

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/03/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260
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W000000	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: 9/30/14, 10/1/14, 10/2/14 and 10/3/14.</p> <p>Facility Number: 000963 Provider Number: 15G449 AIMS Number: 100244740</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/15/14 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 and interview for 3 of 3 sampled clients (#1, #2 and #3) plus 3 additional clients (#4, #5 and #6), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the group home's living room furniture was in good repair for clients #1, #2, #3, #4, #5 and</p>	W000104	<p>CORRECTION:</p> <p><i>The Governing body must exercise general policy, budget and operating direction over the facility. Specifically, the damaged couch will be replaced –a new living room set has been ordered. A review of the facility's physical environment indicated this</i></p>	11/02/2014

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>#6.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/30/14 from 5:10 PM through 5:50 PM and on 10/1/14 from 6:06 AM through 8:15 AM. The group home's living room couch was upholstered with a vinyl type material. The seat of the home's living room couch on the left end of the couch had a 1.5 foot circular section with cracked, missing and damaged vinyl.</p> <p>AS (Administrative Staff) #1 was interviewed on 10/1/14 at 12:33 PM. AS #1 indicated he was not aware of the condition of the group home's living room couch. AS #1 indicated the living room couch should be repaired or replaced.</p> <p>9-3-1(a)</p>		<p>deficient practice did not involve other areas of the home or its furnishings.</p> <p>PREVENTION:</p> <p>Staff will be retrained regarding the need to submit work orders for all necessary repairs as damage occurs and supervisory staff will complete a Home Environment Safety checklist no less than monthly to be reviewed by the Program Manager. Additionally, members of the Operations Team, including the Executive Director and Program Manager, will maintain an increased presence at the facility, performing unscheduled visits to the facility to observe the home's environment and facilitate needed improvements, no less than twice monthly for the next 90 to assure the facility maintains an acceptable physical environment. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Operations Team</p>		

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W000125	<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 record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to ensure clients #1, #2 and #3's individual rights were not violated by the facility's practice of locking drinking cups and glasses without due process or assessed need.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 10/1/14 at 11:18 AM. Client #1's Modification of Individual Rights (MIR) form dated 11/22/13 indicated client #1 would be restricted from access to the group home's drinking cups and glasses. Client #1's MIR form dated 11/22/13 indicated, "Due to the fact that one of [client #1's] housemates cannot control his fluid intake and his health and safety is at high risk, cups and drinking glasses will be secured in a locked cabinet. [Client #1] will have access to the items in the cabinet with staff assistance at all times." Client #1's BSP (Behavior</p>	W000125	<p>CORRECTION:</p> <p><i>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. Specifically, through assessment, the interdisciplinary team has determined that staff can implement Client #4 and #6's fluid restriction successfully without securing drinking glasses. Therefore access will no longer be limited for Clients #1 - #6.</i></p> <p>PERVENTION:</p> <p>The QIDP has been retrained regarding the need to restrictive measures are implemented only when an assessed need has been identified and informed consent has been obtained. The Governing Body has added an</p>	11/02/2014
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	<p>Support Plan) dated 11/22/12 did not indicate client #1 should be restricted from access to cups and glasses. Client #1's ISP (Individual Support Plan) dated 11/22/13 did not indicate client #1 should have restricted/supervised access to cups or drinking glasses.</p> <p>2. Client #2's record was reviewed on 10/1/14 at 9:32 AM. Client #2's MIR form dated 10/1/13 indicated client #2 would be restricted from access to the group home's drinking cups and glasses. Client #2's MIR form dated 10/1/13 indicated, "Due to the fact that one of [client #2's] housemates cannot control his fluid intake and his health and safety is at high risk, cups and drinking glasses will be secured in a locked cabinet. [Client #2] will have access to the items in the cabinet with staff assistance at all times." Client #2's BSP dated 10/2/13 did not indicate client #2 should be restricted from access to cups and glasses. Client #2's ISP dated 10/2/13 did not indicate client #2 should have restricted/supervised access to cups or drinking glasses.</p> <p>3. Client #3's record was reviewed on 10/1/14 at 10:10 AM. Client #3's MIR form dated 2/7/14 indicated client #3 would be restricted from access to the group home's drinking cups and glasses.</p>		<p>additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring, including but not limited to assessing client's need for restrictive programs and their ability to give informed consent. Members of the Operations Team will review facility support documents no less than monthly to assure that accurate informed consent assessments are in place and that prior written informed consent is obtained for all restrictive programs.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Operations Team</p>	

