

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G090	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/15/2016
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3839 CAMELOT LN COLUMBUS, IN 47201
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W 0000 Bldg. 00	<p>This visit was for a full recertification and state licensure survey.</p> <p>Survey Dates: March 10, 11, 14 and 15, 2016</p> <p>Facility Number: 000630 Provider Number: 15G090 AIM Number: 100233920</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/21/16.</p>	W 0000		
W 0120 Bldg. 00	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on record review and interview for 1 of 3 clients (#1) in the sample who attended outside services (school), the facility failed to ensure the school met the needs of the client.</p> <p>Findings include: On 3/10/16 at 1:08 PM, the Regional Program Manager (RPM) indicated he</p>	W 0120	<p>Corrective actions taken: · All county QIDPs were in-serviced to ensure highschool age clients are observed at school at least once a month on 3/31/16. (Attachment A) How will we identify others: · Currently, only one client in group homes attends a high school. Any new clients who will attend high school will have the provision of school observations written into their ISP by the QIDP.</p>	04/14/2016

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>was the Qualified Intellectual Disabilities Professional (QIDP) for the group home. The RPM indicated client #1 attended high school. The RPM indicated he was unsure which high school client #1 attended (there were two high schools in the city). The RPM stated "not from our agency" when asked if anyone was conducting observations at the high school. The RPM indicated he did not know who client #1's teacher was. The RPM called the QIDP - Designee (QIDP - D) during the interview to ask her if she conducted observations at the school. The QIDP - Designee indicated to the RPM she did not conduct observations at client #1's school.</p> <p>On 3/10/16 at 1:30 PM, the QIDP - D indicated she did not conduct observations at client #1's school. The QIDP - D was able to identify the school and client #1's teacher when asked.</p> <p>On 3/11/16 at 10:37 AM, a focused review of client #1's record was conducted. Client #1 attended high school according to his 6/15 to 6/16 Individual Program Plan. There was no documentation the facility conducted observations at the school to ensure the outside services met the needs of the client.</p>		<p>The QAfor group homes will ensure through monthly file review that the provision for school observations are included and followed per the ISP. Measures put in place:</p> <ul style="list-style-type: none"> · Group home observation sheet (Attachment C) Monitoring of corrective action: · All observations are forwarded to the RPM on a monthly basis. The RPM will ensure that observations are completed at school for any clients who attend high school. The RPM will then forward the observations to the director of quality who will then check for proper observations of required sites. 		

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W 0125 Bldg. 00	<p>On 3/14/16 at 11:16 AM, an interview with client #1's teacher was attempted however the school was closed due to spring break until 3/23/16.</p> <p>On 3/11/16 at 11:26 AM, the Quality Assurance/Social Services Manager (QA/SSM) indicated she was listed as the QIDP for the group home. The QA/SSM indicated she had not conducted observations at client #1's school from March 2015 to March 2016.</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.</p> <p>Based on observation, interview and record review for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients had the right to due process in regard to the thermostats (2) being covered and locked.</p> <p>Findings include:</p>	W 0125	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> ·All county QIDPs were in-serviced to avoid restrictive practices such as having a locked thermostat cover on 3/31/16. (Attachment A) ·All group home staff were in-serviced on 3/22/16 to avoid restrictive practices such as having a locked thermostat cover on 3/23/16. (Attachment B) ·All house thermostat covers 	04/14/2016

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	<p>Observations were conducted at the group home on 3/10/16 from 3:38 PM to 5:49 PM and 3/11/16 from 6:00 AM to 7:50 AM. During the observations, there were two thermostats (one in each of the clients' bedroom hallways) of each side of the home (formerly a duplex). The thermostats were covered with a plastic, locked box. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 3/10/16 at 5:48 PM, the Home Manager (HM) indicated the facility put locked covers over the thermostats after client #2 ripped them off the walls. The HM indicated the thermostats had been locked for a couple of months.</p> <p>On 3/10/16 at 3:39 PM, the Qualified Intellectual Disabilities Professional - Designee (QIDP-D) indicated the locked covers on the thermostats were in place to protect the thermostats from the clients breaking them. The QIDP-D indicated none of the clients' plans included the use of locked thermostats. The QIDP-D indicated the thermostats had been locked for 6 years.</p> <p>On 3/11/16 at 6:18 AM, staff #4 indicated she did not know the purpose of the locked thermostats. Staff #4 indicated the thermostats had been locked since she worked at the home</p>		<p>were unlocked and will be accessible to clients.</p> <p>How will we identify others:</p> <ul style="list-style-type: none"> The quality assurance manager will audit all homes on a monthly basis. The audit documents how well each home operates, including checks for restrictive practices, such as having locked thermostats. All QIDPs complete documented home observations and will look for restrictive practices. If any are found, such as locked thermostats, the QIDP will correct the issue by training and disciplinary action as necessary. <p>Measures put in place:</p> <ul style="list-style-type: none"> Group home observation sheet (Attachment C) Group home monthly record review audit (Attachment D) <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> QIDP will perform monthly documented observations on all shifts to ensure staff understand the how to avoid restrictive practices The QA for group homes will audit the home monthly to ensure staff avoid restrictive practices. The QA manager then sends the audit to the RPM who submits a corrective action report to the county QIDP and director of community living. The QIDP must correct all deficiencies with seven days. 		

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	<p>(approximately one year).</p> <p>On 3/11/16 at 10:37 AM, a focused review of client #1's record was conducted. There was no documentation in client #1's record indicating the need for locked thermostats.</p> <p>On 3/11/16 at 9:03 AM, a review of client #2's record was conducted. There was no documentation in client #2's record indicating the need for locked thermostats.</p> <p>On 3/11/16 at 9:40 AM, a review of client #3's record was conducted. There was no documentation in client #3's record indicating the need for locked thermostats.</p> <p>On 3/11/16 at 10:39 AM, a focused review of client #4's record was conducted. There was no documentation in client #4's record indicating the need for locked thermostats.</p> <p>On 3/11/16 at 10:39 AM, a focused review of client #5's record was conducted. There was no documentation in client #5's record indicating the need for locked thermostats.</p> <p>On 3/11/16 at 9:59 AM, a review of client #6's record was conducted. There</p>			

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W 0159 Bldg. 00	<p>was no documentation in client #6's record indicating the need for locked thermostats.</p> <p>On 3/11/16 at 10:50 AM, the Regional Program Manager (RPM) indicated the thermostats should not be locked. The RPM indicated locking the thermostats was an unnecessary restriction.</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 clients in the sample (#2, #3 and #6) and three additional clients (#1, #4 and #5), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' individualized program plans. The QIDP failed to conduct regular observations at the group home. The QIDP failed to conduct regular reviews of the clients' program plans. The QIDP failed to ensure the outside services for client #1 met the needs of the client. The QIDP failed to ensure the clients' program plans were expressed in</p>	W 0159	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> ·The facility will no longer employ QIDP-designees. A new QIDP with the appropriate education and experience has been hired and will start 4/9/16. ·Only QIDPs will be able to make program observations. ·Group home monthly summaries have been revised to include measurable indices of performance, completion dates and methodology for each goal. (Attachment E) ·All county QIDPs were in-serviced on revised monthly summary and goal tracking that is to have measurable indices of performance, completion dates 	04/14/2016

