

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G478		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/15/2013	
NAME OF PROVIDER OR SUPPLIER  RESIDENTIAL CRF INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2534 W SR 44 LIBERTY, IN 47353			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: November 12, 13 and 15, 2013.</p> <p>Surveyor: Vickie Kolb, RN</p> <p>Facility Number: 000992 Provider Number: 15G478 AIM Number: 100244940</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed November 22, 2013 by Dotty Walton, QIDP.</p>			W000000			

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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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, record review and interview for 3 of 3 sample clients (#1, #2 and #3) and 1 additional client (#4), the facility failed to ensure the Interdisciplinary Team (IDT) re-assessed the clients upper and lower extremity strength, gait, balance and level of assistance needed while ambulating and re-assessed client #1 in regard to the use of a splint for her right hand.</p> <p>Findings include:</p> <p>During observations at the group home on 11/12/13 between 1:45 PM and 4 PM and on 11/13/13 between 6:45 AM and 8:30 AM, the following was observed:</p> <p>__ The group home was a ranch style house with a sunken living room. The rear exit door and the medication room was off of the sunken living room requiring the clients to maneuver two steps down and two steps up each time they went to the living room, to get their medications and/or to leave the home via the rear door.</p> <p>__ All of the clients in the home were elderly females, ages 59 to 84.</p> <p>__ Client #1 ambulated independently</p>	W000210	<p>The facility has scheduled updated OT, PT and Speech assessments for Clients #1, #2, #3 and #4 to provide a more thorough assessment of their present needs/deficits in regards to gait, balance, upper and lower extremity strength, and usage of any adaptive devices in place. In addition, the assessments will be used to determine the best possible plan of care to be put in place to meet their needs. In addition, Client #5 and #6 will also receive updated PT, OT and Speech assessments in light of the fact that the home setting is geriatric and all individuals could benefit from a more current assessment of their needs. Assessments are scheduled for December 11 and 12, 2013. Based on the results of the assessments, a plan of care will be developed to best meet their needs. If adaptive devices are recommended, those will be obtained and staff trained on usage. Staff training will be documented, and and additional exerices, interventions or care will be documented. Reviews of the clients care plan will be completed at least every 4 months. Any revisions will be</p>	12/15/2013			

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	<p>with a slow sometimes unsteady gait, her right hand was contractured and non functioning. Client #1 did not wear any adaptive devices on her right hand. The staff prompted client #1 to be careful when going up and down the steps. The staff did not supervise and/or assist client #1 every time client #1 ambulated and/or walked up and down the steps.</p> <p>__ Client #2 had a spinal curvature and was slumped forward and walked with her face down. Client #2 ambulated with a slow, shuffling, sometimes unsteady, gait and reached for obstacles and/or staff to steady herself while walking. Client #2 was seen ambulating independently and ambulating with staff assistance.</p> <p>__ Client #3 ambulated independently at a slow pace. The staff did not assist client #3 up and down the steps in the home.</p> <p>__ Client #4 ambulated at a fast pace. The staff reminded client #4 a few times to slow her pace and to watch what she was doing.</p> <p>The facility's I/As (Incident/Accident Reports) were reviewed on 11/13/13 at 10 AM. The reports indicated on 9/26/13 at 8:45 AM client #1 lost her balance and fell.</p> <p>In regard to client #4, the I/A reports indicated: __ On 10/27/13 at 10:30 AM client #4</p>		made as necessary. The IDT will review at least annually to assure that needs are being met. Responsible: Nursing, QIDP, Direct Care Staff				