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W000159	<p>Client #3's MIR form dated 2/7/14 indicated, "Due to the fact that one of [client #3's] housemates cannot control his fluid intake and his health and safety is at high risk, cups and drinking glasses will be secured in a locked cabinet. [Client #3] will have access to the items in the cabinet with staff assistance at all times." Client #3's ISP dated 2/7/14 did not indicate client #3 should have restricted/supervised access to cups or drinking glasses.</p> <p>AS (Administrative Staff) #1 was interviewed on 10/1/14 at 12:33 PM. AS #1 indicated the drinking cups and glasses were restricted due to clients #4 and #6's polydipsia (excessive thirst). AS #1 indicated clients #1, #2 and #3 did not have polydipsia or an assessed need to be restricted from access to drinking cups or glasses.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the QIDP (Qualified Intellectual</p>	W000159	<p>CORRECTION:</p> <p><i>Each client's active treatment</i></p>	11/02/2014

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	<p>Disabilities Professional) failed to coordinate, integrate and monitor clients #1, #2 and #3's programs by failing to convene the IDT (Interdisciplinary Team) to review/discuss client #1's refusals to participate in medical and vision examinations, to review clients #1, #2 and #3's ISP (Individual Support Plan) objectives for progression/regression of skills, to ensure client #3's CFA (Comprehensive Functional Assessment) was reviewed annually and to ensure the facility's HRC (Human Rights Committee) obtained the written informed consent of clients #1 and #3 or client #2's guardian regarding the facility's restrictive practice of locking drinking cups and glasses.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 10/1/14 at 11:18 AM. Client #1's Visual Care Progress Report (VCPR) dated 6/20/14 indicated, "[Client #1] will not allow me to get close enough to see. Pushes me away when I look in his eyes. Exam unable (sic)." Client #1's Record of Visit form dated 8/20/14 regarding his primary care physician indicated "[Client #1] very uncooperative and wouldn't allow me to touch him and struggled. Unable to do EKG (electrocardiogram)." Client #1's record did not indicate</p>		<p><i>program must be integrated, coordinated and monitored by a qualified mental retardation professional.</i></p> <p>Specifically for Client #1, the QIDP will convene a meeting of the interdisciplinary team to review assessment data to address Client #1's refusals to participate in medical appointments and procedures.</p> <p>Specifically for Clients #1 - #3 and three additional Clients (#4 - #6), the QIDP will be retrained regarding the need to conduct monthly reviews of data and documentation to determine if modifications of learning objectives are indicated no less than quarterly. Quarterly IDT review documentation will be maintained in the clients' records.</p> <p>The QIDP has completed a Comprehensive Functional Assessment for Client #3. A review of facility support documents indicated this deficient practice did not affect any additional clients.</p> <p>Through assessment, the interdisciplinary team has determined that staff can</p>	

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	<p>documentation of IDT (Interdisciplinary Team) review/discussion regarding client #1's refusals to participate in medical and vision examinations.</p> <p>Client #1's QIDP monthly review of client #1's formal ISP objectives indicated the QIDP had reviewed client #1's ISP objectives for progression/regression of skills in July 2014. Client #1's record did not indicate documentation of QIDP review of client #1's program since July 2014.</p> <p>2. Client #2's record was reviewed on 10/1/14 at 9:32 AM. Client #2's QIDP monthly review of client #2's formal ISP objectives indicated the QIDP had reviewed client #2's ISP objectives for progression/regression of skills in July 2014. Client #2's record did not indicate documentation of QIDP review of client #2's program since July 2014.</p> <p>3. Client #3's record was reviewed on 10/1/14 at 10:10 AM. Client #3's QIDP monthly review of client #3's formal ISP objectives indicated the QIDP had reviewed client #3's ISP objectives for progression/regression of skills in July 2014. Client #3's record did not indicate documentation of QIDP review of client #3's program since July 2014.</p> <p>AS (Administrative Staff) #1 was</p>		<p>implement Client #4 and #6's fluid restriction successfully without securing drinking glasses. Therefore access will no longer be limited for Clients #1 - #6.</p> <p>PERVENTION:</p> <p>The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring.</p> <p>The QIDP will be retrained regarding the need to bring all elements of the interdisciplinary team together to address individual needs including but not limited to refusals to participate in necessary medical procedures. Members of the Operations team will review incident data and support documents no less than monthly to assure current assessed needs are addressed appropriately.</p> <p>The QIDP has been trained regarding the need to track and monitor progress on all client learning objectives. Along with the QIDP, members of the Operations Team will conduct active treatment observations and reviews of support documents, to</p>	

