Team members will also receive training on items in B.1 above as it relates to ISP development & facilitating participation by all IST members, especially the individual consumers. Person's Responsible: PD, RA, QIDP's and Management Teams Target Completion Date: 9/15/13	

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W000312	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, the facility failed to include specific criteria as part of a plan of reduction for each medication used for the management or elimination of behaviors and/or symptoms of diagnoses as indicated in 1 of 3 sampled clients (client #1) who was prescribed medications for management of behaviors. Findings include: Client #1's record was reviewed on 8/9/13 at 11:30 A.M. Client #1's Physician's Orders (PO) dated for August 2013 indicated he was prescribed Cymbalta (anti-depressant) for Impulse Control Disorder (ICD), Seroquel (anti-psychotic) for ICD, and Depakene (mood stabilizer) for symptoms of ICD. Client #1's Behavior Support Plan (BSP) dated 3/1/13 indicated he had the targeted behaviors of, (needing to learn) appropriate responses to stress, PICA (an eating disorder consisting of eating or craving non-food items), physical aggression (pushing, charging, kicking),	W000312	Bollman Annual Recertification & Licensure Survey Plan of Correction Survey Event ID ENHQ11 September 2013 W312-Drug Usage Drugs used for control of inappropriate behavior must be used only as an integral part of the consumer's individual support plan (ISP) that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. BCS failed to include specific criteria as part of a medication reduction plan for each medication used for the management or elimination of behaviors &/or symptoms of diagnoses as indicated for Consumer #1 who is prescribed medications for management of behaviors. Corrective Action and Follow-Up for Consumer #1 (C1) and other Bollman residents with Behavior Support Plans (BSP): The QIDP will revise C1's BSP Medication Reduction Plan to include: Plan of reduction for each of his 3 prescribed medications all of which are prescribed for the diagnosis of Impulse Control Disorder. Specific behaviors indicated for	09/15/2013

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	smearing feces and self-injurious behaviors (biting, dropping to floor, bouncing hard on chair). Client #1's BSP did not indicate what specific behaviors Cymbalta, Seroquel and Depakene were prescribed to address. Client #2's BSP did not indicate what specific criteria needed to be achieved for Cymbalta, Seroquel and Depakene to be considered for a possible reductions. Client #1's BSP did not indicate how each of the medications effectiveness could be determined. An interview was conducted with the facility Residential Supported Living Administrator (RSLA) on 8/15/13 at 1:38 P.M. When asked about plans of reduction for behavior medication, the RSLA indicated he could see where if there are different types of medications prescribed it would be difficult to determine which was being effective. The RSLA indicated he could see how it would be beneficial to have the plans of reductions be more specific. The RSLA stated, "We always try to use the least amount of medications possible. Sometimes it takes more than one kind of medication to address the behavior needs of an individual." 9-3-5(a)		each of the prescribed medicationsSpecific criteria needed to be achieved for each of the medications in order to be considered for reduction Indicators for how each of the medications effectiveness can be determined. The revised medication reduction plan will be an addendum to C1's BSP and submitted to the Human Rights Committee (HRC) for a quorum review and approval by 9/15/13. All staff working with C1 across all settings will be trained on the Medication Reduction Plan Addendum by 9/15/13. The HRC meets every other month (the HRC last met on Aug. 28th with the next meeting scheduled for Oct. 30th 2013). The QIDP will have all other Bollman consumers who have BSP's medication reduction plans revised as Addendums as per criteria in A.1 and submitted for HRC review/approval at the next scheduled meeting on Oct. 30th. Person's Responsible: QIDP's, PD, RA and Administrative Assistance for Quality Assurance (AAQA). Target Completion Date: 9/15/13 Corrective Action as it relates to agency wide practices: All residential QIDP's will be trained on the medication reduction plan components listed in A.1 above, as well as training on the SDOH Guidelines and Probes related to the W312 tag. In addition a review of the regulations pertaining to the Drug	

