

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/17/2012
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330
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W0000	<p>This visit was for a post-certification revisit survey (PCR) to the initial certification and state licensure survey completed on 11/21/11.</p> <p>This visit was in conjunction with the investigation of complaint #IN00101513.</p> <p>Dates of Survey: 1/9, 1/10, 1/11 and 1/17/12</p> <p>Facility Number: 0012633 Provider Number: 15G805 Aim Number: N/A</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/23/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
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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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W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the governing body failed to ensure the common living areas of the group home were decorated to give a home like appearance to enhance the quality of life of the clients.</p> <p>Findings include:</p> <p>During the 1/9/12 observation period between 4:35 PM and 6:45 PM and the 1/10/12 observation period between 6:40 AM and 8:00 AM, at the group home, the living rooms, the dining room and the bathrooms were devoid of home like decorations. The 2 living rooms in the group home contained a couch, love seat, a TV behind an enclosed case and a chair. The living rooms were devoid of any other decorations. The windows in the living room and/or dining rooms were frosted from the middle of the window down to the window sill leaving the top of the window exposed. The dining room consisted of a dining room table with chairs, two crayon pictures of trees taped to a wall and a fire exit drawing paper which was taped to a wall. The dining room was devoid of any additional</p>	W0104	<p>CORRECTION: <i>The Governing body must exercise general policy, budget and operating direction over the facility.</i></p> <p>Specifically, the facility has purchased decorative items for the common areas of the home, to replace those that were destroyed during episodes of challenging behavior. The Director Supervised Group Living performed a visual observation of the facility on 1/27/12 and confirmed the presence of the replaced decorative items.</p> <p>PREVENTION: The Program Coordinator/QDDP received additional training on the need to provide a culturally appropriate living environment with decorations on 1/19/12. Emphasis was placed on the fact that the governing body has provided sufficient resources for the facility to replace broken items as needed. Additionally, members of the Operations Team will continue to conduct periodic observations of the facility on an ongoing basis to assure the home is decorated and age appropriate instructional items are available, making recommendations and expediting replacements as needed. Responsible Parties:QDDP, Support Associates, Operations Team</p>	02/16/2012			

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	<p>decorations to enhance client A, B, C and D's home/quality of life. The 2 bathrooms were devoid of any decorations.</p> <p>Confidential staff interview A stated the group home "looked like an institution." Confidential interview A stated the group home did not have decorations as the clients were "destructive." Confidential interview A indicated clients had destroyed a crock pot, coffee pot and would tear down items off the walls.</p> <p>Interview with staff #5 on 1/10/12 at 8:00 AM indicated the group home had Christmas decorations up and the clients tore down the decorations when having behaviors.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on 1/10/12 at 12:16 PM indicated he had purchased decorations for the group home in the past but clients B and C tore them down when having behaviors. The QMRP indicated the clients destroyed 2 crock pots and a coffee maker. The QMRP indicated he was waiting for the facility's maintenance man to come and put items up to prevent the clients from removing/destroying them. The QMRP stated some group home clients came to the group home without personal</p>						

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	<p>belongings like clothes and he was "Trying to get personal items they need." The QMRP stated "The budget would not allow" him to keep purchasing decorations.</p> <p>Interview with administrative staff #2 on 1/11/12 at 9:55 AM indicated the group home should have decorations in the common areas of the group home. Administrative staff #2 indicated the facility could purchase items which the clients could not destroy and/or have maintenance put items up in a manner so the clients could not destroy them.</p> <p>This deficiency was cited on 11/21/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>				