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	<p>behavioral terms providing measurable indices of performance. The QIDP failed to ensure the clients had the right to due process in regard to the thermostats (2) being covered and locked. The QIDP failed to ensure client #3's plan addressed when he was to use his chest strap on his wheelchair. The QIDP failed to ensure client #2's plan to address hypothermia (abnormally low body temperature) was updated to address the psychiatrist and neurologist's recommendations and his Behavior Management Program was updated when his psychotropic medication changed. The QIDP failed to ensure staff did not use a technique for disciplinary purposes with client #2. The QIDP failed to ensure client #2's psychotropic medication reduction plan was attainable. The QIDP failed to ensure client #2's C-PAP (continuous positive airway pressure) machine was available for use at the facility-operated day program and a Bi-PAP (bilevel positive airway pressure) machine was obtained after the neurologist recommended a change from a C-PAP to a Bi-PAP machine. The QIDP failed to ensure clients #1, #2, #3, #4, #5 and #6 were involved with the preparation and clean up during breakfast.</p> <p>Findings include:</p>		<p>and methodology on 3/16/16 (Attachment J)</p> <ul style="list-style-type: none"> ·All county QIDPs were in-serviced to ensure highschool age clients are observed at school at least once a month on 3/31/16. (Attachment A) ·All county QIDPs were in-serviced to avoid restrictive practices such as having a locked thermostat cover on 3/31/16. (Attachment A) ·All group home staff were in-serviced on 3/22/16 to avoid restrictive practices such as having a locked thermostat cover on 3/23/16. (Attachment B) ·All house thermostat covers were unlocked and will be accessible to clients. ·Client #2's Health risk plan for hypothermia and bradycardia has been revised to include directions to transport the Bi-pap machine to the facility operated day program for use during the day (Attachment G) ·All county QIDPs were in-serviced on the need to coordinate with agency nurses and to implement physician directed plans and equipment as soon as the directive is received on 3/31/16. (Attachment A) ·House staff were trained on the new hypothermia and bradycardia health risk plan for client #2, client #3's new dining plan, IPP and health risk plan for potential falls with provisions for the use and placement of the chest strap on 3/23/16 (Attachment B) 		

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	<p>1) On 3/11/16 at 9:03 AM, a review of client #2's record was conducted. There was no documentation the QIDP conducted observations on a regular basis at the group home to ensure staff implemented the client's program plans.</p> <p>On 3/11/16 at 9:40 AM, a review of client #3's record was conducted. There was no documentation the QIDP conducted observations on a regular basis at the group home to ensure staff implemented the client's program plans.</p> <p>On 3/11/16 at 9:59 AM, a review of client #6's record was conducted. There was no documentation the QIDP conducted observations on a regular basis at the group home to ensure staff implemented the client's program plans.</p> <p>On 3/11/16 at 11:26 AM, the Quality Assurance/Social Services Manager (QA/SSM) indicated she was listed as the QIDP for the group home. The QA/SSM indicated she had not conducted observations at the group home from March 2015 to March 2016.</p> <p>2) On 3/11/16 at 9:03 AM, a review of client #2's record was conducted. There was no documentation the QIDP conducted regular reviews of client #2's progress toward meeting his program</p>		<ul style="list-style-type: none"> ·Client #2 will receive a physician ordered Bi-pap machine on 4/4/16. ·Client #2's Behavior management program has been updated to reflect the recent changes in psychotropic medications (Attachment H) ·Client #3's dining plan, IPP and health risk plan for potential falls has been revised to include provisions for the use of his chest strap (Attachment I) ·All county QIDPs were in-serviced on the new training objectives with measurable indices of performance and methodology on 3/31/16.(Attachment A) ·House staff were trained on the new training objectives with measurable indices of performance and proper methodology on 2/18/16 that were scheduled to be implemented 4/1/16 (Attachment F) ·Group home monthly summaries have been revised to include measurable indices of performance and methodology for each goal. (Attachment E) ·All county QIDPs were in-serviced to ensure staff do not implement non-behavior plan approved interventions on 3/31/16. (Attachment A) ·House staff were trained on Client #2's behavior support plan and to not use non-behavior support plan interventions on 3/23/16 (Attachment B) ·All county QIDPs were 	

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	<p>plan training objectives from March 2015 to March 2016. Client #2's Residential Monthly Reports for November 2015, December 2015, January 2016 and February 2016 were prepared by the Home Manager (not a QIDP) and reviewed by the QIDP-D (designee). There was no documentation the QIDP identified by the facility reviewed client #2's program plans from March 2015 to March 2016. The Residential Monthly Reports indicated the client's current percentage for each training objective for the month. There was no documentation if the client met or did not meet the goal. There was no documentation in the report indicating if the percentage was an increase or decrease from the previous month. There was no documentation if the goal was to be continued, revised, discontinued or stopped. The Completion Date section on the form indicated, "Watch for completion criteria and don't keep training if completed." The Completion section was blank for each month.</p> <p>On 3/11/16 at 9:40 AM, a review of client #3's record was conducted. There was no documentation the QIDP conducted regular reviews of client #3's progress toward meeting his program plan training objectives from March 2015 to March 2016. Client #3's Residential</p>		<p>in-serviced to ensure that medication reduction plans are attainable when documented on behavior management plans on 3/31/16. (Attachment A)</p> <ul style="list-style-type: none"> ·Client #2's behavior management plan was revised to ensure his psychotropic medication plan was attainable (Attachment H) ·Client #2's Health risk plan for hypothermia and bradycardia has been revised to include directions to transport the Bi-pap machine to the facility operated day program for use during the day (Attachment G) ·All county QIDPs were in-serviced on the need to coordinate with agency nurses and to implement physician directed plans and equipment as soon as the directive is received on 3/31/16. (Attachment A) ·House staff were trained on the new hypothermia and bradycardia health risk plan for client #2 on 3/23/16 (Attachment B) ·Client #2 will receive a physician ordered Bi-pap machine on 4/4/16. ·Client #2's Behavior management program has been updated to reflect the recent changes in psychotropic medications (Attachment H) ·Staff were in-serviced on informal meal prep training opportunities and active treatment on 3/23/16 (Attachment B) ·All county QIDPs were 	