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			Usage Standard (W310-317) will also be used for training as supports for QIDP's when developing and writing BSP's. All residential QIDP's will incorporate the medication reduction plan criteria in A.1 above when completing annual BSP's for HRC review. Addendums to medication reduction plans will submitted to the HRC in October &/or December 2013 for those consumers whose annual plans do not come up for HRC review prior to April 1st 2014 so as assure that we are on target with IST's working closely with psychiatrists for drugs to be used/prescribed only to the extent that they are necessary. All RMT members, medical team and supervisory staff will be trained items A.1 & B.1 above. SLMT members will be re-trained on the agency philosophy of not using drugs in doses that interfere with consumers daily living activities. Training will also include the importance of advocating for consumers to assure that independent Behavior Consultants are best meeting consumers' needs and that their BSP's are individualized for each waiver consumer and developed with IST involvement/input. No BSP's will EVER be implemented without DCS being trained thoroughly on all components of the plan(s). Person's Responsible: PD, RA, AAQA and QIDP's Target Completion	

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W000368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed to assure medications administered to 1 of 4 sampled clients (client #4) and 2 of 4 additional clients (clients #5 and #7) were administered according to their physician's orders. Findings include: Facility records were reviewed on 8/5/13 at 3:40 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 8/5/12 and 8/5/13. The BDDS reports indicated the following: -A BDDS report dated 7/13/13 for an incident on 7/11/13 at 10:00 P.M. indicated "[Client #4] received two doses of her Keppra (anti-convulsant) 500 mg (milligrams) at her HS (hour of sleep) med. (medication) pass. Her order is written for one tab (tablet). [Client #4] did not suffer any adverse effects from the additional dose. Agency RN was contacted and [client #4] continued her medications as normal. Staff will continue to monitor [client #4], and her PCP (Primary Care Physician) will be notified on Monday 7/15/13. The error will be	W000368	Bollman Annual Recertification & Licensure Survey Plan of Correction Survey Event ID ENHQ11 September 2013 W368-Drug Administration The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. It is the intent of BCS that we meet the standard(s) of drug administration including the expectation that all drugs are administered in compliance with the physician's orders and are administered without error. BCS supports & safeguards in place have not proven to be 100% effective in the elimination of medication errors. Systemic changes to the medication administration process are in effect currently with Bollman starting use of multi-dose medication packs at cycle fill on 8/15/13. Use of multi-dose packs has been effective in reducing medication errors significantly in the two group homes that started the multi-dose pack use in May & June 2013. In addition, one of the group homes will be implementing an eMAR system (oneMAR) effective 9/16/13, with Bollman designated for the same process prior to the end of the year. We are optimistic that the	09/15/2013

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	submitted to the Medication Error Review Team (MERT) and any recommendations will be followed to prevent future errors." -A BDDS report dated 7/9/13 for an incident on 7/9/13 at 6:00 A.M. indicated "[Client #5] received one dose of Ativan (anti-anxiety) 0.5mg (milligrams) belonging to another consumer. Poison control was contacted. They instructed to monitor [client #5], but stated no other instructions. Staff monitored [client #5] throughout the day. She did not suffer any adverse effects from the dose. Agency RN was notified and will assess [client #5] in the A.M. of 7/10/13. The staff responsible was suspended from medication administration pending review by the agency MERT...recommendations include a written warning, observation by the [name of home] House Medication Administrator Mentor (ADM) of two proper medication administrations, and one observation by agency RN before returning to regular medication administration. All MERT recommendations will be completed as recommended." -A BDDS report dated 9/26/12 for an incident on 9/25/12 at 8:10 P.M. indicated "A medication error occurred when [client #5] received another consumer's medication, Ativan (anti-anxiety) 0.5 mg		oneMAR system will eliminate medication errors. BCS was found to be deficient in this standard as evidenced by failure to administer medications for three of the eight Bollman residents according to their physician's orders. Five significant errors for the three consumers occurred between 9/25/12 and 7/11/13, including 3 incidents of consumer(s) receiving a double dose of their prescribed medications and 2 incidents of consumer #5 receiving another consumer's medication. This is unacceptable. In June and August of 2013, management and DCS received extensive training on medication administration, including competency testing of a challenging nature. It is felt that the focus of corrective action for this citation be on providing the Bollman staff with a Medication Administration Remediation Course provided by the RN's with competency testing geared toward problem areas/trends identified through the Incident Report (IR) process and recommendations from the Medication Error Review Team (MERT). Corrective Action and Follow-Up specific to consumers #4, 5 and 7 relating to Medication Errors: Consumer #4 (C4): On 7/11/13 C4 received an additional dose of Keppra 500 mg at HS med pass. She was monitored closely for any adverse effects	