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	<p>indicated she was running to a chair to sit down and tripped over her feet. The report indicated client #4 fell on a carpeted floor and received minor abrasions to her hands and to her knees.</p> <p>__ On 10/21/13 at 7:30 PM client #4 indicated she didn't realize her leg had fallen asleep until she started walking and her leg went out from under her. The report indicated client #4 landed on her right knee.</p> <p>__ On 6/23/13 at 11:55 AM client #4 indicated she tripped over her own feet, stumbled and caught herself on the windowsill. Client #4 "slightly jammed" her right middle finger and obtained an abrasion to her right forearm.</p> <p>__ On 6/23/13 at 7:15 AM client #4 indicated she was sitting on the toilet and slid off the side to the floor. The report indicated client #4 landed on her buttocks and obtained injuries.</p> <p>__ On 6/4/13 at 7:45 AM client #4 stated, "I lost my balance and fell." The report indicated no apparent injuries.</p> <p>__ On 12/2/12 at 5 PM client #4 "lost her balance" and fell while getting up from the kitchen table. The report indicated client #4 obtained a red mark on her back.</p> <p>Client #1's record was reviewed on 11/13/13 at 1 PM.</p> <p>__ Client #1's record indicated client #1 was a 73 year old female. The record</p>			

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	<p>indicated client #1 had diagnoses of, but not limited to, Scoliosis (an abnormal curvature of the spine) and Osteoporosis (porous bones causing reduced bone strength and a higher risk of fractures).</p> <p>__ Client #1's 2013 quarterly physician's orders indicated client #1 took calcium daily for Osteoporosis and Motrin as needed for knee pain.</p> <p>__ Client #1's Occupational Therapy (OT) assessment of 9/24/09 indicated "Rt (right) hand demonstrates flexion contracture, hand is non-functional. Pt (patient) instructed in HEP (home exercise program) for PROM (passive range of motion) in wrist sup/pro (supination/pronation), flexion extension. Radial ulnar deviation and digit extension. Pt. to wear provided splint on R (right hand) as tolerated."</p> <p>__ 9/24/09 PT (Physical Therapy) evaluation to screen for lower extremity strength, gait and balance. The evaluation indicated client #1 was "moderately unsteady with gait and steps - recommend supervision from caregiver. Pt (patient) appeared to struggle with sit to stand transfer and would benefit from LE (lower extremity) strengthening. No further PT at this time. Pt encouraged to do HEP at home 2 - 3 times a week."</p> <p>__ Client #1's ISP (Individualized Support Plan) of 6/18/13 indicated client #1's HEP was discontinued on 7/1/11 due to</p>			

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	<p>Osteoporosis.</p> <p>__ Client #1's Comprehensive Functional Assessment (CFA/ Independent Living Skills Assessment) of 6/18/13 indicated client #1 was able to sit supported for at least one minute, could raise herself to a sitting position and maintain the position unsupported for at least one minute, could crawl across the floor on her hands and knees without her stomach touching the floor and walked as her primary means of getting around.</p> <p>__ Client #1's record indicated no IDT (Interdisciplinary Team) notes.</p> <p>__ Client #1's record indicated client #1 had not been assessed for upper and/or lower extremity strength, gait, balance, level of assistance needed while ambulating and/or the need for a splint for client #1's right hand since client #1's OT/PT assessments of 2009.</p> <p>Client #2's record was reviewed on 11/13/13 at 11:45 AM.</p> <p>__ Client #2's record indicated client #2 was a 70 year old female with diagnoses of, but not limited to Scoliosis, Osteoporosis, Osteoarthritis (a degenerative joint disease) and Schmorl's node (protrusions of the spinal disc's soft tissue into an adjacent disc resulting in severe back pain).</p> <p>__ Client #2's OT evaluation of 1/25/07 indicated "Concerns this date include</p>						