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W0125	<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, interview and record review for 2 of 2 sampled clients (A and B), the facility failed to ensure the clients had access to the remote to the TV and butter knives.</p> <p>Findings include:</p> <p>During the 1/10/12 observation period between 4:35 PM and 6:45 PM, at the group home, client A set the dining room table for supper. Client A placed forks and spoons on the table but did not place any butter knives on the table. At 5:15 PM, staff #7 retrieved 2 butter knives from a cabinet under the sink which had a key lock. Staff #7 placed a butter knife at staff #4's place setting and gave staff #8 a butter knife to cut up client C's hamburger. The staff did not offer the other clients a butter knife to use to place/spread mayonnaise on their bread/hamburger. During the 1/10/12 observation period between 6:40 AM and 8:00 AM at the group home, no butter knives were found in the silverware drawer of the group home. Interview with staff #3 on 1/10/12 at 7:55 AM indicated the butter knives were kept in the</p>	W0125	<p>CORRECTION: <i>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Specifically, access to the facility's butter knives and television remote control is no longer restricted. The Director Supervised Group Living performed a visual observation of the facility on 1/27/12 and confirmed the items were no longer secured.</i></p> <p>PREVENTION: The Program Coordinator/QDDP received additional retraining regarding the need to assure that rights restrictions are implemented only when clinically indicated and after appropriate due process has occurred on 1/19/12. Specific training included the need for documented assessment and interdisciplinary team discussion regarding the need for restrictions as well as the process for obtaining human rights committee approval for any rights restrictions the team determines are necessary to protect the health and safety of clients. Members of the Operations Team will conduct</p>	02/16/2012			

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	<p>silverware drawer. When staff #3 checked the silverware drawer, the staff indicated no butter knives were in the drawer. When asked why there were no butter knives in the silverware drawer, staff #3 stated "Only two are kept out, must be in the dishwasher."</p> <p>During the 1/10/12 observation period between 6:40 AM and 8:00 AM, at the group home at 6:50 AM, staff #3 retrieved the TV remote from the locked staff's office to turn the TV to a different channel for client B. Staff #3 did not allow client B to change the channel himself. Staff #5 who was in the dining room with client C, who was having a behavior, told staff #3 the remote should be in the living room. At 7:10 AM, staff #3 took the remote to the staff's office and locked the office door upon leaving.</p> <p>Client A's record was reviewed on 1/10/12 at 11:17 AM. Client A's 11/4/11 Individual Support Plan (ISP) and/or 12/27/11 Behavior Support Plan (BSP) did not indicate the client had been assessed for the need to lock the remote. Client A's 11/4/11 ISP and/or 12/27/11 BSP also did not indicate the butter knives needed to be locked and/or indicate the client should not have access to butter knives. The client's 11/4/11 ISP and/or 12/27/11 BSP did not indicate the</p>		<p>periodic observations of the home's physical environment to assure that clients' access to their home and its contents is not restricted unnecessarily. Responsible Parties:QDDP, Support Associates, Operations Team</p>				