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	<p>interviewed on 10/3/14 at 10:30 AM. AS #1 indicated clients #1, #2 and #3's ISP objectives should be reviewed by the QIDP on a monthly basis. AS #1 indicated there was no IDT review/discussion regarding client #1's medical or vision examination refusals.</p> <p>4. The QIDP failed to ensure client #3's CFA was reviewed annually. Please see W259.</p> <p>5. The QIDP failed to ensure the facility's HRC obtained the written informed consent of clients #1 and #3 or client #2's guardian regarding the facility's restrictive practice of locking drinking cups and glasses. Please see W263.</p> <p>9-3-3(a)</p>		<p>assure data is collected as required at the facility on a bi-weekly basis.</p> <p>The QIDP will be retrained regarding the need to assure that all relevant assessments are reviewed and updated as needed but no less than annually. Members of the Operations Team including but not limited to the Clinical Supervisor will review facility support documents no less than monthly to assure appropriate assessment occurs as required. The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring.</p> <p>Professional staff will be retrained regarding the need to obtain prior written informed consent from guardians, advocates and healthcare representatives for all restrictive programs prior to implementation. Retraining will focus on assuring that the QIDP has a clear understanding of what specifically constitutes a restrictive program and proper preparation for presenting program modifications guardians and other legal representatives. Prior to granting approval to restrictive programs, the Human</p>		

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W000259	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 3 sampled clients (#3), the facility failed to ensure client #3's CFA (Comprehensive Functional Assessment) was reviewed annually.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 10/1/14 at 10:10 AM. Client #3's CFA dated 2/6/13 indicated client #3's annual</p>	W000259	<p>Rights Committee will obtain confirmation that the facility has received prior written informed consent from guardians or other legal representatives. 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. Administrative staff will conduct visits to the facility as needed but no less than monthly.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION: At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Specifically, Client #3's Comprehensive Functional Assessment will be updated. A review of facility support documents indicated this deficient</p>	11/02/2014

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W000263	<p>functional assessment had been reviewed on 2/6/13. The review did not indicate documentation of additional/more recent annual functional assessment of client #3.</p> <p>AS (Administrative Staff) #1 was interviewed on 10/3/14 at 10:30 AM. AS #1 indicated client #3's CFA should be reviewed annually.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for</p>	W000263	<p>practice did not affect any additional clients.</p> <p>PREVENTION:</p> <p>The QIDP will be retrained regarding the need to assure that all relevant assessments are reviewed and updated as needed but no less than annually. Members of the Operations Team including but not limited to the Clinical Supervisor will review facility support documents no less than monthly to assure appropriate assessment occurs as required. The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	11/02/2014	

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	<p>3 of 3 sampled clients (#1, #2 and #3), the facility's HRC (Human Rights Committee) failed to obtain the written informed consent of clients #1 and #3 or client #2's guardian regarding the facility's restrictive practice of locking drinking cups and glasses.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 10/1/14 at 11:18 AM. Client #1's Modification of Individual Rights (MIR) form dated 11/22/13 indicated client #1 would be restricted from access to the group home's drinking cups and glasses. Client #1's MIR form dated 11/22/13 indicated, "Due to the fact that one of [client #1's] housemates cannot control his fluid intake and his health and safety is at high risk, cups and drinking glasses will be secured in a locked cabinet. [Client #1] will have access to the items in the cabinet with staff assistance at all times." Client #1's ISP (Individual Support Plan) dated 11/22/13 indicated client #1 was a self advocating adult with HCR (Health Care Representative) support. Client #1's record did not indicate documentation of client #1's written informed consent regarding restricted access to cups or drinking glasses. Client #1's HRC form dated 11/1/13 indicated the facility's HRC</p>		<p>CORRECTION:</p> <p><i>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Specifically, through assessment, the interdisciplinary team has determined that staff can implement Client #4 and #6's fluid restriction successfully without securing drinking glasses. Therefore access will no longer be limited for Clients #1 - #6.</i></p> <p>PREVENTION:</p> <p>Professional staff will be retrained regarding the need to obtain prior written informed consent from guardians, advocates and healthcare representatives for all restrictive programs prior to implementation. Retraining will focus on assuring that the QIDP has a clear understanding of what specifically constitutes a restrictive program and proper preparation for presenting program modifications guardians and other legal representatives. Prior to granting approval to restrictive programs, the Human Rights Committee will obtain confirmation that the facility has received prior written informed consent from guardians or other legal representatives. The agency has established a quarterly</p>	