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	<p>bilateral shoulder flexion and abduction and pt. (patient) reports of pain in upper trapezius (a large muscle of the shoulder and upper back). OT recommends home exercise program to focus on shoulders."            __ Client #2's PT evaluation of 3/23/10 indicated client #2 was given a HEP for strengthening of her lower extremities and back with stretching positions for the Scoliosis.            __ Client #2's radiology report of 5/1/12 indicated client #2 had a history of back trauma and back pain. "There are old compression fractures of T12 (thoracic 12 vertebra) and L1 (Lumbar 1 vertebra). There is moderate disc space loss and osteophyte formation (bone spurs) throughout the thoracic spine. There is disc calcification throughout the thoracic spine."            __ Client #2's ISP of 6/18/13 indicated client "Due to diagnosis of Schmorl's node (protrusions of the cartilage of a disc into an adjacent disc) resulting in severe back pain, home exercise program will be discontinued by her physician." The ISP indicated the Schmorl's node in client #2's back was a product of the degenerative process of client #2's aging spine and the "in house exercise program was to be discontinued due to back pain and degenerative condition."            __ Client #2's CFA of 6/18/13 indicated client #2 was able to sit supported for at</p>						

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	<p>least one minute, could raise herself to a sitting position and maintain the position unsupported for at least one minute, could crawl across the floor on her hands and knees without her stomach touching the floor and walked as her primary means of getting around.</p> <p>__ Client #2's radiology report of 9/28/13 indicated an impression of Osteoarthritis and Osteoporosis of the right knee.</p> <p>Client #2's nursing notes indicated, but not all inclusive:</p> <p>__ 12/18/12 client #2 continues to complain of pain and discomfort and "will limp when walking." The note indicated client #2 saw her physician and received a Cortisone (a steroid) injection in her right knee.</p> <p>__ 12/23/13 "...doing better. No further limping noted."</p> <p>__ 1/20/13 Osteoporosis causing back pain.</p> <p>__ 2/27/13 Continues to complain of knee pain. Next injection will be given in April.</p> <p>__ 3/12/13 Continues to complain of occasional knee pain.</p> <p>__ 4/4/13 Continues to have recurrent right knee pain.</p> <p>__ 5/9/13 Client #2 "has been getting daily SubQ (subcutaneous) injections for her Osteoporosis."</p> <p>__ 6/12/13 Continued to have occasional</p>						

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	<p>pain that was relieved with medication.</p> <p>__9/18/13 was given Ibuprofen for knee pain. "Does not want to walk, but will walk with assistance."</p> <p>__9/27/13 Client #2 saw her physician for "severe pain in her right knee." The note indicated client #2's physician reinstated the Fentanyl Patch 50 mcg (micrograms) every 72 hours to treat pain.</p> <p>__10/16/13 client #2 was scheduled to have an MRI (Magnetic Resonance Imaging - a high powered X-ray) of her right knee but was "physically unable to lay flat on her back for the duration of procedure. Notified PCP (Primary Care Physician) and will be scheduled to have MRI under sedation."</p> <p>__Client #2's record indicated no IDT (Interdisciplinary Team) notes.</p> <p>__Client #2's record indicated no OT assessment since the one of 2007.</p> <p>__Client #2's record indicated client #2 had not been assessed for upper or lower extremity strength, gait, balance and level of assistance needed while ambulating since her PT assessment of 2010.</p> <p>Client #3's record was reviewed on 11/13/13 at 2 PM.</p> <p>__Client #3's record indicated client #3 was an 84 year old female with diagnoses of, but not limited to, Dementia and Osteoporosis.</p>						

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	<p>__ Client #3's ISP of 6/18/13 indicated client #3 had an OT/PT evaluation on 9/24/09. The ISP indicated the OT therapist recommended a range of motion program for client #3's upper extremities to assist client #3 with maintaining optimal functioning and for the staff to continue supervising client #3 with her ADLS (Adult Daily Living Skills) to maximize client #3's safety and independence. The ISP indicated the PT therapist recommended someone be with client #3 while climbing up and down steps and staff needed to encourage client #3 to slow her pace in order for her to remain safe. The ISP indicated the PT therapist gave client #3 a HEP to follow two to three times a week.</p> <p>__ Client #3's CFA of 6/18/13 indicated client #3 was able to sit supported for at least one minute, raise herself to a sitting position and maintain the position unsupported for at least one minute and walked as her primary means of getting around. The CFA indicated client #3 could not crawl across the floor on her hands and knees without her stomach touching the floor. The CFA did not indicate an assessment of client #3's ability to go up and down steps, to get on and off the facility van and/or her ability to maneuver different terrain.</p> <p>__ Client #3's record indicated client #3 had not been re-assessed for upper and</p>				