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	<p>facility's Human Rights Committee had reviewed and/or approved the restrictions.</p> <p>Client B's record was reviewed on 1/10/12 at 9:40 AM. Client B's 10/25/11 ISP and/or 12/20/11 BSP did not indicate the client had been assessed for the need to lock the remote. Client B's 10/25/11 ISP and/or 12/20/11 BSP also did not indicate butter knives needed to be locked and/or indicate the client should not have access to butter knives. The client's 10/25/11 ISP and/or 12/20/11 BSP did not indicate the facility's Human Rights Committee had reviewed and/or approved the rights restrictions.</p> <p>Interview with staff #5 on 1/10/12 at 8:00 AM indicated the TV remote was kept in the office due to client B. Staff #5 indicated client B had destroyed 2 remotes. Staff #5 indicated the remote would be kept out but put up when clients started having a behavior. Staff #5 indicated clients A, B, C and D did not have access to the office as it was kept locked.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on 1/10/12 at 12:16 PM stated the remote was kept in the group home's office as the clients had "destroyed and uses as weapon." The QMRP indicated client B</p>			
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	<p>had destroyed previous remotes and would throw them at staff. The QMRP indicated there had been an incident with client B regarding a butter knife with staff in 12/11. The QMRP indicated client A and B's BSPs did not indicate the TV remote and/or butter knives should be locked.</p> <p>Interview with administrative staff #2 on 1/11/12 at 9:55 AM indicated the TV remote and butter knives should not be locked at the group home.</p> <p>This deficiency was cited on 11/21/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>			
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W0137	<p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, interview and record review for 1 of 2 sampled clients (A) and for 1 additional client (D), the facility failed to ensure each client had a right to retain/decorate their bedrooms with personal objects.</p> <p>Findings include:</p> <p>During the 1/9/12 observation period between 4:35 PM and 6:45 PM, at the group home, client A had a single bedroom. Client A had Christmas decorations sitting on the window sill with no other decorations in his room. Client A's bedroom contained 2 windows which were frosted from the middle of the window down to the window sill. Client A did not have curtains up at his window. Client D's bedroom was devoid of decorations and/or personal items posted on the wall of the single bedroom. Client D had a bed, chair and a dresser in his bedroom.</p> <p>Interview with client A on 1/9/12 at 5:30 PM indicated he wanted to put curtains up at his windows. Client A stated he wanted the "short curtains" (Valence) to cover the top part of his windows. Client</p>	W0137	<p>CORRECTION: The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Specifically, staff will assist clients A and D with obtaining personal possessions and personalized decorations for their bedrooms based on client preference and durability during episodes of destructive behavior. PREVENTION: The Program Coordinator/QDDP received additional retraining regarding the need to monitor client's possessions to assure clients have appropriate items beyond clothing based on personal choice and need on 1/19/12. The training focused on the need to develop creative strategies to provide training safe environment that allows for client preference and personalized belongings and decorations in bedrooms and private areas of the home. Members of the Operations Team will conduct periodic observations of active treatment sessions on an ongoing basis to assure clients maintain appropriate personal possessions. Responsible Parties: QDDP, Support Associates, Operations Team</p>	02/16/2012			

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	<p>A indicated he had told the Qualified Mental Retardation Professional (QMRP) of his request. Client A stated he wanted to put up posters on his wall as the walls were "bare." Client A indicated they were not allowed to use nails to hang anything up on the walls. Client A stated he wanted to "string beads" along the top of the walls in his room.</p> <p>Interview with staff #4 on 1/9/12 at 6:25 PM indicated client D did not sleep in his bedroom as the client slept on the living room couch. Staff #4 stated "May help [client D] sleep in his room if personable." Staff #4 indicated clients' bedrooms were not decorated due to the clients in the group home demonstrating behaviors of property destruction.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on 1/10/12 at 12:16 PM indicated clients did not have curtains in their bedrooms and/or decorations due to destruction of property with the clients. The QMRP indicated he was aware client A wanted curtains for his window. The QMRP indicated clients A and D did not demonstrate property destruction of their bedrooms. The QMRP indicated he and/or the facility staff had not had time to take client A out to purchase items for his bedroom.</p>						

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	<p>Interview with administrative staff #2 on 1/11/12 at 9:55 AM indicated clients A and D should be allowed to have personal items/decorations in their bedrooms. Administrative staff #2 indicated client A could have curtains in his bedroom. Administrative staff #2 stated the curtains could be hung with "velcro." Administrative staff #2 also indicated the maintenance staff could put items up in a way where clients could not destroy them.</p> <p>Client A's record was reviewed on 1/10/12 at 11:17 AM. Client A's 11/4/11 Individual Support plan (ISP) and/or 12/27/11 Behavior Support Plan (BSP) did not indicate client A should be restricted from having personal items/belongings/decorations in his bedroom.</p> <p>This deficiency was cited on 11/21/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				