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	<p>approved client #1's MIR form/rights restriction without the written informed consent of client #1.</p> <p>2. Client #2's record was reviewed on 10/1/14 at 9:32 AM. Client #2's MIR form dated 10/1/13 indicated client #2 would be restricted from access to the group home's drinking cups and glasses. Client #2's MIR form dated 10/1/13 indicated, "Due to the fact that one of [client #2's] housemates cannot control his fluid intake and his health and safety is at high risk, cups and drinking glasses will be secured in a locked cabinet. [Client #2] will have access to the items in the cabinet with staff assistance at all times."</p> <p>Client #2's ISP dated 10/2/13 indicated client #2 had a legal guardian. Client #2's record did not indicate documentation of client #2's guardian's written informed consent regarding restricted access to cups or drinking glasses. Client #2's HRC form dated 10/1/14 indicated the facility's HRC approved client #2's MIR form/rights restriction without the written informed consent of client #2's guardian.</p> <p>3. Client #3's record was reviewed on 10/1/14 at 10:10 AM. Client #3's MIR form dated 2/7/14 indicated client #3 would be restricted from access to the group home's drinking cups and glasses.</p>		<p>system of internal audits that review all facility systems including, but not limited to due process and prior written informed consent. Administrative staff will conduct visits to the facility as needed but no less than monthly.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>				

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W000327	<p>Client #3's MIR form dated 2/7/14 indicated, "Due to the fact that one of [client #3's] housemates cannot control his fluid intake and his health and safety is at high risk, cups and drinking glasses will be secured in a locked cabinet. [Client #3] will have access to the items in the cabinet with staff assistance at all times." Client #3's ISP dated 2/7/14 indicated client #3 was a self advocating adult. Client #3's record did not indicate documentation of client #3's written informed consent regarding restricted access to cups or drinking glasses.</p> <p>AS (Administrative Staff) #1 was interviewed on 10/1/14 at 12:33 PM. AS #1 indicated the drinking cups and glasses were restricted. AS #1 indicated written informed consent was needed for restrictive programs.</p> <p>9-3-4(a)</p> <p>483.460(a)(3)(iv) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Based on record review and interview for</p>	W000327	CORRECTION:	11/02/2014			

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	<p>1 of 3 sampled clients (#1), the facility failed to provide or obtain TB (Tuberculosis) testing, x-ray, or symptom screening as part of client #1's annual physical examination.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 10/1/14 at 11:18 AM. Client #1's TB testing form dated 5/23/13 indicated client #1 had received TB testing on 5/23/13. Client #1's record did not indicate additional documentation of annual TB testing, x-ray or symptom screening since 5/23/13.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 10/1/14 at 12:33 PM. LPN #1 indicated client #1's TB test was scheduled for 10/3/14. LPN #1 indicated client #1's TB testing should be completed annually.</p> <p>9-3-6(a)</p>		<p><i>The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Specifically, the team has assisted Client #1 with obtaining a tuberculosis screening test, which produced negative results. A review of facility medical records indicated this deficient practice did not affect any additional clients.</i></p> <p>PREVENTION:</p> <p>The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine appointments and lab tests to assure they occur as recommended. Additionally, Operations Team members including the Nurse Manager will review medical documentation while auditing active treatment sessions, twice monthly for the next 90 days to assure labs and appointments occur as recommended and make recommendations to the Health Services Team as appropriate. After three months the</p>		

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2, #3 and #4), the facility nursing services failed to meet the health needs of clients #1, #2, #3 and #4.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 10/1/14 from 6:06 AM through 8:15 AM. At 6:30 AM, staff #1 prepared client #3's medications for administration by placing client #3's morning medications in a pre-packaged individual serving size container of applesauce. Staff #1 placed client #3's pills directly into the pre-packaged</p>	W000331	<p>administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team</p> <p>CORRECTION:</p> <p><i>The facility must provide clients with nursing services in accordance with their needs. Specifically:</i></p> <p>A CBC has been drawn for Client #1 and nurse will assure that the test occurs monthly as ordered. Additionally a thyroid panel has been obtained for Client #2 and the nurse will assure that the test is completed every six months as ordered. A review of medical documentation indicated that this deficient practice affected clients.</p>	11/02/2014