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	<p>lower extremity strength, gait, balance and/or level of assistance needed while ambulating since her OT/PT assessment of 2009.</p> <p>Client #4's record was reviewed on 11/13/13 at 3 PM.</p> <p>__ Client #4's annual nursing assessment dated May 2012 to May 2013 indicated client #4 was independent in ambulation with full range of motion in all extremities and was able to perform adult daily living skills without difficulty.</p> <p>__ Client #4's falls assessment of 6/24/10 indicated client #4 was given a score of 40 which was a low risk of falls and requiring "standard fall prevention interventions."</p> <p>__ Client #4's record indicated the most recent evaluation by a physical therapist was conducted on 9/19/09 with no significant findings.</p> <p>__ Client #4's record indicated no IDT (Interdisciplinary Team) notes.</p> <p>__ Client #4's record indicated the IDT had not reassessed client #4's ambulatory needs after documented falls on 6/4/13, 6/23/13, 10/21/13 and 10/27/13.</p> <p>Interview with staff #1 and #2 on 11/12/13 at 2 PM indicated all the clients in the group home were elderly retired females. Staff #2 stated clients #2 and #3 had changed "over the past few years" in</p>			

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	<p>that the clients were slowing down and requiring more staff assistance with ADLS and ambulation. Staff #1 stated "We try to look out for all of them and help them as they need it." Staff #1 indicated client #4 had a "few falls recently. I think she just gets to going too fast and doesn't think about what she's doing."</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 11/13/13 at 2 PM, the QIDP stated all the clients were elderly and clients #2 and #3 had "slowed down" and were changing/aging over the years and were more dependent on the staff. When asked for client #1's, #2's, #3's and #4's IDT notes, the QIDP stated, "We get together every Monday and we talk about all of them (the clients)." The QIDP provided no IDT notes for review. The QIDP stated client #4's falls had been discussed by the IDT and "she just gets going too fast." The QIDP indicated the staff were to prompt client #4 to slow down. The QIDP stated clients #1, #2, #3 and #4 had not been assessed in regard to upper/lower extremity strength, gait, balance and level of assistance needed while ambulating by an OT/PT therapist for "several years." The QIDP stated, "We didn't think they needed therapy." The QIDP indicated client #1 was to wear a</p>				

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	hand splint at night.  9-3-4(a)				

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W000240	<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 record review and interview for 1 of 3 sampled clients (#3), the client's ISP (Individualized Support Plan) failed to address how the staff were to supervise, monitor and assist client #3 in regard to the client's dementia.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 11/13/13 at 2 PM. Client #3's 9/26/13 physician's order indicated client #3 was taking Aricept 10 milligrams a day for dementia. Client #3's ISP of 6/18/13 failed to include how and what the staff were to monitor and how the staff were to assist client #3 in regard to the client's dementia.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) and the LPN (Licensed Practical Nurse) on 11/13/13 at 2 PM, the LPN indicated client #3 was taking Aricept for dementia. When asked how and what the staff were to monitor in regard to client #3's dementia, the LPN and QIDP indicated client #3's ISP, risk/health plans and/or BSP (Behavior Support Plan) did not include client #3's</p>	W000240	In order to insure that the Individual Program Plan include relevant interventions to support all individuals, but more specifically those individuals diagnosed with memory loss or Dementia, to support the individual toward independence, Residential CRF will provide a Care Plan that will address how the staff are to supervise, monitor and assist those clients in need. Client #3 will be assessed utilizing the Folstein Mini-Mental State Exam in order to establish a baseline of mental performance. Direct Care Staff will be trained in regard to recording any incidents of observed memory loss and how to intervene. The mental state for Client #3 will be monitored on a daily basis following the initial assessment. A report will be generated on a quarterly basis (4 months) and medication will be adjusted as necessary. The intent of this plan is not to withdraw medication, but to try to determine the effectiveness of the medication being administered as it relates to mental status. All individuals currently receiving treatment for Dementia will be assessed in this way and a care plan developed following the above method. As the general population ages, so	12/15/2013			