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	<p>Monthly Reports for November 2015, December 2015, January 2016 and February 2016 were prepared by the Home Manager (not a QIDP) and reviewed by the QIDP-D (designee). There was no documentation the QIDP identified by the facility reviewed client #3's program plans from March 2015 to March 2016. The Residential Monthly Reports indicated the client's current percentage for each training objective for the month. There was no documentation if the client met or did not meet the goal. There was no documentation in the report indicating if the percentage was an increase or decrease from the previous month. There was no documentation if the goal was to be continued, revised, discontinued or stopped. The Completion Date section on the form indicated, "Watch for completion criteria and don't keep training if completed." The Completion section was blank for each month.</p> <p>On 3/11/16 at 9:59 AM, a review of client #6's record was conducted. There was no documentation the QIDP conducted regular reviews of client #6's progress toward meeting his program plan training objectives from March 2015 to March 2016. Client #6's Residential Monthly Reports for November 2015, December 2015, January 2016 and</p>		<p>in-serviced on informal meal prep training opportunities and active treatment on 3/16/16 (Attachment J)</p> <p>How will we identify others:</p> <ul style="list-style-type: none"> ·Currently, only one client in group homes attends a high school. Any new clients who will attend high school will have the provision of school observations written into their ISP by the QIDP. The QA for group homes will ensure through monthly file review that the provision for school observations are included and followed per the ISP. ·The quality assurance manager will audit all homes on a monthly basis. The audit documents how well each home operates, including checks for restrictive practices, such as having locked thermostats. ·All QIDPs complete documented home observations and will look for restrictive practices. If any are found, such as locked thermostats, the QIDP will correct the issue by training and disciplinary action as necessary. ·The quality assurance manager will audit all homes on a monthly basis. The audit documents how well each home operates, including checks for proper implementation of physician directed orders. The QA will audit the clients' IPPs, health risk plans and behavior 				

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	<p>February 2016 were prepared by the Home Manager (not a QIDP) and reviewed by the QIDP-D (designee). There was no documentation the QIDP identified by the facility reviewed client #6's program plans from March 2015 to March 2016. The Residential Monthly Reports indicated the client's current percentage for each training objective for the month. There was no documentation if the client met or did not meet the goal. There was no documentation in the report indicating if the percentage was an increase or decrease from the previous month. There was no documentation if the goal was to be continued, revised, discontinued or stopped. The Completion Date section on the form indicated, "Watch for completion criteria and don't keep training if completed." The Completion section was blank for each month.</p> <p>On 3/11/16 at 11:26 AM, the Quality Assurance/Social Services Manager (QA/SSM) indicated she was listed as the QIDP for the group home. The QA/SSM indicated she had not conducted reviews of the clients' program plans from March 2015 to March 2016.</p> <p>3) Please refer to W120. For 1 of 3 clients (#1) in the sample who attended outside services (school), the QIDP failed</p>		<p>plans to see if they fully support the clients' needs.</p> <ul style="list-style-type: none"> ·The quality assurance manager will audit all homes on a monthly basis. The audit documents how well each home operates, including checks for proper client goals with measurable indices of performance and methodology. The QA will audit the clients' IPPs to ensure they contain goals with measurable indices of performance with methodology as well as the monthly summaries. ·All group home QIDPs will submit the new monthly summary sheets to the RPM on a monthly basis. The RPM will ensure all clients have measurable indices of performance and methodologies for their training objectives. ·All QIDPs complete documented home observations and will look for restrictive practices and proper implementation of behavior support plans. If any adverse techniques are discovered, the QIDP will correct the issue by training and disciplinary action as necessary. ·The quality assurance manager will audit all homes on a monthly basis. The audit documents how well each home operates, including checks for proper implementation of client behavior support plans. ·The quality assurance manager will audit all homes on a monthly basis. The audit 				

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	<p>to ensure the school met the needs of the client.</p> <p>4) Please refer to W125. For 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the QIDP failed to ensure the clients had the right to due process in regard to the thermostats (2) being covered and locked.</p> <p>5) Please refer to W240. For 2 of 3 clients in the sample (#2 and #3), the facility failed to ensure: 1) client #2's plan to address hypothermia (abnormally low body temperature) was updated to address the psychiatrist and neurologist's recommendations and his Behavior Management Program was updated when his psychotropic medication changed and 2) client #3's plan addressed when he was to use his chest strap on his wheelchair.</p> <p>6) Please refer to W231. For 3 of 3 clients in the sample (#2, #3 and #6), the QIDP failed to ensure the clients' program plans were expressed in behavioral terms providing measurable indices of performance.</p> <p>7) Please refer to W286. For 1 of 3 clients (#2) in the sample with techniques used to address maladaptive behavior, the QIDP failed to ensure staff did not use a technique for disciplinary purposes.</p>		<p>documents how well each home operates,including checks for attainable psychotropic medication reduction plans in theclients' behavior plans.</p> <ul style="list-style-type: none"> ·The quality assurance manager will audit allhomes on a monthly basis. The audit documents how well each home operates,including checks for proper implementation of physician directed orders. The QAwill audit the clients' IPPs , health risk plans and behavior plans to see ifthey fully support the clients' needs. ·The quality assurance manager will audit all homes monthly to ensure adherence to family style dining. ·All QIDPs complete three monthly documented group home observations to ensure staff are implementing family style dining on their monthly documented observations. <p>Measures put inplace:</p> <ul style="list-style-type: none"> ·Group home observation sheet (Attachment C) ·Group home monthly record review audit(Attachment D) ·New group home monthly summary goal sheets withmeasurable indices of performance and methodologies (Attachment E) <p>Monitoring ofcorrective action:</p> <ul style="list-style-type: none"> ·The QA for group homes will audit the homemonthly to ensure 				

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	<p>8) Please refer to W312. For 1 of 3 clients in the sample (#2), the QIDP failed to ensure his psychotropic medication reduction plan was attainable.</p> <p>9) Please refer to W436. For 1 of 3 clients in the sample with adaptive equipment (#2), the QIDP failed to ensure client #2's C-PAP machine was available for use at the facility-operated day program and a Bi-PAP machine was obtained after the neurologist recommended a change from a C-PAP to a Bi-PAP machine.</p> <p>10) Please refer to W488. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the QIDP failed to ensure the clients were involved with the preparation and clean up during breakfast.</p> <p>9-3-3(a)</p>		<p>client goals continue to be implemented with measurable indices of performance and proper methodology. The QA manager then sends the audit to the RPM who submits a corrective action report to the county QIDP and director of community living. The QIDP must correct all deficiencies with seven days.</p> <ul style="list-style-type: none"> ·After the RPM has reviewed all group home monthly summaries, the Director of community living will review the monthly summaries to ensure they have measurable indices of performance and proper methodology for each training objective. ·All observations are forwarded to the RPM on a monthly basis. The RPM will ensure that observations are completed at school for any clients who attend high school. The RPM will then forward the observations to the director of quality who will then check for proper implementation of client behavior plans. ·The house QIDP will complete an additional 3 documented observations a week for two months to ensure staff use behavior plan approved interventions and supports. ·The QA for group homes will audit the home monthly to ensure client behavior plans include attainable psychotropic medication reduction plans. The QA manager then sends the audit 		

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W 0231 Bldg. 00	483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN The objectives of the individual program		to the RPM who submits a corrective action report to the county QIDP and director of community living. The QIDP must correct all deficiencies with seven days. ·The QA for group homes will audit the homemonthly to ensure client IPPs, health risk plans and behavior plans includephysician directed provisions. The QA manager then sends the audit to the RPMwho submits a corrective action report to the county QIDP and director ofcommunity living. The QIDP must correct all deficiencies with seven days. ·QIDP will perform monthly documented observations on all shifts to ensure staff are implementing proper family style dining. ·The QA for group homes will audit the home monthly to ensure proper staff adherence to family style dining. The QA manager then sends the audit to the RPM who submits a corrective action report to the county QIDP and director of community living. The QIDP must correct all deficiencies with seven days. ·The QIDP will make an additional three weekly documented observations looking for proper implementation family style dining for two months.	