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	<p>individual serving size container of applesauce. Client #3's morning medications included but were not limited to Baclofen tablet 10 milligrams (spasticity), Docusate Sodium 100 milligrams (constipation) and Glycopyrrol tablet 1 milligram (hypersalivation). Staff #1 administered client #3's medications with a spoon from the container of applesauce to client #3. Staff #1 placed the container of applesauce, which she had used to administer client #3's medications from, on the medication administration counter and began preparing client #4's morning medications. At 6:50 AM, staff #1 placed client #4's morning medications in the same container of applesauce that had been used to administer client #3 his medications. Staff #1 placed client #4's pill's directly in the same container of applesauce, which had been used to administer client #3's medications. Client #4's morning medications included but were not limited to Buspirone tablet 5 milligrams (anxiety) and Citalopram tablet 20 milligrams (anti-depressant). Staff #1 administered client #4's medications with a different spoon from the container of applesauce that had been used for client #3's medications.</p> <p>Staff #1 was interviewed on 10/1/14 at 6:56 AM. When asked if clients #3 and</p>		<p>The nurse will retrain all staff on medication administration procedures including but not limited to the fact that separate containers of apple sauce must be used for each individual who is assessed as not being able to swallow medications without adaptive assistance.</p> <p>PREVENTION:</p> <p>The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine appointments and lab tests to assure they occur as recommended.</p> <p>Supervisory staff and the facility nurse will provide onsite monitoring, teaching, training and modeling as needed but no less than weekly to ensure that Clients' medication is administered per established protocols.</p> <p>Additionally, Operations Team members including the Nurse Manager will review medical documentation while auditing</p>	

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	<p>#4's medications had been administered from the same container of applesauce, staff #1 stated, "Yes, it was the same but I used a different spoon. Is that okay? Should I use a different applesauce? I just hate to waste that much applesauce." When asked how she had verified all of client #3's pills had been administered prior to placing client #4's medications in the container, staff #1 stated, "I didn't really think of that."</p> <p>2. Client #1's record was reviewed on 10/1/14 at 11:18 AM. Client #1's POF (Physicians Orders Form) dated 8/25/14 indicated client #1 should have his CBC (Complete Blood Count) tested every month. Client #1's ROV (Record of Visit) form dated 10/15/13 indicated, "Ok to change CBC frequency to every month." Client #1's ROV form dated 10/15/13 indicated client #1's diagnoses included but were not limited to Thrombocytopenia (low platelet count). Client #1's record indicated CBC laboratory testing on 3/26/14, 7/22/14 and 8/15/14. The review did not indicate additional documentation of CBC testing.</p> <p>3. Client #2's record was reviewed on 10/1/14 at 9:32 AM. Client #2's POF dated 8/25/14 indicated client #2 should have a thyroid panel completed every 6 months. Client #2's record did not</p>		<p>active treatment sessions, twice monthly for the next 90 days to assure labs and appointments occur as recommended and that medications are administered appropriately. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team</p>		

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W000356	<p>indicate documentation of thyroid panel laboratory testing being completed for client #2.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 10/1/14 at 12:33 PM. When asked if staff should administer multiple clients medications from the same container of applesauce, LPN #1 stated, "No, throw it away and get a new one for each client." LPN #1 indicated clients' laboratory orders should be implemented as written on their POF's.</p> <p>9-3-6(a)</p> <p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>Based on record review and interview for 1 of 3 sampled clients (#2), the facility failed to ensure client #2's dental recommendations were implemented.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 10/1/14 at 9:32 AM. Client #2's Dental Summary form dated 2/12/14 indicated, "Recommend more frequent cleaning due to poor OH (Oral Hygiene). Suggest 3</p>	W000356	<p>CORRECTION:</p> <p><i>The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Specifically, the facility will assist Client #2 with receiving recommended dental follow-up. An audit conducted by the administration team determined</i></p>	11/02/2014

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	<p>month recall." Client #2's record did not indicate additional documentation of dental examination/treatment for client #2.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 10/1/14 at 12:33 PM. LPN #1 indicated client #2's dental recommendations should be followed.</p> <p>9-3-6(a)</p>		<p>that dental follow-along and required follow-up has occurred for the other clients who reside in the facility.</p> <p>PREVENTION:</p> <p>The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine dental appointments and follow-ups to assure they occur as recommended. Additionally, Operations Team members including the Nurse Manager will review medical documentation while auditing active treatment sessions, twice monthly for the next 90 days to dental appointments occur as recommended. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team</p>	