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W0149	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review for 2 of 2 sampled clients (A and B) and for 2 additional clients (C and D), the facility failed to implement its policy and procedures to report all allegations of abuse/neglect to its administrator immediately and to conduct thorough investigations in regard to an elopement incident and client to client aggression.</p> <p>Findings include:</p> <p>The facility's policy and procedures were reviewed on 1/10/12 at 8:36 AM. The facility's 12/7/10 policy and procedures entitled Abuse, Neglect, Exploitation, Mistreatment indicated "...3. Any Adept staff who suspects an individual is the victim of abuse, neglect, mistreatment, or exploitation should immediately notify this suspicion to their Program Coordinator (PC). The PC will then notify the Operations Manager, Licensing and Compliance Coordinator and Director of Operations who will then begin the investigation process. The Executive Director (administrator) and Regional Director will also be notified...." The 12/7/10 policy indicated "...A full investigation will be conducted by ADEPT personnel for incidents occurring</p>	W0149	<p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, abuse or neglect of the client.</i> Specifically, the facility has retrained all direct support staff regarding the need to report all allegations of abuse, neglect, mistreatment and exploitation immediately to their direct supervisor and to continue reporting, following the chain of command until the situation is addressed. Additionally, the facility has completed investigations on all past episodes of client to client aggression and an elopement incident on 12/19/11 that resulted in Client A being tased by the police. PREVENTION: The Program Coordinator/QDDP was retrained regarding agency investigation procedures, with emphasis immediate reporting and timely completion on 1/19/12. Retraining focused on the need for the facility's team to report and complete all investigations into elopement, injuries of unknown origin and client to client aggression. Additionally, training stressed the importance of prioritizing facility support tasks to assure that alleged violations are investigated without delay. The Operations Team will monitor compliance with investigation reporting and completion</p>	02/16/2012	