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	<p>plan must be expressed in behavioral terms that provide measurable indices of performance.</p> <p>Based on record review and interview for 3 of 3 clients in the sample (#2, #3 and #6), the facility failed to ensure the clients' program plans were expressed in behavioral terms providing measurable indices of performance.</p> <p>Findings include:</p> <p>On 3/11/16 at 9:03 AM, a review of client #2's record was conducted. Client #2's 5/15 to 5/16 Individual Program Plan (IPP) indicated he had the following training objectives with no measurable indices of performance indicated: Get water for his medication pass, ID (identify) purpose of meds, learn counting, ID numbers 6-10, ID coins by touch - nickel/quarter, ID coins by touch - penny/dime, ID paper currency, participate in shower, brush teeth am/pm, assist in the kitchen, tidy bedroom, clean toilet, and launder his sheets.</p> <p>On 3/11/16 at 9:40 AM, a review of client #3's record was conducted. Client #3's 6/15 to 6/16 IPP indicated he had the following training objectives with no measurable indices of performance indicated: Stir crushed meds into pudding, increase ability to identify coins by the size and shapes, wash hands prior to meals, brush gums, participate in washing during shower, locate tags in clothing to identify</p>	W 0231	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> ·All county QIDPs were in-serviced on the new training objectives with measurable indices of performance and methodology on 3/31/16.(Attachment A) ·House staff were trained on the new training objectives with measurable indices of performance and proper methodology on 2/18/16 that were scheduled to be implemented 4/1/16 (Attachment F) ·Group home monthly summaries have been revised to include measurable indices of performance and methodology for each goal. (Attachment E) <p>How will we identify others:</p> <ul style="list-style-type: none"> ·The quality assurance manager will audit all homes on a monthly basis. The audit documents how well each home operates, including checks for proper client goals with measurable indices of performance and methodology. The QA will audit the clients' IPPs to ensure they contain goals with measurable indices of performance with methodology as well as the monthly summaries. ·All group home QIDPs will submit the new monthly summary sheets to the RPM on a monthly basis. The RPM will ensure all clients have measurable indices of performance and methodologies 	04/14/2016

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	<p>the front or back of an item, assist stirring items during meal prep, pour liquids for meals, clear place setting, carry laundry to the washer, dust dresser, do not take food from others - Informal, good touch/bad touch, and no to physical aggression.</p> <p>On 3/11/16 at 9:59 AM, a review of client #6's record was conducted. Client #6's 6/15 to 6/16 IPP indicated he had the following training objectives with no measurable indices of performance indicated: Get applesauce/pudding to take evening medications, identify drawer with his medications, clean pill crusher daily, allow temperature to be taken, identify coins, distinguish between coins and paper money by: 1. putting pennies into a piggy bank, compare with dimes and 2. putting quarters into a piggy bank, compare with nickels, wiping after a bowel movement, participate in shower routine, brush teeth, use a napkin, comb hair, vacuum bedroom, put his trash in the trash can, clear dishes after dinner, wipe table after dinner, use pictures to communicate feelings, no to physical aggression, sign "more" for drinks, and sign "bathroom" and "yes/no."</p> <p>The facility failed to develop criteria for the clients to meet their training objectives. The facility failed to develop a plan indicating the number and types of prompts needed in order for the clients to meet their training objectives.</p> <p>On 3/11/16 at 11:26 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the facility was previously cited in regards to the clients' program plans not been written in measurable terms. The QIDP indicated the facility changed the process and procedure for writing the clients' program plans. The QIDP indicated, as the clients' annual reviews were</p>		<p>for their training objectives.</p> <p>Measures put in place:</p> <ul style="list-style-type: none"> ·Group home monthly record review audit(Attachment D) ·New group home monthly summary goal sheets with measurable indices of performance and methodologies (Attachment E) <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> ·The QA for group homes will audit the homemonthly to ensure client goals continue to be implemented with measurable indices of performance and proper methodology. The QA manager then sends the audit to the RPM who submits a corrective action report to the county QIDP and director of community living. The QIDP must correct all deficiencies with seven days. ·After the RPM has reviewed all group homemonthly summaries, the Director of community living will review the monthly summaries to ensure they have measurable indices of performance and proper methodology for each training objective. 		

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W 0240 Bldg. 00	<p>completed, the clients' program plans were being rewritten in the new format with measurable criteria.</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 3 clients in the sample (#2 and #3), the facility failed to ensure: 1) client #2's plan to address hypothermia (abnormally low body temperature) was updated to address the psychiatrist and neurologist's recommendations and his Behavior Management Program was updated when his psychotropic medication changed and 2) client #3's plan addressed when he was to use his chest strap on his wheelchair.</p> <p>Findings include:</p> <p>1) On 3/10/16 at 1:07 PM, a review of the facility's incident reports was conducted and indicated the following: On 1/11/16 at 7:45 PM, client #2 was lethargic after dinner. Client #2 was unable to stand or walk. It had taken client #2 one and a half hours to eat dinner. Client #2's body was cool to the</p>	W 0240	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> ·Client #2's Health risk plan for hypothermia andbradycardia has been revised to include directions to transport the Bi-papmachine to the facility operated day program for use during the day (Attachment G) ·All county QIDPs were in-serviced on the need tocoordinate with agency nurses and to implement physician directed plans andequipment as soon as the directive is received on 3/31/16. (Attachment A) ·House staff were trained on the new hypothermiaand bradycardia health risk plan forclient #2, client #3's new dining plan, IPP and health risk plan for potentialfalls with provisions for the use and placement of the chest strap on 3/23/16 (Attachment B) ·Client #2 will receive a physician orderedBi-pap machine on 4/4/16. ·Client #2's Behavior management program has beenupdated to reflect the recent 	04/14/2016

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	touch. The staff called the Qualified Intellectual Disabilities Professional (QIDP) - Designee and was instructed to go to the emergency room. Client #2 was admitted to the hospital for acute respiratory acidosis (a medical emergency in which decreased ventilation (hypoventilation) increases the concentration of carbon dioxide in the blood and decreases the blood's pH (a condition generally called acidosis), bradycardia (abnormally slow heart function) and hypothermia. His body temperature was 86 degrees Fahrenheit. The 1/12/16 Bureau of Developmental Disabilities Services incident report indicated, in part, "...Also [name of doctor] advised that [client #2] does not expel carbon monoxide and was advised to make sure that [client #2] wears his C-PAP (continuous positive airway pressure) faithfully, and if he seems to be lethargic thru (sic) out the day to put on the C-PAP, which is a problem as he likes to take it off in the night...." The 1/15/16 BDDS follow-up report indicated, in part, "[Client #2] was seen by his PCP (primary care physician) on 1/14/16 for a follow up on fatigue/vertigo and his recent hospital stay... Also for us to continue the C-PAP as directed from the hospital. All staff has been trained to watch for signs of low body temperature, and fatigue and instructed to use the		changes in psychotropic medications (Attachment H) ·Client #3's dining plan, IPP and health riskplan for potential falls has been revised to include provisions for the use ofhis chest strap (Attachment I) How will we identifyothers: ·The quality assurance manager will audit allhomes on a monthly basis. The audit documents how well each home operates,including checks for proper implementation of physician directed orders. The QAwill audit the clients' IPPs , health risk plans and behavior plans to see ifthey fully support the clients' needs. Measures put inplace: ·Group home monthly record review audit(Attachment D) Monitoring ofcorrective action: ·The QA for group homes will audit the homemonthly to ensure client IPPs, health risk plans and behavior plans includephysician directed provisions. The QA manager then sends the audit to the RPMwho submits a corrective action report to the county QIDP and director ofcommunity living. The QIDP must correct all deficiencies with seven days.				