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	<p>use of Aricept, what symptoms/behaviors the staff were to monitor and/or document or how the staff were to supervise and assist client #3 with her ADLs (Adult Daily Living Skills) in regard to dementia. The LPN stated, "I understand what you are saying. If we don't monitor [client #3's] symptoms of dementia and the use of the Aricept, then how will we know if it's working?" The LPN indicated the Aricept would be included in client #3's plan of care.</p> <p>9-3-4(a)</p>		<p>does the ID population. It is anticipated that more and more people with intellectual challenges will begin to show signs of memory loss and/or dementia. Therefore, the Direct Care Staff will serve as the "front line" for the observing and reporting of any individuals who may be showing signs of memory loss. The IDT will be responsible for insuring that the development and implementation of care plans for those in need will be implemented. Responsible: QIDP, Nursing, Behavioral Services, Direct Care Staff</p>		

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W000253	<p>483.440(e)(2) PROGRAM DOCUMENTATION The facility must document significant events that are related to the client's individual program plan and assessments. Based on record review and interview, the facility failed to develop a recording system that described/documented the clients' specified targeted behaviors for 2 of 2 sampled clients (#2 and #3) with BSPs (Behavior Support Plans).</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 11/13/13 at 11:45 AM. Client #2's BSP of 6/18/13 indicated the following targeted behaviors and definitions: resistance (demonstrates reluctance to follow directions), disruption (interacts with others in such a way so as to cause a break in the normal routine), aggression (attacking others with an intent to do harm), hallucinations (seeing or hearing things that are not there) and delusions (engaging in thought that is not based on reality). Client #2's monthly behavior records from November 2012 through October 2013 indicated 377 incidents of disruption, 92 incidents of resistance, 1 incident of aggression on 6/21/13 and 1 incident of delusions. Client #2's monthly behavior records indicated tally marks for each incident. Client #2's record indicated no descriptive and/or narrative</p>	W000253	<p>In order to insure that all significant events that are related to the client's individual program plan and assessments be documented, Residential CRF will implement the following: 1. A thorough evaluation of the individual's behavior status will be completed. 2. A diagnosis of mental illness will be made if indicated by a trained professional. 3. Those symptoms relating to that diagnosis will be included in the client record. 4. Target behaviors based on the symptoms associated with the specific mental illness will be prioritized based on severity and frequency and included in the client record. A description of the target behaviors will be included in the client record. 5. A Behavior Support Plan will be developed to assist the individual in changing those behaviors identified as target behaviors. 6. Target behaviors will be recorded on a monthly behavior record by trained direct care staff as they are observed. More specific notation will be included with the tally of those behaviors. 7. Any observed act of aggression will require some sort of narrative in conjunction with the description already included in the client record. The narrative will include</p>	12/15/2013	

