

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/27/2015
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR SEYMOUR, IN 47274
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W 0000 Bldg. 00	<p>This visit was for a full recertification and state licensure survey.</p> <p>Survey Dates: August 19, 20, 21, 24, 25, 26 and 27, 2015</p> <p>Facility Number: 000632 Provider Number: 15G092 AIM Number: 100233940</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview for 6 of 6 clients (#1, #2, #3, #4, #5 and #6) living in the group home, the facility failed to meet the Condition of Participation: Governing Body. The facility's governing body failed to exercise operating direction over the facility. The governing body failed to implement its policies and procedures to ensure client #2's plan for supervision while smoking was implemented to prevent a fall with injury while smoking</p>	W 0102	<p>Corrective actions taken: · Will In-service staff, day program and house, on client #1 & #2's IPP, BSP and High Risk Plans · Will In-service QIDPs, RPM and Directors on thorough investigation techniques and policy. · Will In-service staff and QIDP on client #5& #6's IPP, BSP and supervision of clients</p> <p>· Incident reporting protocol for QIDPs has been implemented for notifying CEO (attachment A)</p> <p>· Group Home staff and QIDPs will be trained on incident reporting protocol · QIDP no</p>	09/26/2015

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>after dental surgery and a thorough investigation was conducted, clients #5 and #6 were appropriately supervised to prevent them from eloping from the group home and staff immediately reported to the administrator when clients #5 and #6 eloped from the group home. The governing body failed to integrate, coordinate and monitor the clients' program plans. The governing body failed to ensure the clients' training goals and objectives were reviewed on a regular basis from August 2014 to July 2015. The governing body failed to ensure client #1 had the right to due process in regard to staff using his gait belt to keep him sitting in a chair and the facility-operated day program did not unnecessarily restrict client #1's access to his walker. The governing body failed to ensure an accurate accounting of the clients' funds was maintained. The governing body failed to address, in a plan, client #5's refusals to eat meals. The governing body failed to ensure client #1's risk plan for falls included the use of a walker. The governing body failed to ensure staff implemented the clients' program plans as written for: 1) client #1's door alarms, 2) client #1's seat alarm and 3) client #2's plan for supervision while smoking. The governing body failed to ensure client #3's restrictive behavior plan was</p>		<p>longer working for DSI and will not be eligible for rehire. · Monthly Summary has been revised to include RPM review and Director review (attachment B) · Will In-service QIDPs & RPM on monthly summaries · Regional Management checklist has been implemented (attachment C) · Visitor sign in sheet has been implemented and management staff in-serviced (attachment D) · Train Group home staff and day program staff on client rights (attachment E) · Implemented Day program observation sheet (attachment F) · QIDPs will be in-serviced for the proper accounting of client funds · Finance protocol has been implemented and QIDPs and group home staff will be in-serviced (attachment G) · IDT met, revised client #5's HRP to include implement tracking sheet for refusal to eat, weight loss and daily weight monitoring (attachment H) · High risk plan for client #1 has been revised to include use of walker (attachment I) · A daily adaptive equipment/ durable medical equipment checklist has been implemented (attachment J) and QIDPs will be in-serviced · Client #3's restrictive behavior plan has guardian signature (attachment K) · Guardian phone approval protocol (attachment L) and signature follow-up protocol has been implemented (attachment M) and QIDPs will be in-serviced</p>	

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	<p>conducted with written informed consent from his guardian. The governing body failed to ensure quarterly evacuation drills for each shift were conducted affecting clients #1, #2, #3, #4, #5 and #6. The facility's governing body failed to ensure: 1) client #1 had a psychiatric appointment between 9/3/14 to 5/18/15, 2) client #1 had a neurology appointment as recommended, 3) client #3 had a follow-up podiatrist appointment as recommended, 4) client #6 received Cipro for 6 months as ordered (the facility stopped the medication after 5 months), 5) clients #1 and #6 had annual dental appointments, 6) client #1 had an annual evaluation of his vision and hearing, 7) client #5 had a plan to address refusals to eat meals and 8) client #1's risk plan for falls was updated to include the use of a walker. The facility's governing body failed to ensure quarterly evacuation drills for each shift were conducted.</p> <p>Findings include:</p> <p>1) Please refer to W104. For 6 of 6 clients (#1, #2, #3, #4, #5 and #6) living in the group home, the facility's governing body failed to exercise operating direction over the facility. The governing body failed to implement its policies and procedures to ensure client</p>		<p>on it · QIDPs and staff will be in-serviced on emergency drills · Drills will be sent to the agency safety coordinator · Medical appointment tracking form has been implemented (attachment N) · QIDPs, nurses, RPM, MCC and staff will be in-serviced on annual appointment tracking · QIDPs, RPM and Directors will be in-serviced on oversight of the program · Medical book review has been implemented (attachment O), health care coordinators will be in-serviced · Agency nurses will be trained on nurse's checklist and appointment tracking sheet · Medication protocol has been implemented (attachment P) · MCC will implement oversight checklist (attachment Q) · Staff has received TB test (attachment R) · Medical Appointments for clients #1,#3 and #6have been scheduled How will we identify others: · Regional Management Staff will review staff training to ensure staff have been trained on all clients programming &will check door alarms, adaptive equipment & seat alarms to ensure all are in working order. They will also review monthly summaries and goals to ensure that they are being completed. · Regional Management Staff will check finances to ensure that transactions are being documented as they occur · Regional Management Staff will review all restrictive practices to</p>	

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	#2's plan for supervision while smoking was implemented to prevent a fall with injury while smoking after dental surgery and a thorough investigation was conducted, clients #5 and #6 were appropriately supervised to prevent them from eloping from the group home and staff immediately reported to the administrator when clients #5 and #6 eloped from the group home. The governing body failed to integrate, coordinate and monitor the clients' program plans. The governing body failed to ensure the clients' training goals and objectives were reviewed on a regular basis from August 2014 to July 2015. The governing body failed to ensure client #1 had the right to due process in regard to staff using his gait belt to keep him sitting in a chair and the facility-operated day program did not unnecessarily restrict client #1's access to his walker. The governing body failed to ensure an accurate accounting of the clients' funds was maintained. The governing body failed to address, in a plan, client #5's refusals to eat meals. The governing body failed to ensure client #1's risk plan for falls included the use of a walker. The governing body failed to ensure staff implemented the clients' program plans as written for: 1) client #1's door alarms, 2) client #1's seat alarm and 3) client #2's plan for		ensure guardian consent · The agency safety coordinator will review drills to ensure that they are completed on a quarterly basis per policy · Quality Assurance director will review all investigations to ensure a thorough investigation has been conducted · HCCs will review high risk plans to ensure that all adaptive equipment is documented · HCCS will review all medical appointments to ensure that all appointments and follow up appointments are scheduled · HCCs will review all discontinued medications to ensure compliance with physicians order · HR will review employee files for TB test compliance Measures put in place: · Incident reporting protocol · Revised residential monthly report · Regional Management review · Visitor's Log · Staff training has been completed or will be completed by 9/26/15 · Day program observation form · Group home finance protocol · Adaptive equipment/durable medical equipment checklist · Phone approval protocol · Guardian approval documentation protocol · Medical appointment tracking · Rn group home medical book review · Medication protocol · Medical care coordinator protocol Monitoring of corrective action: · Regional Management Staff will perform weekly observation completing	

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	<p>supervision while smoking. The governing body failed to ensure client #3's restrictive behavior plan was conducted with written informed consent from his guardian. The governing body failed to ensure quarterly evacuation drills for each shift were conducted affecting clients #1, #2, #3, #4, #5 and #6. The facility's governing body failed to ensure: 1) client #1 had a psychiatric appointment between 9/3/14 to 5/18/15, 2) client #1 had a neurology appointment as recommended, 3) client #3 had a follow-up podiatrist appointment as recommended, 4) client #6 received Cipro for 6 months as ordered (the facility stopped the medication after 5 months), 5) clients #1 and #6 had annual dental appointments, 6) client #1 had an annual evaluation of his vision and hearing, 7) client #5 had a plan to address refusals to eat meals and 8) client #1's risk plan for falls was updated to include the use of a walker. The facility's governing body failed to ensure quarterly evacuation drills for each shift of personnel were conducted.</p> <p>2) Please refer to W122. For 3 of 27 incident/investigative reports reviewed affecting clients #2, #5 and #6, the facility failed to meet the Condition of Participation: Client Protections. The facility neglected to implement its</p>		<p>Regional Management Staff checklist · Direct Care Management staff will be present in the home daily and perform the active treatment observations for 60 days. (attachment S) · MCC will monitor and perform home record reviews per protocol · Agency Safety coordinator will review drills monthly to ensure compliance · RPM will review TB tests monthly to ensure compliance Competition date: · 9/26/15</p> <p style="text-align: center;">Addendum- 9/24/15</p> <p style="text-align: center;">W102</p> <p>Corrective Actions</p> <ul style="list-style-type: none"> · Cheryl Yeager QIDP, in-serviced day program and house staff, on client #1 & #2's IPP, BSP and High Risk Plans (attachment AA) · Mel Fields, Director of Industry and Community Services, in-service d QIDPs, RPM and Directors on thorough investigation techniques and policy on 9/16/15 (attachment BB) · Cheryl Yeager QIDP, in-serviced staff on client #5 & #6's IPP, BSP and supervision of clients (attachment AA) 				

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	<p>policies and procedures to ensure client #2's plan for supervision while smoking was implemented to prevent a fall with injury while smoking after dental surgery and a thorough investigation was conducted, clients #5 and #6 were appropriately supervised to prevent them from eloping from the group home and staff immediately reported to the administrator when clients #5 and #6 eloped from the group home. The facility failed to ensure client #1 had the right to due process in regard to staff using his gait belt to keep him sitting in a chair and the facility-operated day program did not unnecessarily restrict client #1's access to his walker.</p> <p>For clients #2, #3, #4, #5 and #6, the facility failed to keep an accurate accounting of the clients' funds.</p> <p>3) Please refer to W318. For 3 of 3 clients in the sample (#1, #3 and #6) and one additional client (#5), the facility failed to meet the Condition of Participation: Health Care Services. The facility's health care services failed to ensure: 1) client #1 had a psychiatric appointment between 9/3/14 to 5/18/15, 2) client #1 had a neurology appointment as recommended, 3) client #3 had a follow-up podiatrist appointment as recommended, 4) client #6 received Cipro for 6 months as ordered (the</p>		<ul style="list-style-type: none"> · Mel Fields, Director of Industry and Community Services, in-serviced QIDPs on #5 & #6's IPP, BSP and supervision of clients (attachment BB) · Mel Fields, Director of Industry and Community Services in-serviced QIDPs on incident reporting protocol including notification of CEO on 9/16/15 (attachment BB) · Cheryl Yeager QIDP in-serviced group home staff on incident reporting protocol including notification of CEO on 9/25/15 (attachment CC) · Mel Fields, Director of Industry and Community Services, in-serviced QIDPs on 9/16/15 (attachment BB) · Mel Fields, Director of Industry and Community Services In-serviced QIDPs & RPM on monthly summaries on 9/16/15 (attachment BB) · Mel Fields, Director of Industry and Community Services in-serviced RPM and QIDPs on the Visitor sign in sheet on 9/16/15 (attachment BB) · Mel Fields, Director of Industry and Community Services in-serviced RPM & QIDPs for the proper accounting of client funds 	

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	<p>facility stopped the medication after 5 months), 5) clients #1 and #6 had annual dental appointments, 6) client #1 had an annual evaluation of his vision and hearing, 7) client #5 had a plan to address refusals to eat meals and 8) client #1's risk plan for falls was updated to include the use of a walker.</p> <p>9-3-1(a)</p>		<p>9/16/15 (attachment BB)</p> <ul style="list-style-type: none"> · Mel Fields, Director of Industry and Community Services in-serviced QIDPs on finance protocol on 9/16/15 (attachment BB) · Cheryl Yeager QIDP in-serviced group home staff on finance protocol on 9/25/15 (attachment CC) · Mel Fields, Director of Industry and Community Services in-serviced QIDPs on daily adaptive equipment/ durable medical equipment checklist on 9/16/15 (attachment BB) · Cheryl Yeager QIDP in-serviced group home staff on adaptive equipment/ durable medical equipment checklist on 9/25/15 (attachment CC) · Mel Fields, Director of Industry and Community Services in-serviced QIDPs on Guardian phone approval protocol (attachment L) and signature follow-up protocol has been implemented (attachment M) on 9/16/15 (attachment BB) · Emergency drill protocol has been created (attachment HH) · Mel Fields, Director of Industry and Community Services 	

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			<p>in-serviced QIDPs on emergency drills on 9/16/15 (attachment BB)</p> <ul style="list-style-type: none"> · Cheryl Yeager QIDP in-serviced staff on emergency drills on 9/25/15 (attachment CC) · Mel Fields, Director of Industry and Community Services in-serviced QIDPs, RPM, MCC on annual appointment tracking on 9/16/15 (attachment BB) · Mel Fields, Director of Industry and Community Services in-serviced QIDPs, RPM and Director on oversight of the program on 9/16/15 (attachment BB) · Ann Sanchez, QIDP no longer working for DSI and will not be eligible for rehire. · A daily adaptive equipment/ durable medical equipment checklist has been implemented (attachment J) and QIDPs have been in-serviced by Mel Fields, Director of Industry and Community Services on 9/16/15 (attachment BB). The daily adaptive equipment/ durable medical equipment checklist will be documented daily. <p>Monitoring of Corrective Actions:</p> <ul style="list-style-type: none"> · Regional Management staff is defined as Mel Fields Director of Industry and Community Services, Pam Pace Regional Program 	

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W 0104	483.410(a)(1) GOVERNING BODY		<p>Manager, Lela DeBusk Regional Program Manager, Dundri Osborne Regional Quality Manager or Veronica Anderson Regional Quality Manager will perform weekly observation completing Regional Management Staff checklist</p> <ul style="list-style-type: none"> · Aaron Starr Regional Program Manager, QIDPs, Quality assurance social service manager are defined as direct care management staff · Julie Lawson is the MCC or the Medical Care Coordinator · After the 60 day period, Cheryl Yeager QIDP will perform at minimum weekly observations, Aaron Starr Regional Program Manager will perform weekly observations and Regional Management staff: Mel Fields Director of Industry and Community Services, Pam Pace regional program manager, Lela DeBusk Regional Program Manager, Dundri Osborne Regional Quality Manager or Veronica Anderson Regional Program Manager will perform weekly observation completing Regional Management Staff checklist 	

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Bldg. 00	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 6 of 6 clients (#1, #2, #3, #4, #5 and #6) living in the group home, the facility's governing body failed to exercise operating direction over the facility. The governing body failed to implement its policies and procedures to ensure client #2's plan for supervision while smoking was implemented to prevent a fall with injury while smoking after dental surgery and a thorough investigation was conducted, clients #5 and #6 were appropriately supervised to prevent them from eloping from the group home and staff immediately reported to the administrator when clients #5 and #6 eloped from the group home. The governing body failed to integrate, coordinate and monitor the clients' program plans. The governing body failed to ensure the clients' training goals and objectives were reviewed on a regular basis from August 2014 to July 2015. The governing body failed to ensure client #1 had the right to due process in regard to staff using his gait belt to keep him sitting in a chair and the facility-operated day program did not unnecessarily restrict client #1's access to his walker. The governing body failed to ensure an accurate accounting of the</p>	W 0104	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> · Will In-service staff, day program and house, on client #1 & #2's IPP, BSP and High Risk Plans · Will In-service QIDPs, RPM and Directors on thorough investigation techniques and policy. · Will In-service staff and QIDP on client #5 & #6's IPP, BSP and supervision of clients · Incident reporting protocol for QIDPs has been implemented for notifying CEO (attachment A) · Group Home staff and QIDPs will be trained on incident reporting protocol · QIDP no longer working for DSI and will not be eligible for rehire. · Monthly Summary has been revised to include RPM review and Director review (attachment B) · Will In-service QIDPs & RPM on monthly summaries · Regional Management checklist has been implemented (attachment C) · Visitor sign in sheet has been implemented and management staff in-serviced (attachment D) · Train Group home staff and day program staff on client rights (attachment E) · Implemented Day program observation sheet (attachment F) · QIDPs will be in-serviced for the proper accounting of client funds · Finance protocol has been implemented and QIDPs and group home staff will be in-serviced (attachment G) 	09/26/2015