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	<p>C-PAP machine if [client #2] is unable to be steady on his feet...."</p> <p>On 3/10/16 from 3:38 PM to 5:49 PM, an observation was conducted at the group home. At 4:56 PM, the Home Manager (HM) took client #2's temperature (97.2 degrees Fahrenheit).</p> <p>On 3/10/16 at 5:01 PM, the HM stated if client #2's temperature "goes below 96 or so, call PCP to see what he wants to do."</p> <p>On 3/11/16 at 6:23 AM, staff #4 indicated client #2's temperature was taken every morning at 6:00 AM. Staff #4 indicated when she took client #2's temperature on 3/11/16, client #2's temperature was 97.9 degrees Fahrenheit. Staff #4 stated his temperature was "kind of low." Staff #4 indicated there were no parameters in place. Staff #4 stated if client #2's temperature was "significantly low" she would call the pager and the QIDP-D. Staff #4 stated she "didn't know" when asked to define significantly low. Staff #4 indicated there were parameters in place for client #2's blood pressure but not his temperature.</p> <p>On 3/11/16 at 9:03 AM, a review of client #2's record was conducted and indicated the following:</p>			

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	<p>-Client #2's 1/12/16 discharge instructions from the hospital indicated, "Symptoms to watch for at home? More sleepy/lethargic. If symptoms occur, what will I do? Use CPAP. Call Dr or go to ER (emergency room)."</p> <p>-Client #2's 1/21/16 Neurology Office Visit/Treatment Plan/Med Order indicated, "...change to Bi-PAP(BiPAP refers to Bilevel or two level positive airway pressure. While CPAP generally delivers a single pressure, BiPAP delivers an inhale pressure and an exhale pressure) 12/8."</p> <p>-A 2/1/16 psychiatry Office Visit/Treatment Plan/Med Order indicated, "Please ensure at least daily temp (temperature) VS (vital signs). If temp is less than 96 (degrees Fahrenheit) then notify primary care MD (medical doctor) and if less than 94 (degrees Fahrenheit) then repeat and go to ER if remains at that value or below...."</p> <p>-Client #2's 12/10/15 Health/Risk Plan for obstructive sleep apnea indicated, in part, "May have CPAP during day hours for and signs of dizziness, shortness of breath, or cyanosis (bluish discoloration of the skin) of face, lips and fingernails...."</p>			

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	<p>-Client #2's 8/17/15 Health/Risk Plan for hypothermia and bradycardia related to possible reaction to generic Abilify/Apripirazole: hospitalized for hypothermia and bradycardia related to apripirazole on 08/11/5... Client became lethargic... Monitor temperature and heart rate, twice a month, reporting to Q (QIDP) or nurse if Temperature 96 or less, with heart rate or 60 or less PRN (as needed). If temperature less than 95 or heart rate less than 50 call 911. Then notify Q or nurse... Staff to monitor and record on MARs (Medication Administration Record), temperature, and heart rate twice monthly...."</p> <p>Client #2's Health/Risk Plan for hypothermia and bradycardia was not updated after his hospitalization on 1/11/16. The plan did not indicate client #2's C-PAP machine was to be transported with him to the facility-operated day program for use during the day. The plan was not updated to address the psychiatrist's recommendations on 2/1/16 to include daily temperature and vital signs. There was no documentation the neurologist's recommendations for a BiPAP were addressed in a plan.</p> <p>On 3/11/16 at 10:54 AM, the QIDP-D indicated client #2 should have a health</p>			

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	<p>risk plan to address hypothermia. The QIDP-D indicated there was no plan indicating client #2 needed to have his C-PAP machine at the day program to use if he became lethargic. The QIDP-D indicated she contacted Medicaid regarding the order for a BiPAP. The QIDP-D indicated Medicaid denied the authorization. The QIDP-D indicated the facility appealed the decision and had not heard from Medicaid. The QIDP-D stated, "We need to purchase one."</p> <p>On 3/11/16 at 10:54 AM, the Regional Program Manager (RPM) indicated there was no plan indicating client #2 needed to have his C-PAP machine at the day program to use if he became lethargic.</p> <p>On 3/11/16 at 10:54 AM, the Quality Assurance (QA) Director indicated there was no plan indicating client #2 needed to have his C-PAP machine at the day program to use if he became lethargic.</p> <p>On 3/11/16 at 10:54 AM, the QA staff indicated there was no plan indicating client #2 needed to have his C-PAP machine at the day program to use if he became lethargic.</p> <p>On 3/14/16 at 12:13 PM, the Registered Nurse (RN) indicated she thought there was a plan addressing the</p>			

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	<p>recommendations. The RN indicated client #2 would need to go to the group home to get his C-PAP if he was lethargic.</p> <p>On 3/14/16 at 3:48 PM, the RPM indicated client #2's health risk plan should have been updated. The RPM indicated the nurse and QIDP-D work together to review the doctor's visit forms. The RPM stated, "It should have been updated."</p> <p>2) On 3/11/16 at 9:03 AM, a review of client #2's record was conducted. A 2/1/16 Office Visit/Treatment Plan/Med Order form indicated in the Diagnosis section, "Goal to slowly retrial Abilify." The Medication Order section indicated, in part, "Abilify (agitation/aggression) 5 mg (milligrams) po (by mouth) Q (every) daily and (increase) to 10 mg po Q daily beginning 2/9/16."</p> <p>Client #2's 9/22/15 Behavior Management Program (BMP) did not include Abilify in the psychotropic medication section. The BMP indicated, in part, "On 8/12/15 Abilify was stopped due to allergic reaction and Klonopin was then started on 9/22/15."</p> <p>On 3/11/16 at 10:18 AM, the QA staff indicated client #2's BMP should have</p>			

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	<p>been updated when his medications were changed.</p> <p>On 3/11/16 at 10:18 AM, the QIDP-D indicated client #2's BMP should have been updated when his medications were changed.</p> <p>On 3/11/16 at 10:18 AM, the RPM indicated client #2's BMP should have been updated when his medications were changed.</p> <p>3) On 3/10/16 from 11:55 AM to 12:56 PM, an observation was conducted at the facility-operated day program. At 11:55 AM, client #3 was eating his lunch. Client #3 was sitting in a wheelchair with a strap across his chest.</p> <p>At 12:21 PM, day program staff #1 indicated the strap on his wheelchair was to keep client #3 sitting up straight during meals.</p> <p>On 3/10/16 from 3:38 PM to 5:49 PM, an observation was conducted at the group home. At 4:03 PM, client #3 went to the dining room table. Staff put the strap on his wheelchair across his chest and locked it in place. At 4:18 PM when client #3 was finished with his drink, the staff removed the strap from his chest.</p>			