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	(milligrams), on the evening of 9/25/12. This medication was administered in error to [client #5] due to the failure of direct care staff (DCS) [name of staff] to follow correct medication administration procedure. Immediately following the error the agency RN and the Poison Control center were contacted for instructions regarding possible treatment or monitoring. Poison Control indicated [client #5] was unlikely to experience any major complications and that she may become sleepy or easily fatigued following the incident...PCP (Primary Care Physician) was notified...DCS responsible for the error was instructed to cease administering medications to all consumers until investigation and plan of correcting the cause of the error could be completed...." -A BDDS report dated 3/27/13 for an incident on 3/25/13 at 6:00 A.M. indicated "[Client #7] received 200 mg (milligrams) of the medication Levothyroxine (thyroid) in error instead of the prescribed dose of 100 mg. Levothyroxine on the morning of 3/25/13. Staff responsible, [name of staff] reports she administered the medication (100 mg) at 6:00 A.M., thirty minutes prior to all other medications as prescribed, and then placed the medication back into the med (medication) box and subsequently		from the additional medication with none noted. Her PCP was contacted about the medication error with no further recommendations for treatment &/or monitoring. Recommendations from the MERT included verbal warning for the employee administering the medications, retraining on comparing the MAR to blister pack & triple checks all of which was followed through on by the RM. The RM also completed medication pass observation with the staff noting that she was very thorough in the administration of meds and felt that she met competency to continue passing medications. This staff has had no further medication errors. Consumer #5 (C5): On 7/9/13 at 6 AM med pass, C5 received one dose of Ativan .5 mg belonging to another consumer. C1 is prescribed Lorazepam .5 mg tab one hour prior to medical appointment to assist in cooperation with examination(s). Poison Control was contacted with instructions to monitor C5 throughout the day, there were no further instructions. C5 did not have any adverse effects as a result of taking the medication. Her PCP was notified of the error and had no instructions for further monitoring &/or treatment. Staff administering the medication was suspended from passing medications until the error could be reviewed and assessed for	

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	administered the medication again thirty minutes later with her (client #7's) other medications she routinely receives in the morning. [Client #7's] physician was notified of this error. No further instructions for treatment or monitoring were provided...did not appear to experience any negative side effects...bright pink card has been placed on this medication's blister pack to ensure...further errors from occurring." -A BDDS report dated 11/1/12 for an incident on 10/31/12 at 7:00 A.M. indicated "A medication error occurred for [client #7] when she was administered a double dose of the medication Levothyroxine (thyroid) 100 mg (milligrams). The error occurred as a result of Direct Care Staff (DCS) administering the medication and then a second DCS also administering the medication in error after failing to observe and verify in [client #7's] MAR (medication administration record) or on the medication's blister card that it had already been administered. Agency RN was contacted to notify of error. Instructions were provided to DCS to monitor for any possible adverse effects...PCP (Primary Care Physician) was notified...MERT will discuss and determine plans to prevent future errors from occurring...."		recommendations by the MERT. Recommendations included a written warning; re-training on administering meds per physician's orders, 6 Rights & Triple Checks; Medication Administration Mentor (MAM) observed two proper med passes with staff, as well as an agency RN prior to returning to medication administration without supervision effective 7/23/13 as the observation team members & RM felt confident that she demonstrated competency. The staff has had no further medication errors. On 9/25/12 C5 received another consumer's medication of .5 mg Ativan at PM med pass. The medication was administered in error due to DCS not following correct medication administration procedures. Poison Control was contacted and indicated it was doubtful that C5 would experience any major complications, but that she might become sleepy &/or easily fatigued. C5 was monitored closely for any adverse effects and there were none noted. C5 participated in all normal activities without difficulty during the monitoring period. PCP was notified and had no further instructions for F/U or monitoring. As a result of investigating the medication error the following actions were taken for prevention of recurrence of such errors: a) controlled medications that were previously stored in the same	