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	clients' funds was maintained. The governing body failed to address, in a plan, client #5's refusals to eat meals. The governing body failed to ensure client #1's risk plan for falls included the use of a walker. The governing body failed to ensure staff implemented the clients' program plans as written for: 1) client #1's door alarms, 2) client #1's seat alarm and 3) client #2's plan for supervision while smoking. The governing body failed to ensure client #3's restrictive behavior plan was conducted with written informed consent from his guardian. The governing body failed to ensure quarterly evacuation drills for each shift of personnel were conducted affecting clients #1, #2, #3, #4, #5 and #6. The facility's governing body failed to ensure: 1) client #1 had a psychiatric appointment between 9/3/14 to 5/18/15, 2) client #1 had a neurology appointment as recommended, 3) client #3 had a follow-up podiatrist appointment as recommended, 4) client #6 received Cipro for 6 months as ordered (the facility stopped the medication after 5 months), 5) clients #1 and #6 had annual dental appointments, 6) client #1 had an annual evaluation of his vision and hearing, 7) client #5 had a plan to address refusals to eat meals and 8) client #1's risk plan for falls was updated to include the use of a walker.		IDT met, revised client #5's HRP to include implement tracking sheet for refusal to eat, weight loss and daily weight monitoring (attachment H) · High risk plan for client #1 has been revised to include use of walker (attachment I) · A daily adaptive equipment/ durable medical equipment checklist has been implemented (attachment J) and QIDPs will be in-serviced · Client #3's restrictive behavior plan has guardian signature (attachment K) · Guardian phone approval protocol (attachment L) and signature follow-up protocol has been implemented (attachment M) and QIDPs will be in-serviced on it · QIDPs and staff will be in-serviced on emergency drills · Drills will be sent to the agency safety coordinator · Medical appointment tracking form has been implemented (attachment N) · QIDPs, nurses, RPM, MCC and staff will be in-serviced on annual appointment tracking · QIDPs, RPM and Directors will be in-serviced on oversight of the program · Medical book review has been implemented (attachment O), health care coordinators will be in-serviced · Agency nurses will be trained on nurse's checklist and appointment tracking sheet · Medication protocol has been implemented (attachment P) · MCC will implement oversight checklist (attachment Q) · Staff has received TB test (attachment	

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(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			
	<p>The facility's governing body failed to ensure quarterly evacuation drills for each shift were conducted.</p> <p>Findings include:</p> <p>1) Please refer to W140. For 5 of 6 clients living in the group home (#2, #3, #4, #5 and #6), the facility failed to keep an accurate accounting of the clients' funds.</p> <p>2) Please refer to W149. For 3 of 27 incident/investigative reports reviewed affecting clients #2, #5 and #6, the facility's governing body neglected to implement its policies and procedures to ensure client #2's plan for supervision while smoking was implemented to prevent a fall with injury while smoking after dental surgery and a thorough investigation was conducted, clients #5 and #6 were appropriately supervised to prevent them from eloping from the group home and staff immediately reported to the administrator when clients #5 and #6 eloped from the group home.</p> <p>3) Please refer to W153. For 2 of 27 incident/investigative reports reviewed affecting clients #5 and #6, the governing body failed to ensure staff immediately reported to the administrator when clients #5 and #6 eloped from the group home.</p>		<p>R) · Medical Appointments for clients #1,#3 and #6 have been scheduled How will we identify others: · Regional Management Staff will review staff training to ensure staff have been trained on all clients programming & will check door alarms, adaptive equipment & seat alarms to ensure all are in working order. They will also review monthly summaries and goals to ensure that they are being completed. · Regional Management Staff will check finances to ensure that transactions are being documented as they occur · Regional Management Staff will review all restrictive practices to ensure guardian consent · The agency safety coordinator will review drills to ensure that they are completed on a quarterly basis per policy · Quality Assurance director will review all investigations to ensure a thorough investigation has been conducted · HCCs will review high risk plans to ensure that all adaptive equipment is documented · HCCS will review all medical appointments to ensure that all appointments and follow up appointments are scheduled · HCCs will review all discontinued medications to ensure compliance with physicians order · HR will review employee files for TB test compliance Measures put in place: · Incident reporting</p>				

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	<p>4) Please refer to W154. For 1 of 27 incident/investigative reports reviewed affecting client #2, the facility failed to conduct a thorough investigation of a fall with injury after client #2 had dental surgery.</p> <p>5) Please refer to W159. For 3 of 3 clients (#1, #3 and #6) in the sample and 3 additional clients (#2, #4 and #5), the governing body failed to integrate, coordinate and monitor the clients' program plans. The governing body failed to ensure the clients' training goals and objectives were reviewed on a regular basis from August 2014 to July 2015. The governing body failed to ensure client #1 had the right to due process in regard to staff using his gait belt to keep him sitting in a chair and the facility-operated day program did not unnecessarily restrict client #1's access to his walker. The governing body failed to ensure an accurate accounting of the clients' funds was maintained. The governing body failed to address, in a plan, client #5's refusals to eat meals. The governing body failed to ensure client #1's risk plan for falls included the use of a walker. The governing body failed to ensure staff implemented the clients' program plans as written for: 1) client #1's door alarms, 2) client #1's seat</p>		<p>protocol · Revised residential monthly report · Regional Management review · Visitor's Log · Staff training has been completed or will be completed by 9/26/15 · Day program observation form · Group home finance protocol · Adaptive equipment/durable medical equipment checklist · Phone approval protocol · Guardian approval documentation protocol · Medical appointment tracking · Rn group home medical book review · Medication protocol · Medical care coordinator protocol</p> <p>Monitoring of corrective action: · Regional Management Staff will perform weekly observation completing Regional Management Staff checklist · Direct Care Management staff will be present in the home daily and perform the active treatment observations for 60 days. (attachment S) · MCC will monitor and perform home record reviews per protocol · Agency Safety coordinator will review drills monthly to ensure compliance · RPM will review TB tests monthly to ensure compliance Competition date: · 9/26/15</p> <p>Addendum- 9/24/15</p> <p>W104</p>				

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	<p>alarm and 3) client #2's plan for supervision while smoking. The governing body failed to ensure client #3's restrictive behavior plan was conducted with written informed consent from his guardian. The governing body failed to ensure quarterly evacuation drills for each shift of personnel were conducted affecting clients #1, #2, #3, #4, #5 and #6.</p> <p>6) Please refer to W331. For 3 of 3 clients in the sample (#1, #3 and #6) and one additional client (#5), the facility's governing body failed to ensure: 1) client #1 had a psychiatric appointment between 9/3/14 to 5/18/15, 2) client #1 had a neurology appointment as recommended, 3) client #3 had a follow-up podiatrist appointment as recommended, 4) client #6 received Cipro for 6 months as ordered (the facility stopped the medication after 5 months), 5) clients #1 and #6 had annual dental appointments, 6) client #1 had an annual evaluation of his vision and hearing, 7) client #5 had a plan to address refusals to eat meals, and 8) client #1's risk plan for falls was updated to include the use of a walker.</p> <p>7) Please refer to W440. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility's</p>		<p>Corrective Actions</p> <ul style="list-style-type: none"> · Cheryl Yeager QIDP, in-serviced day program and house staff, on client #1 & #2's IPP, BSP and High Risk Plans (attachment AA) · Mel Fields, Director of Industry and Community Services, in-service d QIDPs, RPM and Directors on thorough investigation techniques and policy on 9/16/15 (attachment BB) · Cheryl Yeager QIDP, in-serviced staff on client #5 & #6's IPP, BSP and supervision of clients (attachment AA) · Mel Fields, Director of Industry and Community Services, in-serviced QIDPs on #5 & #6's IPP, BSP and supervision of clients (attachment BB) · Mel Fields, Director of Industry and Community Services in-serviced QIDPs on incident reporting protocol including notification of CEO on 9/16/15 (attachment BB) · Cheryl Yeager QIDP in-serviced group home staff on incident reporting protocol including notification of CEO on 9/25/15 (attachment CC) · Mel Fields, Director of Industry and Community Services, 	

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	governing body failed to ensure quarterly evacuation drills for each shift of personnel were conducted. 9-3-1(a)		in-serviced QIDPs on 9/16/15 (attachment BB) <ul style="list-style-type: none"> · Mel Fields, Director of Industry and Community Services In-serviced QIDPs & RPM on monthly summaries on 9/16/15 (attachment BB) · Mel Fields, Director of Industry and Community Services in-serviced RPM and QIDPs on the Visitor sign in sheet on 9/16/15 (attachment BB) · Mel Fields, Director of Industry and Community Services in-serviced RPM & QIDPs for the proper accounting of client funds 9/16/15 (attachment BB) · Mel Fields, Director of Industry and Community Services in-serviced QIDPs on finance protocol on 9/16/15 (attachment BB) · Cheryl Yeager QIDP in-serviced group home staff on finance protocol on 9/25/15 (attachment CC) · Mel Fields, Director of Industry and Community Services in-serviced QIDPs on daily adaptive equipment/ durable medical equipment checklist on 9/16/15 (attachment BB) · Cheryl Yeager QIDP 	

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			<p>in-serviced group home staff on adaptive equipment/ durable medical equipment checklist on 9/25/15 (attachment CC)</p> <ul style="list-style-type: none"> · Mel Fields, Director of Industry and Community Services in-serviced QIDPs on Guardian phone approval protocol (attachment L) and signature follow-up protocol has been implemented (attachment M) on 9/16/15 (attachment BB) · Emergency drill protocol has been created (attachment HH) · Mel Fields, Director of Industry and Community Services in-serviced QIDPs on emergency drills on 9/16/15 (attachment BB) · Cheryl Yeager QIDP in-serviced staff on emergency drills on 9/25/15 (attachment CC) · Mel Fields, Director of Industry and Community Services in-serviced QIDPs, RPM, MCC on annual appointment tracking on 9/16/15 (attachment BB) · Mel Fields, Director of Industry and Community Services in-serviced QIDPs, RPM and Director on oversight of the program on 9/16/15 (attachment BB) · Ann Sanchez, QIDP no longer working for DSI and will not be 	

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			<p>eligible for rehire.</p> <ul style="list-style-type: none"> · A daily adaptive equipment/ durable medical equipment checklist has been implemented (attachment J) and QIDPs have been in-serviced by Mel Fields, Director of Industry and Community Services on 9/16/15 (attachment BB). The daily adaptive equipment/ durable medical equipment checklist will be documented daily. <p>Monitoring of Corrective Actions:</p> <ul style="list-style-type: none"> · Regional Management staff is defined as Mel Fields Director of Industry and Community Services, Pam Pace Regional Program Manager, Lela DeBusk Regional Program Manager, Dundri Osborne Regional Quality Manager or Veronica Anderson Regional Quality Manager will perform weekly observation completing Regional Management Staff checklist · Aaron Starr Regional Program Manager, QIDPs , Quality assurance social service manager are defined as direct care management staff · Julie Lawson is the MCC or the Medical Care Coordinator · After the 60 day period , Cheryl Yeager QIDP will perform at minimum weekly observations, Aaron Starr Regional Program Manager will perform weekly 	

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W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview for 3 of 27 incident/investigative reports reviewed affecting clients #2, #5 and #6, and for the facility failed to meet the Condition of Participation: Client Protections. The facility neglected to implement its policies and procedures to ensure client #2's plan for supervision while smoking was implemented to prevent a fall with injury while smoking after dental surgery and a thorough investigation was conducted, clients #5 and #6 were appropriately supervised to prevent them from eloping from the group home and staff immediately reported to the	W 0122	observations and Regional Management staff: Mel Fields Director of Industry and Community Services, Pam Pace regional program manager, Lela DeBusk Regional Program Manager, Dundri Osborne Regional Quality Manager or Veronica Anderson Regional Program Manager will perform weekly observation completing Regional Management Staff checklist Corrective actions taken: · Will In-service staff, day program and house, on client #1 & #2's IPP, BSP and High Risk Plans · Will In-service QIDPs, RPM and Directors on thorough investigation techniques and policy. · Will In-service staff and QIDP on client #5 & #6's IPP, BSP and supervision of clients · Incident reporting protocol for QIDPs has been implemented for notifying CEO (attachment A) · Group Home staff and QIDPs will be trained on incident reporting protocol · QIDP no longer working for DSI and will not be eligible for rehire. · Regional Management checklist has been implemented (attachment C) ·	09/26/2015

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	<p>administrator when clients #5 and #6 eloped from the group home. The facility failed to ensure client #1 had the right to due process in regard to staff using his gait belt to keep him sitting in a chair and the facility-operated day program did not unnecessarily restrict client #1's access to his walker. For clients #2, #3, #4, #5 and #6, the facility failed to keep an accurate accounting of the clients' funds.</p> <p>Findings include:</p> <p>1) Please refer to W125. For 1 of 3 clients in the sample (#1), the facility failed to ensure client #1 had the right to due process in regard to staff using his gait belt to keep him sitting in a chair and the facility-operated day program did not unnecessarily restrict client #1's access to his walker.</p> <p>2) Please refer to W140. For 5 of 6 clients living in the group home (#2, #3, #4, #5 and #6), the facility failed to keep an accurate accounting of the clients' funds.</p> <p>3) Please refer to W149. For 3 of 27 incident/investigative reports reviewed affecting clients #2, #5 and #6, the facility neglected to implement its policies and procedures to ensure client #2's plan for supervision while smoking</p>		<p>Train Group home staff and day program staff on client rights (attachment E) · QIDPs will be in-serviced for the proper accounting of client funds · High risk plan for client #1 has been revised to include use of walker (attachment I) How will we identify others: · Regional Management Staff will review staff training to ensure staff have been trained on all clients programming & will check door alarms, adaptive equipment & seat alarms to ensure all are in working order. They will also review monthly summaries and goals to ensure that they are being completed. · Regional Management Staff will check finances to ensure that transactions are being documented as they occur · Quality Assurance director will review all investigations to ensure a thorough investigation has been conducted · HCCs will review high risk plans to ensure that all adaptive equipment is documented Measures put in place: · Regional Management Staff checklist · Incident reporting protocol · Finance protocol · Adaptive equipment/durable medical equipment checklist · Elopement tracking Monitoring of corrective action: · Regional Management Staff will perform weekly observation completing Regional Management Staff checklist · Direct Care</p>	

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	<p>was implemented to prevent a fall with injury while smoking after dental surgery and a thorough investigation was conducted, clients #5 and #6 were appropriately supervised to prevent them from eloping from the group home and staff immediately reported to the administrator when clients #5 and #6 eloped from the group home.</p> <p>4) Please refer to W153. For 2 of 27 incident/investigative reports reviewed affecting clients #5 and #6, the facility failed to ensure staff immediately reported to the administrator when clients #5 and #6 eloped from the group home.</p> <p>5) Please refer to W154. For 1 of 27 incident/investigative reports reviewed affecting client #2, the facility failed to conduct a thorough investigation of a fall with injury after client #2 had dental surgery.</p> <p>9-3-2(a)</p>		<p>Management staff will be present in the home daily and perform the active treatment observations for 60 days. · MCC will monitor and perform home record reviews per protocol Competition date: · 9/26/15 W122 Addendum, 9-25-2015</p> <p>Corrective Actions:</p> <ul style="list-style-type: none"> · Cheryl Yeager QIDP, in-serviced day program and house, on client #1 & #2's IPP, BSP and High Risk Plans (attachment AA) · Mel Fields, Director of Industry and Community Services, in-serviced QIDPs, RPM and Directors on thorough investigation techniques and policy on 9/24/15 (attachment BB) · Cheryl Yeager QIDP, in-serviced staff on client #5 & #6's IPP, BSP and supervision of clients ((attachment AA) · Mel Fields, Director of Industry and Community Services, in-serviced QIDPs on #5 & #6's IPP, BSP and supervision of clients (attachment BB) · Mel Fields, Director of Industry and Community Services in-serviced QIDPs on incident reporting protocol on 9/16/15 (attachment BB) 		