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	<p>On 3/10/16 at 4:03 PM, the Home Manager (HM) indicated client #3 used his strap when he was eating or drinking. The HM indicated the strap was not used at any other time.</p> <p>On 3/11/16 from 6:00 AM to 7:50 AM, an observation was conducted at the group home. At 6:31 AM, client #3 went to the table for breakfast. Client #3's chest strap was not used during breakfast. Client #3 leaned over his divided plate during breakfast.</p> <p>On 3/11/16 at 6:52 AM, staff #4 indicated client #3's chest strap was used during transports only. Staff #4 indicated client #3's chest strap was not used while client #3 was in the group home. Staff #4 stated, "he hardly wears it."</p> <p>On 3/11/16 at 6:52 AM, staff #5 indicated client #3's chest strap was used during transports only. Staff #5 indicated client #3's chest strap was not used while client #3 was in the group home.</p> <p>On 3/11/16 at 9:40 AM, a review of client #3's record was conducted. Client #3's 6/15 to 6/16 Individual Program Plan (IPP) indicated, in part, "The use of adaptive equipment is to assist [client #3] in being independent during meals. (See Dining Plan) [Client #3] uses a cushion</p>			

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	<p>on his seat to help assist him with sitting more erect while at the table. The cushion should be placed with the thick side of the wedge to the front of the chair and the thin part of the wedge to the back of the chair." Client #3's 4/24/14 Dysphagia Care Plan, 4/23/14 Health/Risk Plan for choking and 4/24/14 Health/Risk Plan for falls did not indicate the use of a wheelchair or a chest strap. Client #3's 11/30/15 Dining Plan indicated, in part, "Staff may assist client when he is unwilling or unable to support his head so that swallowing is good. They should do this by gently placing a hand on his forehead and lifting so chin is parallel to the table. Should sit upright at 90 degrees... Wheel chair designed for dining to position body and head in the proper position for eating....." The Dining Plan did not include the use of the chest strap.</p> <p>There was no documentation in client #3's record indicating when client #3 was to use the chest strap on his wheelchair. Client #3's IPP was not updated when client #3 obtained his wheelchair. Client #3's IPP was not updated to remove the use of a cushion in his chair during meals.</p> <p>On 3/11/16 at 11:06 AM, the Qualified Intellectual Disabilities Professional -</p>				

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W 0286 Bldg. 00	<p>Designee (QIDP-D) indicated client #3's chest strap on his wheelchair was to be used during transport and during meals. The QIDP-D indicated the strap was to aid in his positioning during meals.</p> <p>On 3/11/16 at 11:06 AM, the Regional Program Manager (RPM) indicated client #3 should have a plan to indicate when the chest strap was to be used.</p> <p>On 3/11/16 at 11:06 AM, the Quality Assurance (QA) staff indicated client #3 should have a plan to indicate when the chest strap was to be used.</p> <p>On 3/11/16 at 11:06 AM, the QA Director indicated client #3 should have a plan to indicate when the chest strap was to be used.</p> <p>On 3/14/16 at 12:13 PM, the Registered Nurse indicated client #3 should have a plan addressing the use of the chest strap.</p> <p>9-3-4(a)</p> <p>483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used for disciplinary</p>			

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	<p>purposes. Based on observation, interview and record review for 1 of 3 clients (#2) in the sample with techniques used to address maladaptive behavior, the facility failed to ensure staff did not use a technique for disciplinary purposes.</p> <p>Findings include:</p> <p>On 3/11/16 from 6:00 AM to 7:50 AM, an observation was conducted at the group home. At 6:44 AM, staff #1 stated to client #2, "If you want to go today (grocery shopping), you have to behave." Staff #1 stated to client #2, "If you want to go this afternoon, shopping, you have to do your work." Staff #4 stated to client #2 after he put his spoon in the yogurt serving container, "I guess you won't go with [staff #1] today." At 7:40 AM, staff #1 stated to client #2, "Be good today. If you're good you can go with me (shopping)."</p> <p>On 3/11/16 at 9:03 AM, a review of client #2's record was conducted. Client #2's 9/22/15 Behavior Management Program (BMP) indicated he had the following targeted behaviors for reduction: excessive eating, sneaking food, eating inedible food, incontinence, physical aggression and property destruction. The BMP did not include an</p>	W 0286	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> All county QIDPs were in-serviced to ensure staff do not implement non-behavior plan approved interventions on 3/31/16. (Attachment A) House staff were trained on Client #2's behaviorsupport plan and to not use non-behavior support plan interventions on 3/23/16 (Attachment B) <p>How will we identify others:</p> <ul style="list-style-type: none"> All QIDPs complete documented home observationsand will look for restrictive practices and proper implementation of behaviorsupport plans. If any adverse techniques are discovered, the QIDP will correctthe issue by training and disciplinary action as necessary. The quality assurance manager will audit allhomes on a monthly basis. The audit documents how well each home operates,including checks for proper implementation of client behavior support plans. <p>Measures put inplace:</p> <ul style="list-style-type: none"> Group home observation sheet (Attachment C) Group home monthly record review audit(Attachment D) <p>Monitoring ofcorrective action:</p> <ul style="list-style-type: none"> All observations are forwarded to the RPM on amonthly basis. The RPM will ensure that observations are completed at 	04/14/2016			

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	<p>intervention indicating client #2 would lose an outing for exhibiting maladaptive behavior. The BMP indicated, in part, "Initially positive response will be given to positive behavior and negative behavior will be ignored with the exception of medication. Positive reinforcement will be given for positive behavior or the absence of a negative behavior while concurrently pairing a negative consequence with the negative behavior." In the sneaking food section, the BMP indicated, in part, "Monitor food, ensure he is engaged in appropriate activities... Monitor and redirect to other activities or take out for an activity."</p> <p>On 3/11/16 at 10:51 AM, the Qualified Intellectual Disabilities Professional - Designee indicated the staff's techniques were not part of client #2's plan and the staff should not be doing that.</p> <p>On 3/11/16 at 10:51 AM, the Regional Program Manager indicated the staff's techniques were not part of client #2's plan.</p> <p>On 3/11/16 at 10:51 AM, the Quality Assurance Director indicated the staff's techniques were not part of client #2's plan.</p> <p>9-3-5(a)</p>		<p>school for any clients who attend high school. The RPM will then forward the observations to the director of quality who will then check for proper implementation of client behavior plans.</p> <p>The house QIDP will complete an additional 3 documented observations a week for two months to ensure staff use behavior plan approved interventions and supports.</p>		