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	An interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) on 8/9/13 at 1:45 P.M. The QIDP stated, "Yes, we have had some repeated medication errors." An interview was conducted with the facility Residential Supported Living Administrator (RSLA) on 8/15/13 at 2:02 P.M. The RSLA stated, "We do try to come up with something specific for each medication error to address the cause and stop the potential for it to occur again. We have been looking into getting an EMAR system (electronic medication administration record)." 9-3-6(a)		locked box have been placed in separate container/storage sections and b) pictures of consumers are now affixed to all controlled medications to assist in better identification/visual cues. DCS involved in the medication error received personnel action of a verbal warning outlining the error and expectations of medications beign passed without error, was suspended from passing meds until competency could be demonstrated through observation by RN & RM and a controlled medication competency test with a score of 95% or higher. All criteria were met and DCS returned to passing medications without supervision effective 10/8/12. Consumer #7 (C7): On 3/25/13 at 6 AM med pass C7 received 200 mg of Levothyroxine in error rather than her prescribed dose of 100 mg Levothyroxine. C7 takes this thyroid medication due to low T4 levels. DCS making medication error stated that she administered the medication 30 minutes prior to C7's other meds as prescribed, then placed the medication back in the med box subsequently administered the med again 30 minutes later with C7's other routine AM meds. As a result of reviewing the medication error the MERT recommended that visual cue (bright pink card) be placed on C7's Levothyroxine blister pack to "alert" staff passing meds that this is the med passed 30	

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			minutes prior to other meds. This has been helpful. C7 did not experience any adverse effects from the extra dosage of the medication. PCP notified of error with no instructions for F/U. DCS received personnel action in the form of a verbal warning; she provided peer training/discussion at Bollman house meeting on 3/27/13 focusing on six rights/triple checks, what she had learned from the error & ways they could (DCS) improve on assuring that meds are administered as prescribed at Bollman. This was helpful for the Bollman staff as a team as she is a peer leader in the home. Observations of proper med pass completed by RM with DCS with competency demonstrated. Re-training & competency testing on Medication Administration Guidelines, 6 Rights and Buddy Check procedure were completed.On 10/31/12 at AM medication pass the same medication error occurred as listed above for C7. She received a double dose of Levothyroxine 200 mg rather than her prescribed dose of 100 mg 30 minutes prior to taking her other routine medications per physician's orders. Two staff were involved in this error, as one passed the medication as prescribed and then a 2nd staff administered the same med without following the 6 rights, triple checks &/or reading the	

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			MAR. As a result of review of the med error a separate divider from C7's routine AM meds will be placed in the med box for her AM dose of Levothyroxine to assure that it is given per physician's orders & without error. Verbal warning & competency testing were completed with DCS. Corrective action for Bollman group home: On 9/11/13 all Bollman staff will be participating in a Medication Administration Remediation Course provided by the RN's. This will include competency testing, identifying and problem solving to assure that meds are given per physician's orders and without error. DCS has requested that we look into ways to reduce distractions during medication passes & treatments. This would also add privacy. The RMT will speak with Maintenance Crew Leader about what some options might be for decreasing distractions/providing increased privacy. Medical Home Observation in addition to the RN's monthly house med pass observation was added for supports & opportunities for DCS to talk with/ask questions of the RN's effective 8/13. Proper Handling of Medication(s) protocol implemented 9/2013 as additional safeguard for when medications are delivered from YAH pharmacy to agency &/or group home requires pill count & verification of medications	

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			received through signing off on packing slip.Overflow Controlled Medication Count protocol implemented 9/2013 with overnight shift counting and AM staff checking the count. This protocol was put into place following an incident where controlled medications from a consumers overflow medications were found to be missing on 8/29/13 (reference IR #550080). This incident occurred after the Bollman survey exit and review of investigation will be available for F/U to this survey POC. All DCS working with Bollman consumers across all settings will be trained on the new protocol & procedure listed in B.4 & 5 above by 9/15/13 Persons Responsible: PD, agency RN's and RMT. Target Completion Date: 9/15/13 Corrective Action for BCS Practices Agency Wide as it relates to Medication Administration: The agency Medication Administration Policy is being revised to include changes to training options for the drug administration course "Living in the Community" (LIC) Core A & B. Clarification of MERT process will be included in the revision as well the agency RN's having the final decision on employees competency and ability to pass medication once they have been certified in Core A & B. Their licenses are on the line liability wise for DCS administering medications without following	

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			physician's orders &/or without error. All staff working with residential consumers across all settings will be trained on the Medication Administration Policy changes by 9/15/13. Due to the investigation referenced in B.5 above, additional procedures/protocols have been put into place for additional safeguards relating to Proper Handling of Medication and Overflow Controlled Medication Count. RM's and Medical Department are tracking prescriptions with new orders, transcribing orders, date of medication arrival etc. All DCS working with residential consumers will be trained on the new protocols/procedures listed in B.4 & 5. All RMT members, medical staff and supervisory staff will be trained on new protocols and changes to Medication Administration policy as well as RE-REMINDED that medication errors ARE NEGLECT as per agency Abuse/Neglect policy. SLMT members will be trained on C.1-3 by 9/15/13 and they in turn will train their waiver DCS at next scheduled staff meetings. Persons' responsible: PD, RA, AAQA, Medical Department and RMT's Target Completion Date: 9/15/13.	