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W 0125 Bldg. 00	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>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, record review and interview for 1 of 3 clients in the sample (#1), the facility failed to ensure client #1 had the right to due process in regard to staff using his gait belt to keep him sitting in a chair and the facility-operated day program did not unnecessarily restrict client #1's access to his walker.</p> <p>Findings include:</p> <p>1) On 8/20/15 from 6:29 AM to 7:43 AM an observation was conducted at the</p>	W 0125	<ul style="list-style-type: none"> · Cheryl Yeager QIDP in-serviced staff on incident reporting protocol on 9/25/15 (attachment CC) · Mel Fields, Director of Industry and Community Services in-serviced RPM & QIDPs for the proper accounting of client funds 9/16/15 (attachment BB) <p>Competition date:</p> <ul style="list-style-type: none"> · 9/26/15 <p>Corrective actions taken:</p> <ul style="list-style-type: none"> · QIDP no longer working for DSI and will not be eligible for rehire. · Train Group home staff and day program staff on client rights · Implemented Day program observation sheet (attachment F) · High risk plan for client #1 has been revised to include use of walker (attachment I) · Will In-service staff, day program and house, on client #1 & #2's IPP, BSP and High Risk Plans <p>How will we identify others:</p> <ul style="list-style-type: none"> · Regional Management Staff will review staff training to ensure 	09/26/2015	

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	<p>group home. At 7:15 AM when client #1 attempted to stand up from his dining room chair, staff #3 held onto client #1's gait belt to keep him from standing up. Staff #3 stated, "he knew it was close to time to go. Anxious." Client #1 vocalized as staff #3 held his gait belt. At 7:17 AM, staff #3 stated to client #1, "It's not time to go yet and you need your walker." Client #1 vocalized again as staff #3 held onto his gait belt so he could not stand up. At 7:19 AM, staff #3 released client #1's gait belt and gave him his walker in order for him to go to the medication area to get his medications.</p> <p>On 8/21/15 at 11:42 AM a review of client #1's record was conducted. Client #1's 8/18/15 Individual Program Plan (IPP) and 7/14/15 Behavior Support Program did not include a plan for staff to hold client #1's gait belt to keep him from ambulating. Client #1's IPP indicated, in part, "[Client #1] is not able to do many of the household tasks he used to due to his risk for falls and staff needing to be with him. However, with staff by his side with his gait belt he can still be assisted to do such tasks as wiping off the table or taking his dishes to the sink by placing them on his walker. He can still participate in the household chore chart by performing tasks with staff assistance for safety." The IPP indicated,</p>		<p>staff have been trained on all clients programming & will check door alarms, adaptive equipment & seat alarms to ensure all are in working order. They will also review monthly summaries and goals to ensure that they are being completed. · Regional Management Staff will review all restrictive practices to ensure guardian consent · HCCs will review high risk plans to ensure that all adaptive equipment is documented Measures put in place: · Regional Management review · New day program observation form · Adaptive equipment/durable medical equipment checklist Monitoring of corrective action: · Regional Management Staff will perform weekly observation completing Regional Management Staff checklist · Direct Care Management staff will be present in the home daily and perform the active treatment observations for 60 days. · MCC will monitor and perform home record reviews per protocol Competition date: · 9/26/15 W125 ADDENDUM 9/25/15</p> <p>Corrective Action Taken</p> <p>· A daily adaptive equipment/ durable medical equipment checklist has been implemented (attachment J) and QIDPs will be in-serviced. The daily adaptive equipment/ durable medical</p>				

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	<p>"He started receiving Physical Therapy at home two times a week back in May (2015). He now has a gait belt and rolling walker. He is to have the gait belt on whenever he is up and staff are to walk with him and hold onto it. He loves using his walker. [Client #1] also has a chair alarm and an alarm on his bed to alert staff if he tries to get up."</p> <p>On 8/21/15 at 11:24 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the gait belt was to be used to assist client #1 to be safe while he walked. The QIDP indicated client #1's gait belt should not be used to hold him in his chair. The QIDP stated the staff "should not restrain him with the gait belt."</p> <p>On 8/24/15 at 11:09 AM, the Regional Program Manager (RPM) indicated the staff should not be using client #1's gait belt to hold him in his chair. The RPM stated, "That's not appropriate." The RPM stated, "It's his right to get up." The RPM indicated the gait belt was in place due to falls and should not be used to restrict client #1 from standing up.</p> <p>On 8/24/15 at 11:53 AM, the nurse indicated client #1's gait belt was in place to assist him to be safe while he walks. The nurse indicated the staff should not</p>		<p>equipment checklist will be documented daily.</p> <p>Monitoring of Corrective Actions:</p> <ul style="list-style-type: none"> · Mel Fields Director of Industry and Community Services, Pam Pace regional program manager, Lela DeBusk Regional Program Manager, Dundri Osbourne Regional Quality Manager or Veronica Anderson Regional Program Manager will perform weekly observation completing Regional Management Staff checklist · Cheryl Yeager QIDP, will perform weekly day program observation and document 				

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	<p>be using the gait belt to hold him in a chair. The nurse stated, "That should not be happening if it is."</p> <p>On 8/25/15 at 12:44 PM, the Medical Care Coordinator (MCC) indicated client #1's gait belt was for stabilization. The MCC indicated staff holding the gait belt to keep client #1 sitting in his chair was not a purpose of a gait belt. The MCC indicated the gait belt should only be used for ambulation assistance. The MCC indicated staff using the gait belt for restraint was not an appropriate use of the gait belt.</p> <p>2) On 8/20/15 from 8:19 AM to 9:23 AM an observation was conducted at the facility-operated day program. During the observation, client #1's walker was not located in the same program area with client #1. Client #1's walker was in a separate, adjacent room.</p> <p>At 8:45 AM when day program staff #1 was asked where client #1's walker was located, day program staff #1 stated, "We hide his walker." Staff #1 stated client #1 tried to walk around and "cause trouble." Staff #1 indicated client #1 tried to run people over with his walker.</p> <p>On 8/20/15 at 4:56 PM the Team Lead (TL) indicated there was no plan for staff</p>			

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	<p>to take away client #1's walker. The TL stated they "shouldn't be doing that."</p> <p>On 8/21/15 at 11:42 AM a review of client #1's record was conducted. Client #1's 8/18/15 Individual Program Plan (IPP) and 7/14/15 Behavior Support Program did not include a plan for staff to store client #1's walker in a different program room while client #1 was at the day program. The IPP indicated, in part, "He now has a gait belt and rolling walker. He is to have the gait belt on whenever he is up and staff are to walk with him and hold onto it. He loves using his walker."</p> <p>On 8/21/15 at 11:26 AM, the QIDP indicated client #1's walker should be available to him. The QIDP indicated the staff should not hide client #1's walker. The QIDP indicated there was no plan to hide client #1's walker from him.</p> <p>On 8/24/15 at 11:09 AM, the RPM indicated client #1 needed access to his walker. The RPM stated, "don't understand why they keep it in another room." The RPM indicated this was a client rights violation.</p> <p>On 8/24/15 at 11:53 AM, the nurse indicated client #1's walker should be available to him. The nurse indicated</p>			

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W 0140 Bldg. 00	<p>client #1's walker should not be kept in a different room.</p> <p>On 8/25/15 at 12:44 PM, the MCC indicated client #1's walker should be available to him. The MCC stated, "I'm at a loss to tell you why they hide the walker. That would not be appropriate."</p> <p>9-3-2(a)</p> <p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on observation, record review and interview for 5 of 6 clients living in the group home (#2, #3, #4, #5 and #6), the facility failed to keep an accurate accounting of the clients' funds.</p> <p>Findings include:</p> <p>On 8/20/15 from 3:29 PM to 5:33 PM, an observation was conducted at the group home. At 3:38 PM, staff #2 was sitting at the dining room table updating (adding deposits and withdrawals) the clients' accounts. At 4:02 PM, staff #2 was sitting at the dining room table updating the clients' accounts. At 4:12 PM, staff #2 indicated she completed updating the</p>	W 0140	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> · QIDP no longer working for DSI and will not be eligible for rehire. · QIDPs will be in-serviced for the proper accounting of client funds <p>How will we identify others:</p> <ul style="list-style-type: none"> · Regional Management Staff will check finances to ensure that transactions are being documented as they occur <p>Measures put in place:</p> <ul style="list-style-type: none"> · Regional Management review · Finance protocol <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> · Regional Management Staff will perform weekly observation completing Regional Management Staff checklist · Direct Care Management staff will be present in the home daily and perform the 	09/26/2015

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	<p>clients' accounts and was ready to review the accounts.</p> <p>Client #2's Group Home Resident - Petty Cash Report, dated August 2015, had a starting balance of \$13.21. On 8/20/15, staff #2 documented a withdrawal of \$10.00 dated 8/14/15. The facility failed to ensure staff documented the withdrawal on 8/14/15.</p> <p>Client #3's Group Home Resident - Petty Cash Report, dated August 2015, had a starting balance of \$64.10. The \$0.10 was crossed out with a single line and \$.30 was written above it with no explanation for the change in the balance.</p> <p>Client #4's Group Home Resident - Petty Cash Report, dated August 2015, had a starting balance of \$17.26. On 8/20/15, staff #2 documented client #4 received \$10.00 in cash on 7/31/15. On 8/20/15, staff #2 documented a deposit of \$30.00 on 8/7/15. On 8/20/15, staff #2 documented a withdrawal for camp on 8/7/15. On 8/20/15, staff #2 documented client #4 received \$10.00 in cash on 8/14/15. The facility failed to ensure staff documented the changes in client #4's petty cash on the dates of the transactions.</p> <p>Client #5's Group Home Resident - Petty</p>		<p>active treatment observations for 60 days. Competition date:</p> <ul style="list-style-type: none"> · 9/26/15 <p>W140 ADDENDUM 9-25-15</p> <p>Monitoring of Corrective Actions:</p> <ul style="list-style-type: none"> · House finances will be checked by staff at each transaction and audited on a daily basis. 				

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	<p>Cash Report, dated August 2015, had a starting balance of \$22.92. On 8/20/15, staff #2 documented a withdrawal of \$10.00 for cash on 7/31/15. On 8/20/15, staff #2 documented a deposit of \$30.00 on 8/7/15. On 8/20/15, staff #2 documented a withdrawal of \$10.00 for cash on 8/14/15. On 8/20/15, staff #2 documented a withdrawal of \$11.00 for camp on 8/7/15. The facility failed to ensure staff documented the changes in client #5's petty cash on the dates of the transactions.</p> <p>Client #6's Group Home Resident - Petty Cash Report, dated August 2015, had a starting balance of \$6.97. On 8/20/15, staff #2 documented a deposit of \$30.00 on 8/7/15. On 8/20/15, staff #2 documented a cash withdrawal of \$10.00 on 7/31/15. On 8/20/15, staff #2 documented a withdrawal of \$11.00 for camp on 8/7/15. The facility failed to ensure staff documented the changes in client #6's petty cash on the dates of the transactions.</p> <p>On 8/20/15 at 4:18 PM, staff #2 stated the group home staff "usually" updated the clients' petty cash ledgers as the transactions were made. Staff #2 indicated she was off for a few days recently. Staff #2 indicated the clients' petty cash ledgers should be updated</p>			

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	<p>immediately. Staff #2 indicated the facility should account for the clients' money to the penny. Staff #2 stated, "Not sure what happened to [client #3's]." Staff #2 indicated the first line on the ledgers was documented by someone at the office. Staff #2 indicated the remaining entries were made on this date for transactions that occurred in the past.</p> <p>On 8/21/15 at 11:21 AM, the Qualified Intellectual Disabilities Professional (QIDP) stated she reviewed the clients' finances yesterday afternoon and "could not make sense of it." The QIDP indicated the staff were supposed to be counting the clients' finances during shift change and the staff were not counting the clients' finances. The QIDP indicated the staff should account for the clients' finances at the time money was deposited or withdrawn. The QIDP indicated the transactions should be documented during the shift the transactions were conducted.</p> <p>On 8/24/15 at 11:09 AM, the Regional Program Manager (RPM) indicated the facility should document transactions of the clients' finances as soon as the transaction was made. The RPM indicated the facility needed to keep an on-going accounting of the clients' funds. The RPM stated, "sounds like laziness</p>			

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W 0149 Bldg. 00	<p>(of the staff) more or less."</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 27 incident/investigative reports reviewed affecting clients #2, #5 and #6, the facility neglected to implement its policies and procedures to ensure client #2's plan for supervision while smoking was implemented to prevent a fall with injury while smoking after dental surgery and a thorough investigation was conducted, clients #5 and #6 were appropriately supervised to prevent them from eloping from the group home and staff immediately reported to the administrator when clients #5 and #6 eloped from the group home.</p> <p>Findings include:</p> <p>On 8/19/15 at 9:45 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p>			W 0149	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> · Will In-service staff, day program and house, on client #1 & #2's IPP, BSP and High Risk Plans · Will In-service QIDPs, RPM and Directors on thorough investigation techniques and policy.- · Will In-service staff and QIDP on client #5 & #6's IPP, BSP and supervision of clients · Incident reporting protocol for QIDPs has been implemented for notifying CEO (attachment A) · Group Home staff and QIDPs will be trained on incident reporting protocol · QIDP no longer working for DSI and will not be eligible for rehire. · Regional Management checklist has been implemented (attachment C) · Implemented Day program observation sheet (attachment F) · IDT met, revised client #5's HRP to include implement tracking sheet for refusal to eat, weight loss and daily weight monitoring (attachment H) · High risk plan for client #1 has been revised to include use of 		09/26/2015

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	<p>1) On 8/14/15 client #2 had comprehensive dental treatment in the operating room under general anesthesia for dental decay. The Medical Incident Report (MIR), completed by the Team Lead, indicated the date and time of his fall was 8/14/15 at 12:30 PM. The MIR indicated the location of the incident was "Outside [name of another group home] on concrete." The MIR indicated the type of injuries were "scrapes." The Description of the Incident section indicated, "[Client #2] was sitting in chair on porch - getting ready to smoke. Staff went to find van key. He was on ground - concrete - when I came out. The MIR indicated client #2 had a scrape on his right elbow, 1 inch by 1 inch raised area on his forehead and scrapes on both knees 1.5 inches by 1 inch. The investigation, not dated, indicated, "Client & (and) staff stopped at [name of another group home] to copies (sic) papers from surgery. He was sitting on porch to smoke a cig (cigarette). He got up to walk to van & fell forward. Staff was at the van. Client is still out of it from dental procedure. Client has no pain from fall. Staff will watch scrape for no oncoming infections. After a procedure staff will make sure client is watched closely."</p> <p>The investigation indicated the Team</p>		<p>walker (attachment I) · QIDPs, RPM and Directors will be in-serviced on oversight of the program How will we identify others: · Regional Management Staff will review staff training to ensure staff have been trained on all clients programming & will check door alarms, adaptive equipment & seat alarms to ensure all are in working order. They will also review monthly summaries and goals to ensure that they are being completed. · Regional Management Staff will review all restrictive practices to ensure guardian consent · The agency safety coordinator will review drills to ensure that they are completed on a quarterly basis per policy · Quality Assurance director will review all investigations to ensure a thorough investigation has been conducted · HCCs will review high risk plans to ensure that all adaptive equipment is documented Measures put in place: · Regional Management review · Incident reporting protocol · New day program observation form Monitoring of corrective action: · Regional Management Staff will perform weekly observation completing Regional Management Staff checklist · Direct Care Management staff will be present in the home daily and perform the active treatment observations for 60 days. · MCC will monitor</p>				