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W 0312 Bldg. 00	<p>483.450(e)(2) DRUG USAGE</p> <p>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 1 of 3 clients in the sample (#2), the facility failed to ensure his psychotropic medication reduction plan was attainable.</p> <p>Findings include:</p> <p>On 3/11/16 at 9:03 AM, a review of client #2's record was conducted. Client #2's 9/22/15 Behavior Management Program (BMP) indicated he was prescribed Paxil, Trazodone and Klonopin (Abilify was also a current psychotropic medication not included in the BMP). The BMP indicated, "Medication reduction will be sought by 7/15 if instances are as noted below and in conjunction with psychiatric consultation. On 8/12/15 Abilify was stopped due to allergic reaction and Klonopin was then started on 9/22/15. Food seeking - 0 by 7/15. Physician aggression - 6 by 7/15. Incontinence - 15 by 7/15. Property destruction - 0 by 7/15. IDT (Interdisciplinary team) has weighed</p>	W 0312	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> All county QIDPs were in-serviced to ensure that medication reduction plans are attainable when documented on behavior management plans on 3/31/16. (Attachment A) Client #2's behavior management plan was revised to ensure his psychotropic medication plan was attainable (Attachment H) <p>How will we identify others:</p> <ul style="list-style-type: none"> The quality assurance manager will audit all homes on a monthly basis. The audit documents how well each home operates, including checks for attainable psychotropic medication reduction plans in the clients' behavior plans. <p>Measures put in place:</p> <ul style="list-style-type: none"> Group home monthly record review audit (Attachment D) <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> The QA for group homes will audit the home monthly to ensure client behavior plans include attainable psychotropic medication reduction plans. The 	04/14/2016
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	<p>the risks/benefits of psychotropic medications and determined medications are appropriate. These will be reviewed annually at minimum."</p> <p>Client #2's Residential Monthly Reports for November 2015, December 2015, January 2016 and February 2016 did not include information addressing maladaptive behavior tracking.</p> <p>On 3/11/16 at 10:51 AM, the Qualified Intellectual Disabilities Professional - Designee indicated client #2's BMP needed to be updated to include the current psychotropic medications. The QIDP-D indicated the plan needed updated dates in the plan. The QIDP-D indicated the medication reduction plan was not attainable for food seeking. The QIDP-D indicated food seeking was never zero incidents per month.</p> <p>On 3/11/16 at 10:51 AM, the Quality Assurance Director indicated client #2's medication reduction plan was not attainable for food seeking.</p> <p>On 3/11/16 at 10:51 AM, the Quality Assurance staff indicated client #2's medication reduction plan was not attainable for food seeking.</p> <p>On 3/11/16 at 10:51 AM, the Regional</p>		<p>QA manager then sends the audit to the RPM who submits a corrective action report to the county QIDP and director of community living. The QIDP must correct all deficiencies with seven days.</p>				

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W 0369 Bldg. 00	<p>Program Manager indicated client #2's medication reduction plan was not attainable for food seeking.</p> <p>9-3-5(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 1 of 1 client (#2) who received his medication on 3/10/16 at 5:00 PM, the facility failed to ensure the staff administered the client's medication according to the Physician's Orders.</p> <p>Findings include:</p> <p>On 3/10/16 from 3:38 PM to 5:49 PM, an observation was conducted at the group home. At 4:56 PM, client #2 was administered Renagel (the purpose was not indicated on the packaging or on the physician's orders). The medication packaging indicated the medication was to be administered with meals. From 4:56 PM to 5:49 PM, client #2 did not eat a meal or any food. The chicken pot pie was not going to be completed cooking in the oven until 6:30 PM.</p>	W 0369	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> ·All county QIDPs were in-serviced to ensure they request clarification from the prescribing physician regarding the administration of meal time medications on 3/31/16. (Attachment A) ·House staff were trained on the clarified mealtime medication administration protocol on 3/23/16 (Attachment B) ·The medication administration record and physician's order was changed to reflect that the meal time medications are to be administered 5 minutes before meal time per prescribing physician. <p>How will we identify others:</p> <ul style="list-style-type: none"> ·All QIDPs will coordinate with their house nurses to ensure any meal time medication has proper clarification from the prescribing physician. Staff will be trained in the event of any revisions. 	04/14/2016

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W 0436 Bldg. 00	<p>On 3/11/16 at 9:03 AM, a review of client #2's 2/5/16 Physician's Orders indicated for Renagel, "Take one tablet by mouth three times a day with meals."</p> <p>On 3/11/16 at 10:43 AM, the Qualified Intellectual Disabilities Professional - Designee (QIDP-D) indicated the medication should be administered as ordered with meals, either before or after. The QIDP-D indicated an hour and a half was not with meals.</p> <p>On 3/14/16 at 12:13 PM, the Registered Nurse (RN) indicated the medication should have been administered with dinner. The RN stated, "I thought it was set up for him to get with mealtime."</p> <p>On 3/11/16 at 10:43 AM, the Quality Assurance Director (QAD) indicated client #2's medication should have been administered with food as indicated. The QAD indicated it was a medication error.</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,</p>				<p>The quality assurance manager will audit allhomes on a monthly basis. The audit documents how well each home operates,including checks for proper implementation of physician directed meal timemedication administration.</p> <p>Measures put inplace:</p> <ul style="list-style-type: none"> Group home monthly record review audit(Attachment D) <p>Monitoring ofcorrective action:</p> <ul style="list-style-type: none"> The QA for group homes will audit the home monthly to ensure client physician orders and medication administration records accurately reflect prescribing physician recommendations for meal time administration of medications. . The QA manager then sends the audit to the RPM who submits a corrective action report to the county QIDP and director of community living. The QIDP must correct all deficiencies with seven days. 		

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	<p>eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review for 1 of 3 clients in the sample with adaptive equipment (#2), the facility failed to ensure client #2's C-PAP (continuous positive airway pressure) machine was available for use at the facility-operated day program and a Bi-PAP (bilevel positive airway pressure) machine was obtained after the neurologist recommended a change from a C-PAP to a Bi-PAP machine.</p> <p>Findings include:</p> <p>On 3/10/16 from 11:55 AM to 12:56 PM, an observation was conducted at the facility-operated day program. During the observation, client #2 was present. Client #2's CPAP machine was not present for his use at the facility-operated day program.</p> <p>On 3/10/16 at 1:07 PM, a review of the facility's incident reports was conducted and indicated the following: On 1/11/16 at 7:45 PM, client #2 was lethargic after dinner. Client #2 was unable to stand or walk. It had taken client #2 one and a half hours to eat dinner. Client #2's body was cool to the touch. The staff called the Qualified Intellectual Disabilities</p>	W 0436	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> ·Client #2's Health risk plan for hypothermia and bradycardia has been revised to include directions to transport the Bi-pap machine to the facility operated day program for use during the day (Attachment G) ·All county QIDPs were in-serviced on the need to coordinate with agency nurses and to implement physician directed plans and equipment as soon as the directive is received on 3/31/16. (Attachment A) ·House staff were trained on the new hypothermia and bradycardia health risk plan for client #2 on 3/23/16 (Attachment B) ·Client #2 will receive a physician ordered Bi-pap machine on 4/4/16. ·Client #2's Behavior management program has been updated to reflect the recent changes in psychotropic medications (Attachment H) <p>How will we identify others:</p> <ul style="list-style-type: none"> ·The quality assurance manager will audit all homes on a monthly basis. The audit documents how well each home operates, including checks for proper implementation of physician directed orders. The QA will audit the clients' IPPs, health risk plans and behavior plans to see if they fully support 	04/14/2016			