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W000434	483.470(f)(3) FLOORS The facility must have exposed floor surfaces and floor coverings that promote maintenance of sanitary conditions. Based on observation and interview, the facility failed to maintain the bathroom floors in good repair and sanitary conditions for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7 and #8) who lived in the home. Findings include: Observations at the group home where clients #1, #2, #3, #4, #5, #6, #7 and #8 lived, were conducted on 8/5/13 at 2:50 P.M. The light colored vinyl flooring in the West and East bathrooms had dark gray stained areas beside the tub/showers and by the drains located in the center of the bathroom floors. The West bathroom had a 24" x 10" (twenty-four inches by ten inches) gray area by the drain, and an irregularly shaped gray area 20" x 30" (twenty inches by thirty inches) in front of the shower. The East bathroom had a dark gray area 23" x 10" (twenty-three inches by ten inches) in front of the tub and an "L" shaped dark gray area 20" x 20" (twenty inches by twenty inches) by the drain. An interview was conducted with client	W000434	W434-Floors The facility must have exposed floor surfaces and floor coverings that promote maintenance of sanitary conditions. The citation addressed failure to maintain two bathroom floors in good repair and sanitary conditions. On Sept. 5th 2013 the bathroom floors were assessed by the Maintenance Crew Leader and the BCS President, who do ADA assessments for all group homes. It was the opinion of the team that the floors are unsightly, but not unsanitary. The grey stained areas beside the tubs/showers and drains located in the center of the bathroom floors have heavy wheel chair and shower chair traffic due to the home being totally accessible and three of the residents use wheelchairs for mobility & independence. Corrective Action and Follow-up specific to the Bollman Consumers: A Work Order was submitted to the Maintenance Department on 9/4/13 to assess the east & west bathrooms at the Bollman home for stains and sanitation concerns. The Maintenance Crew Leader and President assessed the bathrooms on 9/5/13. The vinyl floors appear to be discolored as a result of wheelchair use. On	09/15/2013

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	#3 at 3:46 P.M. on 8/7/13. When asked about the bathroom floors client #3 stated, "They aren't dirty. I don't know what it is." An interview was conducted with Direct Care Staff (DCS) #2 on 8/15/13 at 1:08 P.M. When asked about the bathroom flooring, DCS #2 stated, "Yes, I think the darkened areas are just from some water damage under the vinyl." An interview was conducted with the Residential Manager (RM) on 8/15/13 at 2:20 P.M. The RM stated, "Yes, I did notice the stains. I have been having the third shift staff address the areas, but it seems to be a more deep rooted issue." The RM indicated there were no work orders available for review. 9-3-7(a)		9/5/13, Resource Maintenance Company was contacted to assess the two Bollman bathrooms. On 9/6/13 the owner of Resource Maintenance assessed the bathrooms with the RM in attendance to point out the areas of concern. Resource Maintenance will contact the BCS assessment team and make arrangements to buff the bathroom floors in order to improve on the appearance of the bathroom flooring the week of 9/9/13. Resource Maintenance Contractor did state while assessing the bathroom floors on 9/6/13 that sanitation concerns were not an issue for the two bathrooms in the home. Person's Responsible: Maintenance Department Target Completion Date: 9/15/13 Corrective Action as it relates to monitoring practices that promote maintenance of sanitary conditions agency wide: The Residential Manager Check Off Sheet was revised 6/2012 to include regular checks of environmental issues such as walls, doorways, furniture, carpeting, flooring, etc. are in good condition and if needs are noted, RM's will follow through with utilizing the BCS Work Request process. All BCS RMT members will be re-trained on utilizing the RM Check Off Sheet to address identified needs and complete work requests when environmental issues are	

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			identified by 9/15/13. Persons Responsible: Program Director; RA and RM's. Target Completion Date: 9/15/13	