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	<p>Lead was supervising client #2 at the time. The Team Lead's interview indicated, "[Client #2] set (sic) in chair at [name of another group home]. He got up to walk around and fell down, a red place (sic) front of forehead, (right) elbow scrape 2" (inches) long x (by) 1", scraped both knees, under his nose, bloody nose." The interview with client #2 indicated, "He says he didn't fall."</p> <p>There was no documentation in the investigation client #2's Behavior Support Program was reviewed. The investigation did not explain how the Team Lead, during the interview, knew how client #2 fell when the MIR indicated she found him on the ground. The investigation was not thorough.</p> <p>On 8/21/15 at 11:40 AM a focused review of client #2's record was conducted. Client #2's Behavior Support Program (BSP), dated 2015, indicated, in part, "[Client #2] will smoke in the presence of staff only due to inappropriate disposal of cigarettes. [Client #2] will place hot ashes from an ashtray in the trash."</p> <p>On 8/26/15 at 12:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated at the time she conducted the investigation, she was not</p>		<p>and perform home record reviews per protocol Competition date: · 9/26/15 W149 Addendum- 9/25/15</p> <p>Corrective actions taken:</p> <ul style="list-style-type: none"> · Cheryl Yeager QIDP, in-serviced day program and house staff, on client #1 & #2's IPP, BSP and High Risk Plans (attachment AA) · Mel Fields, Director of Industry and Community Services, in-service d QIDPs, RPM and Directors on thorough investigation techniques and policy on 9/16/15 (attachment BB) · Cheryl Yeager QIDP, in-serviced staff on client #5 & #6's IPP, BSP and supervision of clients ((attachment AA) · Mel Fields, Director of Industry and Community Services, in-serviced QIDPs on #5 & #6's IPP, BSP and supervision of clients (attachment BB) · Mel Fields, Director of Industry and Community Services in-serviced QIDPs on incident reporting protocol and oversight of program on 9/16/15 (attachment BB) · Cheryl Yeager QIDP in-serviced group home staff on incident reporting protocol on 	

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	<p>aware client #2 had a plan to be supervised while he smoked. The QIDP indicated she did not review his BSP for the investigation and did not include the information in the investigation. The QIDP indicated the Team Lead did not witness the fall. The QIDP indicated the Team Lead thought client #2 attempted to get up and fell down but the Team Lead did not witness the fall. The QIDP indicated she should have indicated the Team Lead was speculating about what happened. The QIDP indicated her investigation was not thorough. The QIDP indicated client #2, she now knew, should have been supervised at the time of his fall since he was smoking. The QIDP indicated the Team Lead did not implement client #2's plan as written and was negligent.</p> <p>On 8/26/15 at 1:26 PM, the Regional Program Manager (RPM) indicated the QIDP's investigation should have included a review of his BSP. The RPM indicated client #2 was to be supervised while smoking. The RPM indicated the investigation should have addressed the Team Lead was not supervising client #2 according to his BSP. The RPM indicated the investigation was not thorough. The RPM, when read the MIR report and the Team Lead's statement included in the investigation, stated,</p>		9/25/15 (attachment CC)				

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	<p>"doesn't make sense that the investigation and MIR didn't match." The RPM stated the facility should have reviewed the incident "more thoroughly." The RPM indicated the facility should have conducted a full investigation. The RPM stated, "Something slipped through the cracks."</p> <p>2) On 8/24/15 at 3:04 PM, the RPM sent a text to the surveyor's work phone indicating, in part, "FYI (for your information), [name of group home] had 2 elopements this past weekend. Weekend staff did not report in a timely manner. The Q (Qualified Intellectual Disabilities Professional) suspended them this morning for suspected neglect and failure to report. An investigation is ongoing. Thought you should know."</p> <p>A. On 8/24/15 at 5:06 PM, the QIDP sent an email with the following incident: On 8/23/15 (should be 8/22/15) at 12:00 PM, client #5 was called to take his medicine for the noon medication pass. Staff could not find him. Client #5 was not in his room and he was not outside where he normally sits. The staff at the home called the staff who went grocery shopping to ask her if client #5 went shopping. Client #5 did not go shopping. The staff at the group home went outside and he was coming down the street. The</p>			

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	<p>Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/24/15, indicated, "Staff will check on client every 5 minutes to make sure he is outside the house. Staff is suspended that was working Saturday (8/22/15) and received counseling memo's (sic). All house staff will be retrained on 'Clients Rights' on DSI (Developmental Services, Inc.) online training within 48 hrs (hours). DSI will not tolerate this behaviors (sic) from our staff."</p> <p>On 8/25/15 at 5:35 PM, the QIDP indicated in documentation attached to an email, "[Staff #2 and staff #5] both worked Saturday and Sunday and they were the only staff at that shift. They were verbally suspended until the investigation is completed. [Client #5] was gone about 1 hr (hour), 12:00 PM until 1:00 PM."</p> <p>On 8/21/15 at 11:32 AM a focused review of client #5's record was conducted. Client #5's August 2015 BSP indicated, in part, "[Client #5] is diagnosed with Intellectual Disability, history of strokes, traumatic brain injury, and depression, NOS (not otherwise specified). On 7/18/03, [client #5] had his first stroke (prior to moving into the group home). He resided in a small efficiency apartment at the time and</p>			

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	<p>reportedly did not eat on a regular basis. [Client #5] experienced significant weight loss. As a result, [client #5] was initially placed on Paxil for weight gain due to strokes. His weight is now stable. [Client #5] has a history of increases in and decreases in Paxil due to short-term memory loss and increased irritability related to the stroke." The BSP indicated client #5 had the following targeted behaviors: "Verbal agitation: Defined as using a tone of voice louder than normal when upset; Yelling; Telling others what to do. Physical aggression: Defined as physically touching someone during an episode of anger; Slapping; Hitting. There is a history of this, but it rarely occurs. It is very important that the QIDP and group home nurse are notified if [client #5] is demonstrating an increase in irritability and poor moods, especially on a daily basis. Due to his history of strokes, this may need to be addressed by his physician."</p> <p>Client #5's Individual Program Plan (IPP), dated 8/18/15, indicated, in part, "Moreover, [client #5] remains confused at times and requires physical assistance with most daily living skills. Some days, it appears that [client #5] has gained back some of his abilities he lost as a result of the strokes, and, other days, [client #5] requires a lot of assist from staff. [Client</p>			

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	<p>#5] is a very pleasant and cooperative man. He is close friends with his roommate and is involved with a co-worker at [name] sheltered workshop. Due to confusion, [client #5] has difficulty at times remaining on task and this can be frustrating to him. [Client #5] can be temperamental and yell out at his housemates when agitated; he continues on Paxil and Tripletail (sic) daily, which helps him to be more even-tempered. [Client #5] does not have significant behavioral issues, but is easily agitated by certain peers in the home, so staff must monitor this closely and encourage [client #5] to report his frustrations. If [client #5] becomes upset, encourage him to express his frustrations, provide support, and help him develop coping mechanisms. During the winter months, he may choose to sit in his room away from others until he calms down. It is very important that [client #5] does not become too stressed, as this increases his stroke risk. Please notify the nurse and QIDP immediately if you notice significant changes in [client #5's] mental health. It is recommended that [client #5]: Receives 24-hour supervision in order to maintain his physical health and personal well-being. [Client #5] is considered high-risk for financial, emotional, and mental exploitation without supervision. [Client #5] requires</p>			

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	<p>access to 24-hour supervision to assist in decision-making skills."</p> <p>On 8/26/15 at 12:38 PM, the QIDP indicated client #5 did not have a plan to have alone time in the community. The QIDP indicated client #5 should not have been away from the group home unsupervised. The QIDP indicated client #5 was supposed to be supervised at all times. The QIDP indicated the staff should know where client #5 was located at all times. The QIDP indicated the staff was negligent. The QIDP indicated the staff failed to immediately report the incident to the administrator. The QIDP indicated the Team Lead was aware client #5 eloped from the group home on 8/23/15 when staff came to her apartment to pick up client #6 who eloped to her apartment. The Team Lead reported to the QIDP the staff informed the Team Lead on 8/23/15 of client #5's elopement on 8/22/15. The QIDP indicated no one notified her including the Team Lead when the Team Lead called her on 8/23/15 to report client #6's elopement incident. The QIDP indicated the incident date on the BDDS report was incorrect. The incident date was 8/22/15 and not 8/23/15. The QIDP indicated the facility had a policy prohibiting neglect and the facility should prevent neglect. The QIDP indicated the facility's</p>			

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	<p>investigation was on-going.</p> <p>B. On 8/24/15 at 4:37 PM, the QIDP sent an email with the following incident: On 8/23/15 at 2:00 PM, client #6 walked from the group home to the apartment complex where the Team Lead lived. The BDDS report, dated 8/24/15, indicated, "Team Lead called at the house and asked the staff at the house, where client was, they reported that he was outside. Team Lead said, 'No he is here at my apartment.' She told staff to come and get him. Staff went to get client at Team Leads (sic) apartment. When the TM (team manager)/staff asked client why he walked he said he got into it with the staff. This client has never walked away from the house previously. Both staff is (sic) suspended until investigation is completed, they will also receive a Counseling memo. DSI will not put up with neglect and abuse with the clients. All staff in the house will be retrained on 'Client rights' within 48 hrs."</p> <p>On 8/25/15 at 5:35 PM, the QIDP indicated in a document attached to an email, "[Client #6] and (said) staff accused [client #6] (sic) talking roughly to another client. [Client #6] said he didn't say anything. Staff told him that she was going to call the team lead. He said she hollered that statement. He told</p>			

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	<p>her his stomach was hurting and he said she was playing (sic) game on her phone. We are still investigating this issue."</p> <p>On 8/21/15 at 1:14 PM, a review of client #6's record was conducted. Client #6's IPP, dated 8/18/15, indicated, in part, "[Client #6] has the following diagnoses: mild intellectual disability, anxiety, depression, bilateral inguinal hernias, obesity, hypertension, flat feet, urge urinary incontinence, and (sic) severe lymphedema, edema, Barretts (sic) Esphagus (sic), GERD (gastroesophageal reflux disease) and history of Prostate Cancer. As mentioned previously, [client #6] is diagnosed with depression and anxiety. He is prescribed Cymbalta and Wellbutrin XL. Since moving to [name of group home], [client #6] has had a few instances of reporting to staff that he is sad or anxious. He misses his family and would like to be closer. At times, [client #6] requires reassurance that he has not done anything wrong when he is approached about a medical concern or when a housemate has a behavior outburst. [Client #6] has made a few statements out of frustration to staff members, but his overall mood has been pleasant, cooperative, and kind. [Client #6] has a formal behavior plan addressing depression, anxiety and verbal aggression. It is recommended that</p>			

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	<p>[client #6]: Receives 24-hour supervision where his social, developmental, medical, and emotional needs can be met. [Client #6] is considered high-risk for financial, emotional, and mental exploitation without supervision. [Client #6] requires access to 24-hour supervision to assist in decision-making skills."</p> <p>On 8/26/15 at 12:38 PM, the QIDP indicated client #6 did not have a plan for alone time in the community. The QIDP indicated client #6 should not have been away from the group home unsupervised. The QIDP indicated client #6 was supposed to be supervised at all times. The QIDP indicated the staff should know where client #6 was located at all times. The QIDP indicated the staff was negligent. The QIDP indicated when she asked the Team Lead how far her apartment was from the group home, the Team Lead told her she just walked from her apartment to the group home recently and it took her 30 minutes. The QIDP indicated client #6 told her he stopped to rest on a bench during his walk. The QIDP indicated she had not located the bench yet that client #6 said he rested on during his walk. The QIDP indicated the facility had a policy prohibiting neglect and the facility should prevent neglect. The QIDP indicated the facility's investigation was on-going.</p>			

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	<p>On 8/26/15 at 1:26 PM, the RPM indicated the QIDP was made aware of the incidents of clients #5 and #6 eloping on 8/24/15 and she immediately reported the incidents to the RPM on 8/24/15. The RPM indicated the staff should have immediately reported the incidents to the QIDP. The RPM indicated, when told the QIDP reported to the surveyor she was aware of client #6's elopement on 8/23/15, the QIDP failed to immediately report the incident to him on 8/23/15. The RPM indicated the incidents were reported to him on 8/24/15. The RPM indicated the incident date of client #5's elopement was 8/22/15 and not 8/23/15 as indicated on the BDDS report. The RPM indicated both clients #5 and #6 should be supervised by staff. The RPM indicated neither client had a plan for alone time in the community. The RPM indicated the staff was negligent since the staff did not know where the clients were at all times. The RPM indicated the facility had a policy prohibiting neglect of the clients and the facility should prevent neglect of the clients.</p> <p>A review of the facility's policy on conducting investigations was conducted on 8/19/15 at 10:39 AM. The facility's Protocol for Completing Investigations, dated 1/3/06, indicated, "Any event</p>			

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	<p>involving the potential or actual risk of harm to a client served, will be documented, reported, investigated and corrective action taken to alleviate the potential for future risk. The investigation must be initiated within 24 hours and completed within 5 working days." The policy indicated, in part, "...will be investigated immediately and thoroughly." The policy indicated, "Instances of suspected violations of rights, abuse or neglect, or inadequate protection of the health and safety of individuals served will be investigated immediately and thoroughly. Examples of inadequate protection of health and safety include but are not limited to: injuries of unknown origin, behavior incidents resulting in client/staff injuries, accidents resulting in the need of medical treatment, incidents caused by possible staff neglect and suspected criminal activity by staff or clients. Staff should notify their supervisor/QIDP/emergency pager within 30 minutes of the discovery of the concern. The investigation must be thorough and shall include the following: a. Review of the incident reports, b. Interview with the client and or guardian and/or advocate, c. Interview of all staff involved including whenever possible: i. Person suspected of violation (if abuse, neglect is suspected), ii. Person (s) who witnessed the incident or</p>			

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W 0153 Bldg. 00	<p>discovered the concern, iii. Other staff who provide services to the individual, and d. Interview of others having knowledge of the incident or concern." The policy defined neglect as, "Alleged, suspected, or actual neglect: Failure to provide appropriate supervision, care, or training. Failure to provide a safe, clean, and sanitary environment. Failure to provide food and medical services as needed. Failure to provide medical supplies or safety equipment per ISP."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 2 of 27 incident/investigative reports reviewed affecting clients #5 and #6, the facility failed to ensure staff immediately reported to the administrator when clients #5 and #6 eloped from the group home.</p> <p>Findings include: On 8/24/15 at 3:04 PM, the Regional Program Manager (RPM) sent a text to the surveyor's work phone indicating, in</p>	W 0153	<p>Corrective actions taken: · Will In-service QIDPs, RPM and Directors on thorough investigation techniques and policy.- · Will In-service staff and QIDP on client #5 & #6's IPP, BSP and supervision of clients · Incident reporting protocol for QIDPs has been implemented for notifying CEO (attachment A) · Group Home staff and QIDPs will be trained on incident reporting protocol · QIDP no longer working for DSI and will not be eligible for rehire. · Regional</p>	09/26/2015

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	<p>part, "FYI (for your information), [name of group home] had 2 elopements this past weekend. Weekend staff did not report in a timely manner. The Q (Qualified Intellectual Disabilities Professional) suspended them this morning for suspected neglect and failure to report. An investigation is ongoing. Thought you should know."</p> <p>1) On 8/24/15 at 5:06 PM, the Qualified Intellectual Disabilities Professional (QIDP) sent an email with the following incident: On 8/23/15 at 12:00 PM, client #5 was called to take his medicine for the noon medication pass. Staff could not find him. Client #5 was not in his room and he was not outside where he normally sits. The staff at the home called the staff who went grocery shopping to ask her if client #5 went shopping. Client #5 did not go shopping. The staff at the group home went outside and he was coming down the street. The Bureau of Developmental Disabilities Services incident report, dated 8/24/15, indicated, "Staff will check on client every 5 minutes to make sure he is outside the house. Staff is suspended that was working Saturday and received counseling memo's (sic). All house staff will be retrained on 'Clients Rights' on DSI (Developmental Services, Inc.) online training within 48 hrs (hours).</p>		<p>Management checklist has been implemented (attachment C) · Train Group home staff and day program staff on client rights (attachment E) · QIDPs, RPM and Directors will be in-serviced on oversight of the program · Drills will be sent to the agency safety coordinator How will we identify others: · Regional Management Staff will review staff training to ensure staff have been trained on all clients programming & will check door alarms, adaptive equipment & seat alarms to ensure all are in working order. They will also review monthly summaries and goals to ensure that they are being completed. · The agency safety coordinator will review drills to ensure that they are completed on a quarterly basis per policy · Quality Assurance director will review all investigations to ensure a thorough investigation has been conducted Measures put in place: · Regional Management review · Incident reporting protocol Monitoring of corrective action: · Regional Management Staff will perform weekly observation completing Regional Management Staff checklist · Direct Care Management staff will be present in the home daily and perform the active treatment observations for 60 days. · Agency Safety coordinator will review drills monthly to ensure compliance</p>	