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	Professional (QIDP) - Designee and was instructed to go to the emergency room. Client #2 was admitted to the hospital for acute respiratory acidosis (a medical emergency in which decreased ventilation (hypoventilation) increases the concentration of carbon dioxide in the blood and decreases the blood's pH (a condition generally called acidosis), bradycardia (abnormally slow heart function) and hypothermia. His body temperature was 86 degrees Fahrenheit. The 1/12/16 Bureau of Developmental Disabilities Services incident report indicated, in part, "...Also [name of doctor] advised that [client #2] does not expel carbon monoxide and was advised to make sure that [client #2] wears his C-PAP (continuous positive airway pressure) faithfully, and if he seems to be lethargic thru (sic) out the day to put on the C-PAP, which is a problem as he likes to take it off in the night...." The 1/15/16 BDDS follow-up report indicated, in part, "[Client #2] was seen by his PCP (primary care physician) on 1/14/16 for a follow up on fatigue/vertigo and his recent hospital stay... Also for us to continue the C-PAP as directed from the hospital. All staff has been trained to watch for signs of low body temperature, and fatigue and instructed to use the C-PAP machine if [client #2] is unable to be steady on his feet...."		the clients' needs. Measures put in place: ·Group home monthly record review audit(Attachment D) Monitoring of corrective action: ·The QA for group homes will audit the homemonthly to ensure client IPPs, health risk plans and behavior plans includephysician directed provisions. The QA manager then sends the audit to the RPMwho submits a corrective action report to the county QIDP and director ofcommunity living. The QIDP must correct all deficiencies with seven days.				

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	<p>On 3/11/16 at 9:03 AM, a review of client #2's record was conducted and indicated the following:</p> <p>-Client #2's 1/12/16 discharge instructions from the hospital indicated, "Symptoms to watch for at home? More sleepy/lethargic. If symptoms occur, what will I do? Use CPAP. Call Dr or go to ER (emergency room)."</p> <p>-Client #2's 1/21/16 Neurology Office Visit/Treatment Plan/Med Order indicated, "...change to Bi-PAP(BiPAP refers to Bilevel or two level positive airway pressure. While CPAP generally delivers a single pressure, BiPAP delivers an inhale pressure and an exhale pressure) 12/8."</p> <p>-Client #2's 12/10/15 Health/Risk Plan for obstructive sleep apnea indicated, in part, "May have CPAP during day hours for and signs of dizziness, shortness of breath, or cyanosis (bluish discoloration of the skin) of face, lips and fingernails..."</p> <p>Client #2's Health/Risk Plan for hypothermia and bradycardia was not updated after his hospitalization on 1/11/16. The plan did not indicate client #2's C-PAP machine was to be</p>			

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	<p>transported with him to the facility-operated day program for use during the day. There was no documentation the neurologist's recommendations for a BiPAP were addressed in a plan.</p> <p>On 3/11/16 at 10:54 AM, the QIDP-D indicated there was no plan indicating client #2 needed to have his C-PAP machine at the day program to use if he became lethargic. The QIDP-D indicated client #2's CPAP was not transported with him to the day program daily. The QIDP-D indicated she contacted Medicaid regarding the order for a BiPAP. The QIDP-D indicated Medicaid denied the authorization. The QIDP-D indicated the facility appealed the decision and had not heard from Medicaid. The QIDP-D stated, "We need to purchase one."</p> <p>On 3/11/16 at 10:54 AM, the Regional Program Manager (RPM) indicated there was no plan indicating client #2 needed to have his C-PAP machine at the day program to use if he became lethargic.</p> <p>On 3/11/16 at 10:54 AM, the Quality Assurance (QA) Director indicated there was no plan indicating client #2 needed to have his C-PAP machine at the day program to use if he became lethargic.</p>			

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W 0488 Bldg. 00	<p>On 3/11/16 at 10:54 AM, the QA staff indicated there was no plan indicating client #2 needed to have his C-PAP machine at the day program to use if he became lethargic.</p> <p>On 3/14/16 at 12:13 PM, the Registered Nurse (RN) indicated client #2 would need to go to the group home to get his C-PAP if he was lethargic.</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>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 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients were involved with the preparation and clean up during breakfast.</p> <p>Findings include:</p> <p>On 3/11/16 from 6:00 AM to 7:50 AM, an observation was conducted at the group home. At 6:19 AM, staff #1 used a food processor to puree breakfast bars. At 6:21 AM, staff #1 placed 4 breakfast bars in a bowl and used scissors to cut the</p>	W 0488	<p>Corrective actionstaken:</p> <ul style="list-style-type: none"> ·Staff were in-serviced on informal meal prep training opportunities and active treatment on 3/23/16 (Attachment B) ·All county QIDPs were in-serviced on informal meal prep training opportunities and active treatment on 3/16/16 (Attachment J) <p>How we will identifyothers:</p> <ul style="list-style-type: none"> ·The quality assurance manager will audit all homes monthly to ensure adherence to family style dining. ·All QIDPs complete three monthly documented group home observations to ensure staff are implementing family style dining 	04/14/2016

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	<p>bars into bite sized pieces. Staff #1 opened a can of frozen orange juice concentrate. Staff #1 stated to client #2, "We are going to eat in a few minutes as soon as I get it all ready." At 6:27 AM, staff #1 added milk to the food processor and turned it on. At 6:29 AM, staff #1 placed a serving container of yogurt on the table. Staff #1 stated to client #2, who was sitting at the dining room table, "Yeah, we're going to eat pretty soon. It's coming." At 6:41 AM, staff #1 poured client #6's orange juice. At 6:49 AM, staff #1 poured client #3's juice. At 6:50 AM, staff #1 poured client #6 more juice. At 6:52 AM, staff #4 removed the milk from the table and put it in the refrigerator. Staff #1 rinsed off dishes and placed them in the dishwasher. At 6:55 AM, staff #4 removed additional items from the table. Staff #1 rinsed dishes and placed them into the dishwasher. At 7:07 AM, staff #1 wiped off the kitchen counters. At 7:12 AM, staff #1 wiped off the table and chairs. At 7:17 AM, staff #1 washed the food processor.</p> <p>On 3/11/16 at 10:46 AM, the Social Services Manager indicated the clients should be involved with meal preparation and clean up.</p> <p>On 3/11/16 at 10:46 AM, the Qualified</p>		<p>on their monthly documented observations.</p> <p>Measures put in place:</p> <ul style="list-style-type: none"> ·Group home observation sheet (Attachment C) ·Group home monthly record review audit (Attachment D) <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> ·QIDP will perform monthly documented observations on all shifts to ensure staff are implementing proper family style dining. ·The QA for group homes will audit the home monthly to ensure proper staff adherence to family style dining. The QA manager then sends the audit to the RPM who submits a corrective action report to the county QIDP and director of community living. The QIDP must correct all deficiencies with seven days. ·The QIDP will make an additional three weekly documented observations looking for proper implementation family style dining for two months. 				

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	<p>Intellectual Disabilities Professional - Designee indicated the clients should be involved with meal preparation and clean up.</p> <p>On 3/11/16 at 10:46 AM, the Quality Assurance Director indicated the clients should be involved with meal preparation and clean up.</p> <p>On 3/11/16 at 10:46 AM, the Regional Program Manager indicated the clients should be involved with meal preparation and clean up.</p> <p>9-3-8(a)</p>				