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	<p>documentation of client #2's incidents of targeted behaviors.</p> <p>Client #3's record was reviewed on 11/13/13 at 2 PM. Client #3's BSP of 6/18/13 indicated the following targeted behaviors and definitions: talks to herself (mumbling and talking about unrelated topics to her self), agitation (assumes a very tense body posture) and verbal aggression (cursing at others). Client #3's monthly behavior records from May 2012 through October 2013 indicated 238 incidents of talking to self and 27 incidents of agitation. Client #3's monthly behavior records indicated tally marks for each incident. Client 3's record indicated no descriptive and/or narrative/documentation of client #3's incidents of targeted behaviors.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 11/13/13 at 2 PM, the QIDP indicated the staff did not write a descriptive note or comment in regard to the clients' targeted behaviors. When asked about the incident of aggression in regard to client #2 on 6/21/13 and the definition of client #2's targeted behavior of aggression (attacking others with an intent to do harm), the QIDP stated, "If it was serious, they would have filled out an Incident form." The QIDP indicated she</p>		<p>more specific information which will help to determine times, who the victim(s) are, consequences, antecedents to behaviors, or other information to allow for staff to investigate and resolve the issues. 8 Any serious acts of aggression will also be reported to appropriate authorities per BDDS Incident Reporting policies, investigated and followed to resolution. Staff training will reflect changes in behavior incident documentation. Behavior documentation will be reviewed monthly or more frequently if necessary to address any issues. The IDT will address any issues, and if necessary be reviewed by HRC. Responsible: QIDP, Behavioral Clinician, Direct Care Staff,</p>				

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	<p>did not know what happened that day or if the aggression involved another client. The QIDP stated, "We can start documenting it, that won't be a problem."</p> <p>Telephone interview with the BC (Behavior Clinician) on 11/15/13 at 9:30 AM stated the staff "should" document a descriptive note or comment "I would think, especially if it was agitation or aggression."</p> <p>9-3-4(a)</p>			
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W000312	<p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 2 sampled clients receiving medications to control behaviors (#3), the facility failed to ensure the client's BSP (Behavior Support Plan) specified the targeted behaviors for which client #3 took psychoactive medication and to ensure a specific plan of reduction to reduce and eventually eliminate the behaviors for which each psychoactive medication was to target.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 11/13/13 at 2 PM. Client #3's 9/26/13 physician's order indicated client #3 was taking Risperdal for Schizophrenia and Ativan for anxiety. Client #3's BSP of 6/18/13 indicated client #3 had targeted behaviors of talking to herself, agitation and verbal abuse. Client #3's "Medication Utilization Plan" indicated "reductions will be made as the behavior specific criteria are achieved as stated below.... Object 1: decrease incidents to 30 or less for 90 consecutive days. Target date</p>	W000312	<p>A thorough evaluation of the behaviors which apply to meds taken for behavioral control will be completed. The Medication Utilization Plan, or MUP will be revised to specify which behaviors are to be reduced prior to consideration for a medication reduction. The revision will include clear criteria for an attempted reduction. The definitions of target behaviors will clearly indicate which medications are prescribed for which behaviors. An attempt at a reduction will be made, also taking into consideration which medications should be titrated first. If an incident varies from the definition of target behaviors provided for that client, brief comments will be included on the monthly behavior record to summarize current trends in behaviors. A reduction will be attempted annually unless the IDT and HRC feel that an attempt is contra indicated for the consumer at that time, and will be entered into the record. . Reductions, successful and unsuccessful will be documented in the client record. It is the policy of Residential CRF that</p>	12/15/2013			

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	<p>9/18/13. Object 2: decrease incidents to 25 or less for 90 consecutive days by 12/18/13." The plan did not specify the targeted behaviors for which each medication was taken and/or the specific behaviors that were to be reduced before a reduction would be considered.</p> <p>Telephone interview with the BC (Behavior Clinician) on 11/15/13 at 9:30 AM indicated client #3's BSP did not specify the targeted behaviors for which client #3 took Risperdal and Ativan. The BC indicated the plan of reduction did not specify the behaviors to be reduced prior to the consideration of a reduction in the Risperdal and/or the Ativan.</p> <p>9-3-5(a)</p>		<p>medications are prescribed and administered at the lowest effective levels, and reduced in as conscientious and expedient a manner as possible. The MUP for other consumers will be revised as needed to reflect these changes. The MUP will be reviewed at least every 4 months to assure that reviews can be done in a timely manner. Responsible: Behavioral Clinician, QIDP, Nursing, Direct Care Staff</p>		