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	<p>DSI will not tolerate this behaviors (sic) from our staff."</p> <p>On 8/25/15 at 5:35 PM, the QIDP indicated in a document attached to an email, "[Staff #2 and staff #5] both worked Saturday and Sunday and they were the only staff at that shift. They were verbally suspended until the investigation is completed. [Client #5] was gone about 1 hr (hour), 12:00 PM until 1:00 PM."</p> <p>On 8/26/15 at 12:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the staff failed to immediately report the incident to the administrator. The QIDP indicated the Team Lead was aware client #5 eloped from the group home on 8/23/15 when staff came to her apartment to pick up client #6 who eloped to her apartment. The Team Lead reported to the QIDP the staff informed the Team Lead on 8/23/15 of client #5's elopement on 8/22/15. The QIDP indicated no one notified her of client #5's elopement including the Team Lead when the Team Lead called her on 8/23/15 to report client #6's elopement incident.</p> <p>2) On 8/24/15 at 4:37 PM, the QIDP sent an email with the following incident: On 8/23/15 at 2:00 PM, client #6 walked</p>		<p>Competition date: · 9/26/15 W153 Addendum- 9/24/15</p> <p>Corrective actions taken:</p> <ul style="list-style-type: none"> · Mel Fields, Director of Industry and Community Services, in-service d QIDPs, RPM and Director on thorough investigation techniques and policy on 9/16/15 (attachment BB) · Cheryl Yeager QIDP, in-serviced staff on client #5 & #6's IPP, BSP and supervision of clients (attachment AA) · Mel Fields, Director of Industry and Community Services, in-serviced QIDPs on #5 & #6's IPP, BSP and supervision of clients (attachment BB) · Mel Fields, Director of Industry and Community Services in-serviced QIDPs on incident reporting protocol on 9/16/15 (attachment BB) · Incident reporting protocol for QIDPs has been implemented for notifying CEO (attachment A) · John Kirk, agency safety coordinator, in-serviced group home staff and day program staff on client rights (attachment E) 	

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	<p>from the group home to the apartment complex where the Team Lead lived. The BDDS report, dated 8/24/15, indicated, "Team Lead called at the house and asked the staff at the house, where client was, they reported that he was outside. Team Lead said, 'No he is here at my apartment.' She told staff to come and get him. Staff went to get client at Team Leads (sic) apartment. When the TM (team manager)/staff asked client why he walked he said he got into it with the staff. This client has never walked away from the house previously. Both staff is (sic) suspended until investigation is completed, they will also receive a Counseling memo. DSI will not put up with neglect and abuse with the clients. All staff in the house will be retrained on 'Client rights' within 48 hrs."</p> <p>On 8/25/15 at 5:35 PM, the QIDP indicated in documentation attached to an email, "[Client #6] and (said) staff accused [client #6] (sic) talking roughly to another client. [Client #6] said he didn't say anything. Staff told him that she was going to call the team lead. He said she hollered that statement. He told her his stomach was hurting and he said she was playing (sic) game on her phone. We are still investigating this issue."</p> <p>On 8/26/15 at 12:38 PM, the QIDP</p>		<p>Mel Fields, Director of Industry and Community Services in-serviced QIDPs, RPM and Director on oversight of the program on 9/16/15 (attachment BB)</p>				

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W 0154 Bldg. 00	<p>indicated she was informed of the incident by the Team Lead after client #6 was picked up from the Team Lead's apartment on 8/23/15.</p> <p>On 8/26/15 at 1:26 PM, the RPM indicated the QIDP was made aware of the incidents on 8/24/15 and she immediately reported the incidents to the RPM on 8/24/15. The RPM indicated the staff should have immediately reported the incidents to the QIDP who would report to the RPM. The RPM indicated, when told the QIDP reported to the surveyor she was aware of client #6's elopement on 8/23/15, the QIDP failed to immediately report the incident to him on 8/23/15.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 27 incident/investigative reports reviewed affecting client #2, the facility failed to conduct a thorough investigation of a fall with injury after client #2 had dental surgery.</p> <p>Findings include:</p>	W 0154	<p>Corrective Actions Taken · Cheryl Yeager QIDP in-serviced house staff and day program staff on client #2's IPP, BSP and HRPs on 9/14/15 (attachment AA) · Mel Fields, Director of Industry and Community Services, in-service d QIDPs, RPM and Director on thorough investigation techniques and</p>	09/26/2015			

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	<p>On 8/19/15 at 9:45 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 8/14/15 client #2 had comprehensive dental treatment in the operating room under general anesthesia for dental decay. The Medical Incident Report (MIR), completed by the Team Lead, indicated the date and time of his fall was 8/14/15 at 12:30 PM. The MIR indicated the location of the incident was "Outside [name of another group home] on concrete." The MIR indicated the type of injuries were "scrapes." The Description of the Incident section indicated, "[Client #2] was sitting in chair on porch - getting ready to smoke. Staff went to find van key. He was on ground - concrete - when I came out. The MIR indicated client #2 had a scrape on his right elbow, 1 inch by 1 inch raised area on his forehead and scrapes on both knees 1.5 inches by 1 inch. The investigation, not dated, indicated, "Client & (and) staff stopped at [name of another group home] to copies (sic) papers from surgery. He was sitting on porch to smoke a cig (cigarette). He got up to walk to van & fell forward. Staff was at the van. Client is still out of it from dental procedure. Client has no pain from fall. Staff will watch scrape for no oncoming infections. After a</p>		<p>policy on 9/16/15 (attachment BB) · Former Team Lead received a disciplinary action A for failing to follow client #2's HRPs · Linda Clouse, Director of Quality Assurance, will review all investigations to ensure a thorough investigation has been completed. · DSI group home incident documentation protocol has been created (attachment EE) · Group Home Staff, QIPD's, and RPM's will receive annual training on Abuse, Neglect, Mistreatment, and Exploitation. How we will identify others: · Linda Clouse, Director of Quality Assurance, will review all investigations to ensure a thorough investigation has been conducted. Measures put in place: · DSI group home incident documentation protocol has been created (attachment EE) · Mel Fields, Director of Industry and Community Services, in-service d QIDPs, RPM and Director on thorough investigation techniques and policy on 9/16/15 (attachment BB) · Linda Clouse, Director of Quality Assurance, will review all investigations to ensure a thorough investigation has been completed. Monitoring of Corrective actions: · Linda Clouse, Director of Quality Assurance, will review all investigations to ensure a thorough investigation has been completed.</p>				

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	<p>procedure staff will make sure client is watched closely."</p> <p>The investigation indicated the Team Lead was client #2's staff at the time of this fall. The Team Lead's interview indicated, "[Client #2] set (sic) in chair at [name of another group home]. He got up to walk around and fell down, a red place (sic) front of forehead, (right) elbow scrape 2" (inches) long x (by) 1", scraped both knees, under his nose, bloody nose." The interview with client #2 indicated, "He says he didn't fall."</p> <p>There was no documentation in the investigation client #2's Behavior Support Program was reviewed. The investigation did not explain how the Team Lead, during the interview, knew how client #2 fell when the MIR indicated she found him on the ground. The investigation was not thorough.</p> <p>On 8/21/15 at 11:40 AM a focused review of client #2's record was conducted. Client #2's Behavior Support Program (BSP), dated 2015, indicated, in part, "[Client #2] will smoke in the presence of staff only due to inappropriate disposal of cigarettes. [Client #2] will place hot ashes from an ashtray in the trash."</p>			

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	<p>On 8/26/15 at 12:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated at the time she conducted the investigation, she was not aware client #2 had a plan to be supervised while he smoked. The QIDP indicated she did not review his BSP for the investigation and did not include the information in the investigation. The QIDP indicated the Team Lead did not witness the fall. The QIDP indicated the Team Lead thought client #2 attempted to get up and fell down but the Team Lead did not witness the fall. The QIDP indicated she should have indicated the Team Lead was speculating about what happened. The QIDP indicated her investigation was not thorough.</p> <p>On 8/26/15 at 1:26 PM, the Regional Program Manager (RPM) indicated the QIDP's investigation should have included a review of client #2's BSP. The RPM indicated client #2 was to be supervised while smoking. The RPM indicated the investigation should have addressed the Team Lead was not supervising client #2 according to his BSP. The RPM indicated the investigation was not thorough. The RPM, when read the MIR report and the Team Lead's statement included in the investigation, stated, "doesn't make sense that the investigation and MIR didn't</p>			

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W 0159 Bldg. 00	<p>match." The RPM stated the facility should have reviewed the incident "more thoroughly." The RPM indicated the facility should have conducted a full investigation. The RPM stated, "Something slipped through the cracks."</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 observation, record review and interview for 3 of 3 clients (#1, #3 and #6) in the sample and 3 additional clients (#2, #4 and #5), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' program plans. The QIDP failed to ensure the clients' training goals and objectives were reviewed on a regular basis from August 2014 to July 2015. The QIDP failed to ensure client #1 had the right to due process in regard to staff using his gait belt to keep him sitting in a chair and the facility-operated day program did not unnecessarily restrict client #1's access to his walker. The QIDP failed to ensure an accurate accounting of the clients' funds was maintained. The QIDP failed to address,</p>	W 0159	<p>Corrective actions taken: · Will In-service staff, day program and house, on client #1 IPP, BSP and High Risk Plans-QIDP on and staff on · Will In-service staff and QIDP on client #5 & #6's IPP, BSP and supervision of clients · QIDP no longer working for DSI and will not be eligible for rehire. · In-service QIDPs & RPM on monthly summaries · Monthly Summary has been revised to include RPM review and Director review (attachment B) · Regional Management checklist has been implemented (attachment C) · Train Group home staff and day program staff on client rights (attachment E) · Implemented Day program observation sheet (attachment F) · Finance protocol has been implemented and QIDPs and group home staff will</p>	09/26/2015

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	<p>in a plan, client #5's refusals to eat meals. The QIDP failed to ensure client #1's risk plan for falls included the use of a walker. The QIDP failed to ensure staff implemented the clients' program plans as written for: 1) client #1's door alarms, 2) client #1's seat alarm and 3) client #2's plan for supervision while smoking. The QIDP failed to ensure client #3's restrictive behavior plan was conducted with written informed consent from his guardian. The QIDP failed to ensure quarterly evacuation drills for each shift of personnel were conducted affecting clients #1, #2, #3, #4, #5 and #6.</p> <p>Findings include:</p> <p>1) On 8/21/15 at 11:42 AM, a review of client #1's record was conducted. Client #1's record did not contain documentation the QIDP reviewed his progress toward completing his training objectives on a monthly or quarterly basis from August 2014 to July 2015.</p> <p>On 8/21/15 at 12:21 PM, the QIDP indicated she was unable to locate or provide evidence client #1's goals and objectives were reviewed for progress and revised during the past year. The QIDP indicated the facility did not have documentation client #1's goals and objectives were implemented for the past</p>		<p>be in-serviced (attachment G) · QIDPs will be in-serviced for the proper accounting of client funds · High risk plan for client #1 has been revised to include use of walker (attachment I) · A daily adaptive equipment/ durable medical equipment checklist (attachment J) has been implemented and QIDPs will be in-serviced · Client #3's restrictive behavior plan has a signature from his guardian (attachment K) · Guardian phone approval protocol (attachment L) and signature follow-up protocol (attachment L) has been implemented and QIDPs will be in-serviced on it · QIDPs and staff will be in-serviced on emergency drills · Drills will be sent to the agency safety coordinator · QIDPs, RPM and Directors will be in-serviced on oversight of the program How will we identify others: · Regional Management Staff will review staff training to ensure staff have been trained on all clients programming & will check door alarms, adaptive equipment & seat alarms to ensure all are in working order. They will also review monthly summaries and goals to ensure that they are being completed. · Regional Management Staff will check finances to ensure that transactions are being documented as they occur · Regional Management Staff will review all restrictive practices to</p>				

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	<p>year. The QIDP stated, "I couldn't find any." The QIDP indicated she reported her concerns to the Regional Program Manager (RPM).</p> <p>On 8/21/15 at 12:30 PM, a review of client #3's record was conducted. Client #3's record did not contain documentation the QIDP reviewed his progress toward completing his training objectives on a monthly or quarterly basis from August 2014 to July 2015.</p> <p>On 8/21/15 at 12:31 PM, the QIDP indicated she was unable to locate documentation his goals and objectives were implemented during the past year. The QIDP indicated the Team Lead told her they were completed and submitted to the former QIDP. The QIDP indicated she could not locate the documentation.</p> <p>On 8/21/15 at 1:14 PM, a review of client #6's record was conducted. Client #6's record did not contain documentation the QIDP reviewed his progress toward completing his training objectives on a monthly or quarterly basis from August 2014 to June 2015.</p> <p>On 8/21/15 at 12:31 PM, the QIDP indicated she was unable to locate documentation client #6's goals and objectives were implemented during the</p>		<p>ensure guardian consent · The agency safety coordinator will review drills to ensure that they are completed on a quarterly basis per policy · Quality Assurance director will review all investigations to ensure a thorough investigation has been conducted · HCCs will review high risk plans to ensure that all adaptive equipment is documented Measures put in place: · Regional Management review · Finance protocol · New day program observation form · Adaptive equipment/durable medical equipment checklist · Guardian approval documentation protocol</p> <p>Monitoring of corrective action: · Regional Management Staff will perform weekly observation completing Regional Management Staff checklist · Direct Care Management staff will be present in the home daily and perform the active treatment observations for 60 days. · MCC will monitor and perform home record reviews per protocol</p> <p>Competition date: · 9/26/15 W159 Addendum 9/24/15</p> <p>Corrective Actions:</p> <ul style="list-style-type: none"> · Ann Sanchez, former QIDP, is no longer working for DSI and will not be eligible for rehire · Mel Fields, Director of Industry and Community Services 				

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	<p>past year. The QIDP indicated the Team Lead told her they were completed and submitted to the former QIDP. The QIDP indicated she could not locate the documentation.</p> <p>On 8/24/15 at 11:09 AM, the RPM stated the clients' did not have documentation of their goals and objectives being reviewed on a regular basis due to a "lack of oversight." The RPM stated, "Should not have happened. Not a good thing." The RPM stated, "I take ownership of this."</p> <p>2) Please refer to W125. For 1 of 3 clients in the sample (#1), the QIDP failed to ensure client #1 had the right to due process in regard to staff using his gait belt to keep him sitting in a chair and the facility-operated day program did not unnecessarily restrict client #1's access to his walker.</p> <p>3) Please refer to W140. For 5 of 6 clients living in the group home (#2, #3, #4, #5 and #6), the QIDP failed to ensure an accurate accounting of the clients' funds was maintained.</p> <p>4) Please refer to W227. For 1 of 3 non-sampled clients (#5), the QIDP failed to address, in a plan, client #5's refusals to eat meals.</p>		<p>in-serviced QIDPs, RPM and Director on oversight of the program on 9/16/15 (attachment BB)</p> <ul style="list-style-type: none"> · Mel Fields, Director of Industry and Community Services In-serviced QIDPs & RPM on monthly summaries and program oversight on 9/16/15 (attachment BB) · Monthly summary revised to include review by RPM and Director Kay Boas (Attachment B). · John Kirk, Agency Safety Coordinator, in-serviced Group home and day program staff on client rights (attachment E) · Workshop Observation Form has been implemented and Mel Fields, Director of Industry and Community Services in-serviced RPM & QIDPs (Attachment BB) · Finance protocol implemented (Attachment G) · Mel Fields, Director of Industry and Community Services in-serviced RPM & QIDPs for the proper accounting of client funds and finance protocol 9/16/15 (attachment BB) · Cheryl Yeager QIDP in-serviced group home staff on finance protocol on 9/25/15 (attachment CC) 		

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	<p>5) Please refer to W240. For 1 of 3 clients in the sample (#1), the QIDP failed to ensure client #1's risk plan for falls included the use of a walker.</p> <p>6) Please refer to W249. For 1 of 3 clients in the sample (#1) and one additional client (#2), the QIDP failed to ensure staff implemented the clients' program plans as written for: 1) client #1's door alarms, 2) client #1's seat alarm and 3) client #2's plan for supervision while smoking.</p> <p>7) Please refer to W263. For 1 of 3 clients in the sample (#3), the QIDP failed to ensure his restrictive behavior plan was conducted with written informed consent from his guardian.</p> <p>8) Please refer to W440. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the QIDP failed to ensure quarterly evacuation drills for each shift of personnel were conducted.</p> <p>9-3-3(a)</p>		<ul style="list-style-type: none"> · IDT met, revised client #5's HRP to implement tracking sheet for refusal to eat, weight loss and daily weight monitoring (attachment H) · High risk plan for client #1 has been revised to include use of walker (attachment I) · A daily adaptive equipment/ durable medical equipment checklist has been implemented (attachment J) and QIDPs and RPM have been in-serviced by Mel Fields, director of Industry and Community services (attachment BB) · The daily adaptive equipment/ durable medical equipment checklist will be documented daily. · Cheryl Yeager QIDP in-serviced group home staff on adaptive equipment/ durable medical equipment checklist on 9/25/15 (attachment CC) · Mel Fields, Director of Industry and Community Services in-serviced QIDPs on emergency drills on 9/16/15 (attachment BB) · Cheryl Yeager QIDP in-serviced staff on emergency drills on 9/25/15 (attachment CC) · Client #3's restrictive behavior plan has guardian 	

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			<p>signature (attachment K)</p> <ul style="list-style-type: none"> · Guardian phone approval protocol (attachment L) and signature follow-up protocol has been implemented (attachment M) and QIDPs and RPM have been in-serviced on it by Mel Fields Director of Industry and Community Services on 9/16/15 (attachment BB) · Emergency Drill Protocol has been implemented (attachment HH) · Mel Fields, Director of Industry and Community Services in-serviced RPM & QIPD's on Emergency Drill Protocol 9/16/15 (attachment BB) · Cheryl Yeager QIDP in-serviced group home staff on Emergency Drill Protocol on 9/25/15 (attachment CC) · John Kirk, agency Safety Coordinator, will receive drills on a monthly basis <p>How we are going to identify Other:</p> <ul style="list-style-type: none"> · QIDP, RPM, Director will review monthly summaries to ensure they have been completed 	

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			<ul style="list-style-type: none"> · QIDP and RPM will review staff training to ensure all staff have been trained in client rights · QIPDs and RPM will review client finances to ensure all transactions have been documented timely · HCCs will review home medical communication logs and weekly weight tracking to ensure refusals to eat are addressed. · HCC will review high risk plans to ensure all adaptive equipment is documented · QIDP and RPM will check all door alarms and seat alarms to ensure they are in working order · John Kirk, agency safety coordinator will review drills to ensure that drills are in compliance · QIDP and RPM will review restrictive BSP to ensure guardian signature is present <p>Measures put in place:</p> <ul style="list-style-type: none"> · Revised monthly summary · Finance protocol · Day program observation form implemented · Daily adaptive 	

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			<p>equipment/durable equipment checklist checked daily</p> <ul style="list-style-type: none"> · Guardian approval documentation protocol · Signature follow up protocol · Refusal to eat tracking · Medical book review has been implemented · Emergency Drill Protocol <p>Monitoring of Corrective measures:</p> <ul style="list-style-type: none"> · Mel Fields Director of Industry and Community Services, Pam Pace regional program manager, Lela DeBusk Regional Program Manager, Dundri Osborne Regional Quality Manager or Veronica Anderson Regional Program Manager will perform weekly observation completing Regional Management Staff checklist · Julie Lawson, Medical Care Coordinator, will monitor and perform home record reviews per the Medical Care coordinator Oversight Protocol semi-monthly (attachment GG) · QIDP will perform weekly observation at workshop 	

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W 0227 Bldg. 00	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, record review and interview for 1 of 3 non-sampled clients (#5), the facility failed to address, in a plan, client #5's refusals to eat meals.</p> <p>Findings include:</p> <p>On 8/20/15 from 3:29 PM to 5:33 PM an observation was conducted at the group home. At 4:53 PM when client #5 was asked to wash his hands for dinner, client #5 told staff #3 he did not want to eat. Dinner started at 4:59 PM and client #5 did not eat. At 5:13 PM the Team Lead asked client #5 if he wanted something else to eat during dinner. Client #5 stated, "I'm good."</p> <p>On 8/20/15 at 4:53 PM staff #3 stated client #5 refused to eat "at times."</p> <p>On 8/21/15 at 11:32 AM a focused review of client #5's record was conducted. Client #5's August 2015</p>	W 0227	<p>Corrective Action Taken: · IDT met, revised client #5's HRP to implement tracking sheet for refusal to eat, weight loss and daily weight monitoring (attachment H) How we will identify others: · QIDPs and health care coordinators will review clients' medical files to ensure that refusals to eat are being documented and weight tracking is being done monthly or as needed. Measures put in place: · refusal to eat tracking sheet · Daily weight monitoring Monitoring of Corrective Action: · Health care coordinator will review refusal to eat tracking sheet and daily weight monitoring weekly. · Julie Lawson, Medical Care Coordinator, will monitor and perform home record reviews per the Medical Care coordinator Oversight Protocol semi-monthly (attachment GG)</p>	09/26/2015

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	<p>Behavior Support Program did not have a plan addressing refusals to eat. Client #5's BSP indicated, in part, "[Client #5] is diagnosed with Intellectual Disability, history of strokes, traumatic brain injury, and depression, NOS (not otherwise specified). On 7/18/03, [client #5] had his first stroke (prior to moving into the group home). He resided in a small efficiency apartment at the time and reportedly did not eat on a regular basis. [Client #5] experienced significant weight loss. As a result, [client #5] was initially placed on Paxil for weight gain due to strokes. His weight is now stable." Client #5's 8/18/15 Individual Program Plan (IPP) did not address refusals to eat. Client #5's IPP indicated, in part, "[Client #5's] weight is monitored closely, as he had been significantly underweight prior to moving into the group home, and he must eat 3 meals a day (low-cholesterol diet)." The IPP indicated, "[Client #5] follows a low-cholesterol diet. Weight loss is monitored closely and is reported to his physician. [Client #5] should eat 3 meals daily at consistent times." There was no documentation of a plan in client #5's record to address his refusals to eat.</p> <p>On 8/21/15 at 11:31 AM, the Qualified Intellectual Disabilities Professional (QIDP) stated client #5 refused to eat</p>			

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	<p>"sometimes" when he was upset. The QIDP indicated client #5 needed a plan for staff to implement when client #5 refused to eat.</p> <p>On 8/24/15 at 11:09 AM the Regional Program Manager (RPM) indicated he was not aware of client #5's refusals to eat. The RPM indicated if the staff said he was refusing to eat, at times, then client #5 needed a plan to address refusals to eat.</p> <p>On 8/24/15 at 11:53 AM the nurse indicated she was not aware client #5 was refusing to eat meals at times. The nurse indicated client #5 had an as needed (PRN) order for Carnation Instant Breakfast (CIB) but the order may need to be a routine order. The nurse indicated client #5 had lost 6 pounds since January 2015. The nurse indicated she instructed the group home staff to get a routine CIB order. The nurse indicated client #5 needed a plan to address refusals to eat.</p> <p>On 8/25/15 at 12:44 PM, the Medical Care Coordinator (MCC) indicated client #5 needed a plan to address refusals to eat.</p> <p>9-3-4(a)</p>			

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W 0240 Bldg. 00	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview for 1 of 3 clients in the sample (#1), the facility failed to ensure client #1's risk plan for falls included the use of a walker.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/20/15 from 6:29 AM to 7:43 AM and 8/20/15 from 3:29 PM to 5:33 PM. During the observations at the group home, client #1 had a walker. When client #1 stood up to ambulate, staff prompted client #1 to use his walker.</p> <p>On 8/21/15 at 11:42 AM a review of client #1's record was conducted. Client #1's Health/Risk Plan for falls, dated 7/2/15, indicated, in part, "Client wants to remain independent, but has poor safety awareness. Unsteady gait when walking by himself." The plan indicated staff would, "Assist with walking using gait belt and one assist. One assist with a [brand name] gait belt at all times when up. Limit w/c (wheelchair) use only when needed: when too tired to walk, too painful, when not cooperating." There</p>	W 0240	<p>Corrective Action taken: · Client # 1's HRP for falls has been revised to include use of a walker (attachment I) · Cheryl Yeager QIDP, in-serviced day program and house staff, on client #1's High Risk Plans (Attachment AA) · Implemented Day program observation sheet (attachment F) How will we identify others: · Health care coordinators will review high risk plans to ensure that all adaptive equipment is documented. · QIPD's will perform Workshop observations to ensure that adaptive equipment is present and available for clients. Measures put in place: · Medical book review has been implemented (attachment FF) · Implemented Day program observation sheet (attachment F) Monitoring of Corrective Action: · Julie Lawson, Medical Care Coordinator , will monitor and perform home record reviews per the Medical Care coordinator Oversight Protocol semi-monthly (attachment GG) 9/26/15 · QIPD will perform weekly Workshop observation</p>	09/26/2015			

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	<p>was no documentation in the plan addressing the use of a walker. The plan did not indicate client #1 had a walker.</p> <p>Client #1's 8/18/15 IPP indicated, in part, "[Client #1] is not able to do many of the household tasks he used to due to his risk for falls and staff needing to be with him. However, with staff by his side with his gait belt he can still be assisted to do such tasks as wiping off the table or taking his dishes to the sink by placing them on his walker. He can still participate in the household chore chart by performing tasks with staff assistance for safety... He started receiving Physical Therapy at home two times a week back in May. He now has a gait belt and rolling walker. He is to have the gait belt on whenever he is up and staff are to walk with him and hold onto it. He loves using his walker... [Client #1] fell and broke his leg in December 04. Since then he has had an uneven gait as he has one leg longer than the other. [Client #1] has therapeutic shoes with a built up sole for his left leg. [Client #1] uses a gait belt and rolling walker for safety. Staff must be with him when he is up and holding onto his gait belt if he is walking. [Client #1] loves his new walker. Despite his uneven gait he is still very quick on his feet when he wants to be... He has to have his gait belt and rolling walker."</p>			

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W 0249 Bldg. 00	<p>On 8/25/15 at 11:48 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #1 was to use his walker at all times. The QIDP indicated client #1's risk plan should include the use of the walker. The QIDP indicated the plan in client #1's record was dated 7/2/15. On 8/25/15 at 11:55 AM, the QIDP stated "not yet" when asked if the use of the walker was added to his risk plan for falls.</p> <p>On 8/25/15 at 12:44 PM, the Medical Care Coordinator (MCC) indicated the use of a walker should be part of client #1's risk plan for falls.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 1 of 3 clients in the sample (#1) and one additional client (#2), the facility failed to ensure staff implemented the clients' program plans as written for:</p>	W 0249	<p>Corrective actions taken: · Cheryl Yeager, QIDP, In-serviced staff, day program and house, on client #2's IPP, BSP and High Risk Plans on 9/14/15 (attachment AA) · Daily adaptive</p>	09/26/2015

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	<p>1) client #1's door alarms, 2) client #1's seat alarm and 3) client #2's plan for supervision while smoking.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 8/20/15 from 3:29 PM to 5:33 PM. At 4:02 PM, the garage door alarm was activated however the sound was barely audible due to the battery being low. The other three exit door alarms were not activated. At 4:28 PM, three of the four door alarms were turned off. The garage door alarm was on but when it sounded it was barely audible. At 4:41 PM when client #5 entered the group home from the driveway entrance, the door alarm did not sound.</p> <p>On 8/20/15 at 3:45 PM, staff #2 indicated the front two exit doors had alarms. Staff #2 indicated the side and back doors did not have alarms. Staff #2 indicated client #1 had elopement in his plan and he attempted to elope out the front two doors.</p> <p>On 8/20/15 at 7:13 AM, staff #3 indicated the door alarms were in place for client #1's elopement.</p> <p>On 8/21/15 at 11:42 AM a review of client #1's record was conducted. Client</p>		<p>equipment/ durable medical equipment checklist has been implemented and staff will document daily. · Mel Fields, Director of Industry and Community Services in-serviced QIDPs on daily adaptive equipment/ durable medical equipment checklist on 9/16/15 (attachment BB) · Cheryl Yeager QIDP in-serviced staff on adaptive equipment/ durable medical equipment checklist on 9/25/15 (attachment CC) How will we identify others: · QIDPs and RPM will review client BSPs to ensure that staff have been trained on client BSPs. · QIDPs and RPM will check door and seat alarms in order to ensure all are in working order Measures put in place: · Daily Adaptive equipment/durable medical equipment checklist that will be checked daily · Group Home weekly observation checklist (attachment GG) Monitoring of corrective action: · Mel Fields Director of Industry and Community Services, Pam Pace regional program manager, Lela DeBusk Regional Program Manager, Dundri Osborne Regional Quality Manager or Veronica Anderson Regional Program Manager will perform weekly observation completing Regional Management Staff checklist</p>		

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	<p>#1's Individual Program Plan (IPP), dated 8/18/15, indicated, in part, "24 hour care in a home that has alarms on the doors to prevent elopement... Targeted behaviors include physical aggression, inappropriate toileting (flushing more than three time and attempting to deliberately flush items down the toilet) and elopement. Elopement has not been a problem, but leaving the alarms on the doors was discussed at his IPP meeting and it was decided to leave them on just as another precautionary measure."</p> <p>On 8/21/15 at 11:28 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the door alarms should be turned on at all times when client #1 was in the home.</p> <p>On 8/24/15 at 11:09 AM, the Regional Program Manager (RPM) indicated client #1's plan for door alarms should be implemented as written.</p> <p>2) Observations were conducted at the group home on 8/20/15 from 6:29 AM to 7:43 AM and on 8/20/15 from 3:29 PM to 5:33 PM. On 8/20/15 at 7:03 AM staff #3 indicated client #1 had a bed alarm and seat alarm to alert staff when he got up. At 7:09 AM when client #1 stood up from his dining room chair, the seat alarm did not sound. At 7:14 AM, staff</p>			

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	<p>#3 indicated she turned on client #1's chair alarm.</p> <p>On 8/20/15 at 3:45 PM, staff #2 indicated client #1 had a seat alarm to notify staff when he got up due to falls. Staff #2 indicated client #1 also had a bed alarm. At 5:32 PM when client #1 finished his dinner he stood up. The chair alarm did not sound.</p> <p>On 8/21/15 at 11:42 AM a review of client #1's record was conducted. Client #1's IPP, dated 8/18/15, indicated, in part, "[Client #1] also has a chair alarm and an alarm on his bed to alert staff if he tries to get up." Client #1's Health/Risk Plan for falls, dated 7/2/15, indicated in the Preventative Measures section, "Alarm to bed and chair at all times."</p> <p>On 8/21/15 at 11:28 AM, the QIDP indicated client #1's seat alarm should be on when he was sitting in a chair to alert staff when he stood up.</p> <p>On 8/24/15 at 11:09 AM the RPM indicated client #1's plan for the use of a seat alarm should be implemented as written.</p> <p>On 8/24/15 at 11:53 AM the nurse indicated client #1's plan for the use of a seat alarm should be implemented as</p>			

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	<p>written.</p> <p>3) On 8/20/15 from 6:29 AM to 7:43 AM an observation was conducted at the group home. At 7:21 AM, client #2 went out the back door to smoke. Client #2 was not being supervised while he was outside smoking. Client #2 came in from smoking at 7:29 AM.</p> <p>On 8/21/15 at 11:40 AM a focused review of client #2's record was conducted. Client #2's Behavior Support Program (BSP), dated 2015, indicated, in part, "[Client #2] will smoke in the presence of staff only due to inappropriate disposal of cigarettes. [Client #2] will place hot ashes from an ashtray in the trash."</p> <p>On 8/21/15 at 11:30 AM, the QIDP stated "I'm not sure" when asked if client #2 needed to be supervised while he smoked. The QIDP indicated she had previously asked the Team Lead if client #2 needed supervision and the Team Lead indicated client #2 normally sat in a chair on the deck. The QIDP indicated, after reviewing client #2's BSP, client #2 should smoke in the presence of staff.</p> <p>On 8/24/15 at 11:09 AM the RPM indicated client #2's plan for supervision should be implemented as written. The</p>			

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W 0263 Bldg. 00	<p>RPM indicated client #2 was supposed to be supervised so he did not burn himself and smoke the cigarette butt. The RPM stated client #2 was "supposed to be supervised."</p> <p>On 8/24/15 at 11:53 AM the nurse indicated client #2's plan for supervision while smoking should be implemented as written.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#3), the facility's specially constituted committee (Human Rights Committee - HRC) failed to ensure his restrictive behavior plan was conducted with written informed consent from his guardian.</p> <p>Findings include:</p> <p>On 8/21/15 at 12:30 PM a review of client #3's record was conducted. Client #3's Individual Program Plan (IPP), dated 8/18/15, indicated client #3 had a</p>	W 0263	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> · Client #3's restrictive behavior plan has guardian signature (attachment K) · Guardian phone approval protocol (attachment L)and signature follow-up protocol (attachment M)has been implemented and QIDPs will be in-serviced on it <p>How will we identify others:</p> <ul style="list-style-type: none"> · Regional Management Staff 	09/26/2015	

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	<p>guardian. Client #3's current Behavior Support Program, dated 2014, indicated he was prescribed Naltrexone (for self injurious behavior and autism), Risperidone (for self injurious behavior and autism), and Quetiapine (for autism) as psychotropic medications. Client #3's Human Rights Committee Review form, dated 7/14/15, indicated at the bottom of the page, "Phone approval by guardian 7/11/15 - mailed to guardian to sign." There was no documentation of client #3's record of written informed consent for his restrictive plan.</p> <p>On 8/21/15 at 12:51 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the form was mailed to client #3's guardian to obtain written informed consent. The QIDP indicated the facility had not received the signed form from the guardian.</p> <p>On 8/24/15 at 11:09 AM, the Regional Program Manager (RPM) indicated the facility should have written informed consent from the client's guardian. The RPM stated, "need to plan ahead of time to obtain the signature." The RPM stated the facility needed "better follow up from the Q (QIDP)."</p> <p>9-3-4(a)</p>		<p>will review all restrictive practices to ensure guardian consent</p> <p>Measures put in place:</p> <ul style="list-style-type: none"> · Regional Management review · Phone approval protocol · Guardian approval documentation protocol <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> · Regional Management Staff will perform weekly observation completing Regional Management Staff checklist · Direct Care Management staff will be present in the home daily and perform the active treatment observations for 60 days. · MCC will monitor and perform home record reviews per protocol <p>Competition date:</p> <ul style="list-style-type: none"> · 9/26/15 	

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W 0318 Bldg. 00	<p>483.460 HEALTH CARE SERVICES</p> <p>The facility must ensure that specific health care services requirements are met. Based on observation, record review and interview for 3 of 3 clients in the sample (#1, #3 and #6) and one additional client (#5), the facility failed to meet the Condition of Participation: Health Care Services. The facility's health care services failed to ensure: 1) client #1 had a psychiatric appointment between 9/3/14 to 5/18/15, 2) client #1 had a neurology appointment as recommended, 3) client #3 had a follow-up podiatrist appointment as recommended, 4) client #6 received Cipro for 6 months as ordered (the facility stopped the medication after 5 months), 5) clients #1 and #6 had annual dental appointments, 6) client #1 had an annual evaluation of his vision and hearing, 7) client #5 had a plan to address refusals to eat meals and 8) client #1's risk plan for falls was updated to include the use of a walker.</p> <p>Findings include:</p> <p>1) Please refer to W227. For 1 of 3 non-sampled clients (#5), the facility's health care services failed to address, in a plan, client #5's refusals to eat meals.</p> <p>2) Please refer to W240. For 1 of 3</p>	W 0318	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> · IDT met, revised client #5's HRP to include implement tracking sheet for refusal to eat, weight loss and daily weight monitoring (attachment H) · Cheryl Yeager QIDP, in-serviced staff on client #5 HRP (attachment AA) · High risk plan for client #1 has been revised to include use of walker (attachment I) · Cheryl Yeager QIDP, in-serviced day program and house staff, on client #1's High Risk Plans (Attachment AA) · Missed appointments have been scheduled · Medical appointment tracking form has been implemented (attachment N) · Medication protocol has been implemented (attachment P) · Julie Lawson Medical Care Coordinator has in-serviced health care coordinators on nurse's checklist and annual appointment tracking sheet (attachment DD) · Mel Fields, Director of Industry and Community Services in-serviced QIDPs, RPM, MCC on annual appointment tracking on 9/16/15 (attachment BB) · Julie Lawson Medical Care Coordinator has in-serviced health care coordinators on medical book review checklist(attachment DD) <p>How will we identify others:</p> <ul style="list-style-type: none"> · Health Care Coordinators will review high risk plans to ensure 	09/26/2015			

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	<p>clients in the sample (#1), the facility's health care services failed to ensure client #1's risk plan for falls included the use of a walker.</p> <p>3) Please refer to W323. for 1 of 3 clients in the sample (#1), the facility's health care services failed to ensure client #1's vision and hearing were evaluated annually.</p> <p>4) Please refer to W331. For 3 of 3 clients in the sample (#1, #3 and #6) and one additional client (#5), the facility's health care services failed to ensure: 1) client #1 had a psychiatric appointment between 9/3/14 to 5/18/15, 2) client #1 had a neurology appointment as recommended, 3) client #3 had a follow-up podiatrist appointment as recommended, 4) client #6 received Cipro for 6 months as ordered (the facility stopped the medication after 5 months), 5) clients #1 and #6 had annual dental appointments, 6) client #1 had an annual evaluation of his vision and hearing, 7) client #5 had a plan to address refusals to eat meals and 8) client #1's risk plan for falls was updated to include the use of a walker.</p> <p>5) Please refer to W348. For 2 of 3 clients in the sample (#1 and #6), the facility's health care services failed to</p>		<p>that all adaptive equipment is documented · Health Care Coordinators will review all medical appointments to ensure that all appointments and follow up appointments are scheduled · Health Care Coordinators will review all discontinued medications to ensure compliance with physicians order · Health Care coordinators will review other clients' HRP's and monthly weight records.</p> <p>Measures put in place: · Medical appointment tracking and nurses checklist · Health Care Coordinator medical book review · Medication protocol Monitoring of corrective action: · Mel Fields Director of Industry and Community Services, Pam Pace regional program manager, Lela DeBusk Regional Program Manager, Dundri Osborne Regional Quality Manager or Veronica Anderson Regional Program Manager will perform weekly observation completing Regional Management Staff checklist · Health Care Coordinators will perform Weekly Medical Book Review. · Medical Care Coordinator, Julie Lawson, will monitor and perform record reviews semi-monthly per protocol</p>				

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W 0323 Bldg. 00	<p>ensure the clients had annual dental examinations.</p> <p>9-3-6(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#1), the facility failed to ensure client #1's vision and hearing were evaluated annually.</p> <p>Findings include:</p> <p>On 8/21/15 at 11:42 AM a review of client #1's record was conducted. Client #1's record did not contain documentation of a vision examination. Client #1's most recent hearing examination was conducted on 11/3/14. The Reason for Visit section indicated, "Test hearing - not able because patient could not comprehend instructions." The form was initialed by the nurse and dated 11/12/14. The nurse documented "noted" on the form. There was no documentation of a follow-up hearing examination. Client #1's annual physical, dated 6/29/15, did not include an</p>	W 0323	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> Medical appointment tracking form has been implemented (attachment N) Julie Lawson Medical Care Coordinator has in-serviced health care coordinators on nurse's checklist and annual appointment tracking sheet (attachment DD) Mel Fields, Director of Industry and Community Services in-serviced QIDPs, RPM, MCC on annual appointment tracking on 9/16/15 (attachment BB) Medical book review has been implemented (attachment O) Julie Lawson Medical Care Coordinator has in-serviced health care coordinators (attachment DD) <p>How will we identify others:</p> <ul style="list-style-type: none"> Health Care Coordinators will review all medical appointments and annual exams to ensure that all appointments and annual exams are scheduled <p>Measures put in place:</p> <ul style="list-style-type: none"> Medical annual appointment tracking Medical Book Review <p>Monitoring of</p>	09/26/2015

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W 0331 Bldg. 00	<p>evaluation of client #1's vision and hearing.</p> <p>On 8/24/15 at 11:09 AM the Regional Program Manager (RPM) indicated there should be an annual review of the client's vision and hearing by the primary care physician. The RPM indicated the client's annual physical should include an evaluation of his hearing and vision. The RPM stated, "As an agency we are responsible."</p> <p>On 8/24/15 at 11:53 AM the nurse indicated client #1 had a vision exam scheduled on 4/21/15 but the appointment was missed due to not being on the appointment calendar. The nurse indicated client #1's 2014 vision exam documentation should be in his record for review. The nurse indicated client #1 did not have a hearing follow-up exam.</p> <p>On 8/25/15 at 12:44 PM, the Medical Care Coordinator (MCC) indicated client #1's vision and hearing should be evaluated annually.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p>		<p>corrective action: · Mel Fields Director of Industry and Community Services, Pam Pace regional program manager, Lela DeBusk Regional Program Manager, Dundri Osborne Regional Quality Manager or Veronica Anderson Regional Program Manager will perform weekly observation completing Regional Management Staff checklist · Julie Lawson, Medical Care Coordinator will monitor and perform home record reviews semi-monthly per protocol</p>		

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	<p>Based on observation, record review and interview for 3 of 3 clients in the sample (#1, #3 and #6) and one additional client (#5), the facility's nursing services failed to ensure: 1) client #1 had a psychiatric appointment between 9/3/14 to 5/18/15, 2) client #1 had a neurology appointment as recommended, 3) client #3 had a follow-up podiatrist appointment as recommended, 4) client #6 received Cipro for 6 months as ordered (the facility stopped the medication after 5 months), 5) clients #1 and #6 had annual dental appointments, 6) client #1 had an annual evaluation of his vision and hearing, 7) client #5 had a plan to address refusals to eat meals and 8) client #1's risk plan for falls was updated to include the use of a walker.</p> <p>Findings include:</p> <p>1) On 8/21/15 at 11:42 AM a review of client #1's record was conducted. Client #1's record contained two visits to the psychiatrist dated 9/3/14 and 5/18/15 from 8/19/14 to 8/21/15.</p> <p>On 8/21/15 at 11:56 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #1 should go to the psychiatrist every three months. The QIDP indicated the nurse told her that client #1 had not seen his psychiatrist</p>	W 0331	<p>Corrective actions taken: · Appointment Tracking form has been implemented (Attachment N) · Julie Lawson Medical Care Coordinator has in-serviced health care coordinators on nurse's checklist and appointment tracking sheet (attachment DD) · Medication protocol has been implemented (attachment P) · Julie Lawson Medical Care Coordinator has in-serviced health care coordinators on medication protocol(attachment DD) · Annual exams have been scheduled · IDT met, revised client #5's HRP to include implement tracking sheet for refusal to eat, weight loss and daily weight monitoring (attachment H) · High risk plan for client #1 has been revised to include use of walker (attachment I) · Client #1 HRP revise to include use of walker · Psych appointments have been scheduled · Med book review implemented (Attachment O) · Julie Lawson Medical Care Coordinator has in-serviced health care coordinators medical book reviews(attachment DD)</p> <p>How will we identify others: · HCCS will review all medical appointments to ensure that all appointments and follow up appointments are scheduled · HCCs will review all discontinued medications to ensure compliance with physicians order · HCCs will review HRP's to</p>	09/26/2015			

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	<p>every three months.</p> <p>On 8/24/15 at 11:09 AM, the Regional Program Manager (RPM) indicated he was not aware client #1 did not see his psychiatrist for 8 months. The RPM stated it was an "oversight" by the QIDP and the nurse. The RPM indicated they should review the documentation to see when the next appointment was due.</p> <p>On 8/24/15 at 11:53 AM, the nurse indicated client #1 had an appointment scheduled on 11/25/14 but he was in the hospital at the time. The nurse indicated client #1 had an appointment scheduled on 2/18/15 but the appointment was canceled due to bad weather. The nurse indicated client #1 had an appointment scheduled on 8/11/15 but the appointment was rescheduled. The nurse indicated the record needed to contain documentation of missed, canceled and rescheduled appointments.</p> <p>On 8/25/15 at 12:44 PM, the Medical Care Coordinator (MCC) indicated client #1 should have had a psychiatric visit every 3-6 months. The MCC stated it was "hard to understand" why client #1 went 8 months with no appointment. The MCC indicated client #1 was prescribed psychiatric medications and needed to be seen by the psychiatrist.</p>		<p>ensure all adaptive equipment is documented · HCC will review group home medical documentation and weekly weight trends for refusals to eat</p> <p>Measures put in place · Medical appointment tracking sheet · HCC medical book review · Medication protocol · Refusal to eat tracking</p> <p>Monitoring of corrective action: · Mel Fields Director of Industry and Community Services, Pam Pace regional program manager, Lela DeBusk Regional Program Manager, Dundri Osborne Regional Quality Manager or Veronica Anderson Regional Program Manager will perform weekly observation completing Regional Management Staff checklist · Julie Lawson, MCC will monitor and perform home record reviews semi-monthly per protocol</p>				

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	<p>2) On 8/21/15 at 11:42 AM a review of client #1's record was conducted. Client #1's record indicated he had a neurology appointment on 5/5/14. The appointment form indicated a follow-up visit was scheduled on 11/10/14 at 2:45 PM. The form indicated client #1 was to have a follow-up appointment in 6 months. There was no documentation in client #1's record of a follow-up neurology appointment on 11/10/14.</p> <p>On 8/25/15 at 11:49 AM the RPM sent the following documentation for review by email from the nurse, "Called neurology on [client #1's] appts (appointments). He had one on 5/5/14, suppose (sic) to have one 11/10/14 and it was canceled & (and) do not know why. Called the doctor's office & they have no reason. Does not have another appt until 10/5/15 @ (at) 11:45. That is the soonest we could get him in. This appt was made 2 weeks ago."</p> <p>On 8/21/15 at 12:06 PM, the QIDP indicated the appointment should have been held as scheduled. The QIDP indicated she was aware of the issue after reviewing client #1 records with the nurse recently.</p> <p>On 8/24/15 at 11:09 AM, the RPM</p>			

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	<p>indicated the appointment should have been held as scheduled and the documentation in the group home for review. The RPM indicated the facility needed to find out if the appointment was held and if not, schedule another appointment immediately.</p> <p>On 8/24/15 at 11:53 AM, the nurse indicated client #1 was supposed to have an appointment on 11/10/14 but she was unable to locate the documentation. The nurse indicated she was not sure if the appointment was held or not. The nurse indicated the appointment should have been held as scheduled.</p> <p>On 8/25/15 at 12:44 PM, the MCC indicated client #1 was supposed to have an appointment with the neurologist in November 2014 but the appointment was canceled. The MCC indicated client #1 should have had a follow-up appointment as recommended. The MCC indicated she needed to find out why the appointment was canceled. The MCC indicated the facility should not cancel neurology appointments since they were hard to get scheduled.</p> <p>3) On 8/21/15 at 12:30 PM a review of client #3's record was conducted. On 12/30/14 client #3 had an appointment with the podiatrist. The Reason for Visit</p>			

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	<p>indicated, "Long thick nails x (times) 10." The appointment form indicated there was a follow-up visit scheduled on 3/3/15 at 10:00 AM. The form indicated, "RTC (return to clinic) 9 W (weeks)." There was no documentation of an appointment on 3/3/15 in client #3's record.</p> <p>On 8/24/15 at 11:09 AM, the RPM indicated client #3's appointment should have been held as scheduled.</p> <p>On 8/24/15 at 11:53 AM, the nurse indicated client #3 had a follow-up appointment scheduled on 3/3/15 but she had not seen the documentation. The nurse indicated the last time client #3 went to the podiatrist the podiatrist's staff told the group home staff that client #3's insurance would not cover his visits. The nurse indicated the podiatrist refused to see client #3 due to client #3's insurance not paying. The nurse indicated the facility should cover the cost of the care and client #3 should have been seen on 3/3/15.</p> <p>On 8/25/15 at 12:44 PM, the MCC indicated client #3 had an appointment on 12/30/14 and a follow-up appointment scheduled on 3/3/15. The 3/3/15 appointment was not held due to insurance not covering the cost. The</p>			

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	<p>MCC indicated the facility should have paid for the appointment if client #3's insurance did not cover it. The MCC indicated the QIDP should have looked into the situation and convened the interdisciplinary team to figure out what to do since the insurance was not paying.</p> <p>4) On 8/21/15 at 1:14 PM a review of client #6's record was conducted. On 1/27/15, client #6 received an order for Cipro for a prostate infection to be given for 6 months. Client #6's January 2015 Medication Administration Record (MAR) indicated the facility started the medication on January 28, 2015. Client #6's MAR for June 2015 indicated the facility stopped the medication on 6/28/15. Client #6's July MAR indicated, "ASD (automatic stop date) (after) 6 months." Client #6's Cipro was not administered from June 29, 2015 to July 28, 2015 as ordered.</p> <p>On 8/21/15 at 11:18 AM, the QIDP indicated the facility stopped the order a month too soon.</p> <p>On 8/24/15 at 11:09 AM, the RPM indicated client #6 should have received his medication as ordered. The RPM indicated if there was a reason the medication was stopped earlier than prescribed there should be documentation</p>			

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	<p>in his record to account for the facility stopping the medication. The RPM indicated the medication error should have been caught by the QIDP or the nurse.</p> <p>On 8/24/15 at 11:53 AM, the nurse indicated the medication should have been administered as ordered. The nurse indicated the medication should have been given for 6 months. The nurse stated, "that may be my fault." The nurse indicated she stopped the medication early. The nurse indicated 6 months would have been 7/28/15 and not 6/28/15.</p> <p>On 8/25/15 at 12:44 PM, the MCC indicated the nurse stopped the order early due to counting wrong from the start date to the end date. The MCC indicated the Team Lead should have caught the error as well. The MCC indicated the medication was not administered for the prescribed time. The MCC indicated since the medication was ordered for 6 months, the group home would have continued to receive the medication. The staff at the group home should have questioned why the medication was still being delivered. The MCC indicated the nurse told her it was the nurse's fault for transcribing and stopping the medication early. The MCC</p>			

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	<p>indicated it was a medication error.</p> <p>5) On 8/21/15 at 11:42 AM a review of client #1's record was conducted. Client #1's most recent dental examination was conducted on 1/16/14. The form indicated the Reason for Visit was "Annual check-up." There was no documentation in client #1's record he had a dental exam since 1/16/14.</p> <p>On 8/21/15 at 1:14 PM a review of client #6's record was conducted. Client #6's most recent dental examination was conducted on 7/19/14. There was no documentation in client #6's record he had an annual dental appointment since 7/19/14.</p> <p>On 8/21/15 at 1:21 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the clients should have annual dental exams.</p> <p>On 8/24/15 at 11:09 AM the Regional Program Manager (RPM) indicated the clients should have at least an annual dental exam.</p> <p>On 8/24/15 at 11:53 AM, the nurse indicated the clients should have an annual dental exam. The nurse indicated clients #1 and #6 had dental appointments on 8/6/15. The nurse stated</p>			

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	<p>the documentation from the appointment "may be in my box."</p> <p>On 8/25/15 at 12:44 PM, the MCC indicated the clients should have dental appointments at least annually.</p> <p>6) On 8/21/15 at 11:42 AM a review of client #1's record was conducted. Client #1's record did not contain documentation of a vision examination. Client #1's most recent hearing examination was conducted on 11/3/14. The Reason for Visit section indicated, "Test hearing - not able because patient could not comprehend instructions." The form was initialed by the nurse and dated 11/12/14. The nurse documented "noted" on the form. There was no documentation of a follow-up hearing examination. Client #1's annual physical, dated 6/29/15, did not include an evaluation of client #1's vision and hearing.</p> <p>On 8/24/15 at 11:09 AM the RPM indicated there should be an annual review of the client's vision and hearing by the primary care physician. The RPM indicated the client's annual physical should include an evaluation of his hearing and vision. The RPM stated, "As an agency we are responsible."</p>			

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	<p>On 8/24/15 at 11:53 AM the nurse indicated client #1 had a vision exam scheduled on 4/21/15 but the appointment was missed due to not being on the appointment calendar. The nurse indicated client #1's 2014 vision exam documentation should be in his record for review. The nurse indicated client #1 did not have a hearing follow-up exam.</p> <p>On 8/25/15 at 12:44 PM, the MCC indicated client #1's vision and hearing should be evaluated annually.</p> <p>7) On 8/20/15 from 3:29 PM to 5:33 PM an observation was conducted at the group home. At 4:53 PM when client #5 was asked to wash his hands for dinner, client #5 told staff #3 he did not want to eat. Dinner started at 4:59 PM and client #5 did not eat. At 5:13 PM the Team Lead asked client #5 if he wanted something else to eat during dinner. Client #5 stated, "I'm good."</p> <p>On 8/20/15 at 4:53 PM staff #3 stated client #5 refused to eat "at times."</p> <p>On 8/21/15 at 11:32 AM a focused review of client #5's record was conducted. Client #5's August 2015 Behavior Support Program did not address refusals to eat. Client #5's 8/18/15 Individual Program Plan (IPP)</p>						

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	<p>did not address refusals to eat. Client #5's IPP indicated, in part, "[Client #5's] weight is monitored closely, as he had been significantly underweight prior to moving into the group home, and he must eat 3 meals a day (low-cholesterol diet)." The IPP indicated, "[Client #5] follows a low-cholesterol diet. Weight loss is monitored closely and is reported to his physician. [Client #5] should eat 3 meals daily at consistent times." There was no documentation of a plan to address client #5's refusals to eat.</p> <p>On 8/21/15 at 11:31 AM, the QIDP stated client #5 refused to eat "sometimes" when he was upset. The QIDP indicated client #5 needed a plan for staff to implement when client #5 refused to eat.</p> <p>On 8/24/15 at 11:09 AM the RPM indicated he was not aware of client #5's refusals to eat. The RPM indicated if the staff said he was refusing to eat, at times, then client #5 needed a plan to address refusals to eat.</p> <p>On 8/24/15 at 11:53 AM the nurse indicated she was not aware client #5 was refusing to eat meals at times. The nurse indicated client #5 had an as needed (PRN) order for Carnation Instant Breakfast (CIB) but the order may need to be a routine order. The nurse indicated</p>			

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	<p>client #5 had lost 6 pounds since January 2015. The nurse indicated she instructed the group home staff to get a routine CIB order. The nurse indicated client #5 needed a plan to address refusals to eat.</p> <p>On 8/25/15 at 12:44 PM, the MCC indicated client #5 needed a plan to address refusals to eat.</p> <p>8) Observations were conducted at the group home on 8/20/15 from 6:29 AM to 7:43 AM and 8/20/15 from 3:29 PM to 5:33 PM. During the observations at the group home, client #1 had a walker. When client #1 stood up to ambulate, staff prompted client #1 to use his walker.</p> <p>On 8/21/15 at 11:42 AM a review of client #1's record was conducted. Client #1's Health/Risk Plan for falls, dated 7/2/15, indicated, in part, "Client wants to remain independent, but has poor safety awareness. Unsteady gait when walking by himself." The plan indicated staff would, "Assist with walking using gait belt and one assist. One assist with a [brand name] gait belt at all times when up. Limit w/c (wheelchair) use only when needed: when too tired to walk, too painful, when not cooperating." There was no documentation in the plan addressing the use of a walker. The plan</p>				

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	<p>did not indicate client #1 had a walker.</p> <p>Client #1's 8/18/15 IPP indicated, in part, "[Client #1] is not able to do many of the household tasks he used to due to his risk for falls and staff needing to be with him. However, with staff by his side with his gait belt he can still be assisted to do such tasks as wiping off the table or taking his dishes to the sink by placing them on his walker. He can still participate in the household chore chart by performing tasks with staff assistance for safety... He started receiving Physical Therapy at home two times a week back in May. He now has a gait belt and rolling walker. He is to have the gait belt on whenever he is up and staff are to walk with him and hold onto it. He loves using his walker... [Client #1] fell and broke his leg in December 04. Since then he has had an uneven gait as he has one leg longer than the other. [Client #1] has therapeutic shoes with a built up sole for his left leg. [Client #1] uses a gait belt and rolling walker for safety. Staff must be with him when he is up and holding onto his gait belt if he is walking. [Client #1] loves his new walker. Despite his uneven gait he is still very quick on his feet when he wants to be... He has to have his gait belt and rolling walker."</p> <p>On 8/25/15 at 11:48 AM, the QIDP</p>			

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	<p>indicated client #1 was to use his walker at all times. The QIDP indicated client #1's risk plan should include the use of the walker. The QIDP indicated the plan in client #1's record was dated 7/2/15. On 8/25/15 at 11:55 AM, the QIDP stated "not yet" when asked if the use of the walker was added to his risk plan for falls.</p> <p>On 8/25/15 at 12:44 PM, the MCC indicated the use of a walker should be part of client #1's risk plan for falls.</p> <p>On 8/24/15 at 11:53 AM, the nurse indicated some of the clients' appointments were not written on the appointment calendar so the appointments were missed. The nurse indicated the staff who took the clients to their appointments should write in the next appointment on the calendar. The nurse indicated some appointments were missed due to bad weather. The nurse indicated some appointments were missed due to not having staff available to take the clients to their appointments. The nurse indicated the facility needed to ensure the clients' appointments were not missed due to scheduling errors and not having staff available.</p> <p>On 8/25/15 at 12:44 PM, the MCC indicated the clients' medical</p>			

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W 0348 Bldg. 00	<p>appointment documentation should be placed in the clients' records immediately. The MCC stated the issues at the group home were due to a "lack of supervision for a long time at the Team Lead and QIDP levels." The MCC indicated there was a lack of a team approach at the home. The MCC indicated there was a lack of communication at the home. The MCC indicated the staff needed to document and communicate to the nurse when appointments were scheduled.</p> <p>9-3-6(a)</p> <p>483.460(e)(1) DENTAL SERVICES</p> <p>The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement.</p> <p>Based on record review and interview for 2 of 3 clients in the sample (#1 and #6), the facility failed to ensure the clients had annual dental examinations.</p> <p>Findings include:</p> <p>On 8/21/15 at 11:42 AM a review of client #1's record was conducted. Client #1's most recent dental examination was</p>	W 0348	<p>Corrective actions taken: · Medical appointment tracking form has been implemented (attachment N) · Medical book review has been implemented including Annual Exams and Dental exams (attachment O) · Julie Lawson Medical Care Coordinator has in-serviced health care coordinators on appointment tracking sheet and Medical Book Review(</p>	09/26/2015

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	<p>conducted on 1/16/14. The form indicated the Reason for Visit was "Annual check-up." There was no documentation in client #1's record he had a dental exam since 1/16/14.</p> <p>On 8/21/15 at 1:14 PM a review of client #6's record was conducted. Client #6's most recent dental examination was conducted on 7/19/14. There was no documentation in client #6's record he had an annual dental appointment since 7/19/14.</p> <p>On 8/21/15 at 1:21 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the clients should have annual dental exams.</p> <p>On 8/24/15 at 11:09 AM the Regional Program Manager (RPM) indicated the clients should have at least an annual dental exam.</p> <p>On 8/24/15 at 11:53 AM, the nurse indicated the clients should have an annual dental exam. The nurse indicated clients #1 and #6 had dental appointments on 8/6/15. The nurse stated the documentation from the appointment "may be in my box."</p> <p>9-3-6(a)</p>		<p>attachment DD) How will we identify others: · HCCs will review dental appointments to ensure that they have been scheduled Measures put in place: · Medical appointment tracking · Medical Book Review Monitoring of corrective action: · Julie Lawson, MCC , will monitor and perform home record reviews per protocol on a semi-monthly basis · Mel Fields Director of Industry and Community Services, Pam Pace regional program manager, Lela DeBusk Regional Program Manager, Dundri Osborne Regional Quality Manager or Veronica Anderson Regional Program Manager will perform weekly observation completing Regional Management Staff checklist</p>	

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W 0440 Bldg. 00	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure quarterly evacuation drills for each shift of personnel were conducted.</p> <p>Findings include:</p> <p>On 8/20/15 at 3:36 PM a review of the facility's evacuation drills was conducted. From 8/20/14 to 8/20/15, the facility conducted two evacuation drills (one on 8/15/15 at 1:33 PM and one on 3/10/15 at 11:37 PM). The facility did not conduct quarterly evacuation drills for each shift of personnel from 8/20/14 to 8/20/15. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 8/20/15 at 3:37 PM the Qualified Intellectual Disabilities Professional (QIDP) indicated she was unable to locate any additional evacuation drill documentation for the past year. The QIDP indicated the facility should conduct one drill per shift per quarter.</p> <p>On 8/20/15 at 3:38 PM the Team Lead (TL) stated, "Know we conducted drills</p>	W 0440	<p>Corrective actions taken: · Emergency Drill Protocol has been implemented (attachment HH) · Mel Fields, Director of Industry and Community Services in-serviced QIDPs and RPM on emergency drills on 9/16/15 (attachment BB) · Cheryl Yeager QIDP in-serviced house staff on drill protocol 9/25/15 (attachment CC) How will we identify others: · John Kirk, Agency Safety Coordinator, will review drills to ensure that they are completed per agency policy</p> <p>Measures put in place: · Emergency Drill protocol · John Kirk Agency safety Coordinator will review drills on a monthly basis to ensure compliance</p> <p>Monitoring of corrective action: · John Kirk, agency safety coordinator, will review drills monthly to ensure compliance</p>	09/26/2015

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W 9999 Bldg. 00	<p>during the past year." The TL indicated she submitted the drill forms to the office.</p> <p>On 8/24/15 at 11:09 AM the Regional Program Manager (RPM) indicated the group home had a drill schedule to inform the staff when to conduct evacuation drills. The RPM indicated the QIDP was supposed to follow up and turn the drills in to the RPM. The RPM stated, "Obviously was not done." The RPM stated the group home staff "claimed" they turned in the originals to the office but the originals were to be kept in the home and copies submitted to the office. The RPM indicated the two drills reviewed were the only drills he could locate. The RPM indicated the facility should conduct one drill per shift per quarter.</p> <p>9-3-7(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met:</p>	W 9999	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> Staff has received TB test and will attach document (attachment R) <p>How will we identify others:</p>	09/26/2015			

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	<p>460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 employee (staff #4) files reviewed, the facility failed to ensure an annual Mantoux (5TU, PPD) tuberculosis (TB) screening was conducted.</p> <p>Findings include:</p> <p>On 8/19/15 at 10:39 AM a review of the facility's employee files was conducted.</p>		<ul style="list-style-type: none"> · HR will review employee files for TB test compliance <p>Measures put in place:</p> <ul style="list-style-type: none"> · Regional Management review <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> · RPM will review TB tests monthly to ensure compliance <p>Completion date:</p> <ul style="list-style-type: none"> · 9/26/15 		

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	<p>Staff #4's employee file indicated her most recent Mantoux was completed on 2/18/14. There was no documentation in staff #4's employee file indicating she had a Mantoux completed since 2/18/14.</p> <p>On 8/19/15 at 10:43 AM, the Director of Family Services indicated the staff should have an annual TB test.</p> <p>On 8/20/15 at 3:43 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the staff should have an annual TB test.</p> <p>On 8/24/15 at 11:09 AM, the Regional Program Manager indicated the staff should have an annual TB test.</p> <p>9-3-3(e)</p>			