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	<p>residentially (client to client)...." The facility's 12/7/10 policy and procedures defined physical abuse as "the act or failure to act that results or could result in physical injury to an individual. Non-accidental injury inflicted by another person or persons...." The policy defined intimidation/emotional abuse as "...the act or failure to act that results or could result in emotional injury to an individual. The act of insulting or coarse language or gestures directed toward an individual that subject him/her to humiliation or degradation...." The facility's 12/7/10 policy defined "Emotional/physical neglect" as "...failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being...and to provide a safe environment...."</p> <p>The facility failed to ensure staff reported all allegations of abuse and/or neglect immediately to the administrator for clients B and C. Please see W153.</p> <p>The facility failed to thoroughly investigate all client to client abuse/aggression and an incident involving an elopement which resulted in a client being tased by police for clients A, B, C and D. Please see W154.</p>		<p>timelines and coordinate corrective measures as needed. RESPONSIBLE PARTIES: QDDP, Support Associates, Operations Team</p>				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/17/2012
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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	
W0153	<p>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.</p> <p>Based on interview and record review for 5 of 15 allegations of abuse and/or neglect reviewed, the facility failed to ensure staff immediately reported allegations of abuse and/or neglect to the administrator immediately for clients B and C.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 1/10/12 at 8:54 AM and on 1/11/12 at 9:48 AM. The facility's 12/25/11 reportable incident report indicated "A co-worker reported seeing staff [staff #6] slap [client C] in (sic) the hand twice and hit him in the head with a pillow in response to an episode of physical aggression."</p> <p>The facility's undated Investigation Summary indicated the facility staff did not immediately report the allegation of abuse to their supervisor and/or the administrator immediately as the staff reported the incident the next day on 12/26/11. The facility's undated investigation indicated staffs' witness statements indicated staff #6 had cut the</p>	W0153	<p>CORRECTION: <i>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.</i> Specifically, the facility has retrained all direct support staff regarding the need to report all allegations of abuse, neglect, mistreatment and exploitation immediately to their direct supervisor and to continue reporting, following the chain of command until the situation is addressed. PREVENTION: The Program Coordinator/QDDP was retrained regarding agency investigation procedures, with emphasis immediate reporting on 1/19/12. The PC/QDDP will incorporate agency reporting procedures into monthly staff inservice training to assure staff are aware of their responsibility for reporting allegations of abuse, neglect, mistreatment and exploitation. Staff who do not follow agency and state reporting guidelines will be subject to performance action up to and including termination of employment. Responsible Parties:QDDP, Support</p>	02/16/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/17/2012	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330			
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	<p>ends of client C's jump rope off to prevent the client from hitting her with them on 12/23/11, the staffs' witness statements indicated staff #6 had "forced" client C down to the ground in the past when restraining, and was "poking him (client B) in the stomach..., [staff #6] was also sitting in the med room and banging on the med room window at [client B] and then made faces at him which made him angry..." in the past. The undated investigation summary indicated staffs' witness statements indicated staff #6 had turned the TV off on clients in the past and removed/took client C's pop away from him when he made a mess. The facility's undated investigation summary did not indicate the above mentioned allegations had been immediately reported to the administrator.</p> <p>Interview with administrative staff #2 on 1/11/12 at 9:55 AM indicated facility staff should report all allegations of abuse and/or neglect to the administrator immediately.</p> <p>9-3-2(a)</p>		Associates, Health Services Team, Operations Team				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/17/2012	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330			
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W0154	<p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 10 of 11 allegations of abuse and/or neglect reviewed for clients A, B, C and D, the facility failed to conduct client to client investigations and/or to document an investigation in regard to an elopement incident where a client got tased by police.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The facility's reportable incident reports and/or investigations were reviewed on 1/10/12 at 8:54 AM and on 1/11/12 at 9:48 AM. The facility's 12/19/11 reportable incident report indicated "[Client A] was eating breakfast when a housemate became agitated and began throwing his shoes. Staff attempted to redirect [client A] to the kitchen to provide for his safety and he became combative and threw his plate (sic) Staff used You're Safe, I'm Safe (YSIS) personal safety techniques (physical restraints) per his Behavior Support Plan but [client A] remained upset and ran out of the home's unlocked front door. Staff followed him and attempted to convince him to return to the house as he approached [name of highway]. With staff accompanying him, 			W0154	<p>CORRECTION: <i>The facility must have evidence that all alleged violations are thoroughly investigated.</i> Specifically, the facility has completed investigations on all past episodes of client to client aggression and an elopement incident on 12/19/11 that resulted in Client A being tased by the police. PREVENTION: The Program Coordinator/QDDP was retrained regarding agency investigation procedures, with emphasis immediate reporting and timely completion on 1/19/12. Retraining focused on the for the facility's team to complete all investigation into elopement, injuries of unknown origin and client to client aggression. Additionally, training stressed the importance of prioritizing facility support tasks to assure that alleged violations are investigated without delay. The Operations Team will monitor compliance with investigation reporting and completion timelines and coordinate corrective measures as needed. RESPONSIBLE PARTIES:QDDP, Support Associates, Operations Team</p>		02/16/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/17/2012
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330
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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
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	<p>he walked west on [name of highway], weaving between the grass and the edge of the road. Staff flagged down a police care (sic) for assistance and after assessing the situation, the police officer called for back-up. Staff and police attempted to help [client A] calm himself but he remained physically aggressive. Police instructed him to lie face down on the ground and he reached toward the officer's utility belt which held a firearm. The officer informed [client A] that if he reached for the belt again he would be tased. He continued to reach for the belt and police used a taser to subdue him...."</p> <p>The facility's 12/19/11 reportable incident report and/or investigations did not indicate the 12/19/11 incident was investigated as no documentation was provided an investigation had been completed. The 12/19/11 reportable incident report did not indicate how many staff were working at the group home at the time of the incident, indicate how many staff followed the client, and/or indicate why staff did not utilize YSIS techniques to prevent the client from getting to the highway to prevent the police from tasing the client. The 12/19/11 reportable incident report did not indicate/include any recommendations from the 12/19/11 incident.</p> <p>Interview with the Qualified Mental</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/17/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330		
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	<p>Retardation Professional (QMRP) on 1/10/12 at 12:16 PM indicated the 12/19/11 incident was investigated. The QMRP indicated there were 3 staff working at the time of the incident and client B was also having a behavior at the time client A eloped/ran off from the group home. The QMRP indicated the staff were attempting to deal with client B and protect the other clients when client A became upset and ran off. The QMRP stated client A got a "head start" on the staff so the client was able to get to the highway before staff could stop the client. The QMRP indicated police drove by the client and staff and then came to assist the staff with client A. The QMRP indicated the police tased client A after he had been instructed to not react toward the Police's belt which held the officer's gun. The QMRP indicated the investigation was with the office located in another city.</p> <p>Interview with administrative staff #2 on 1/11/12 at 9:55 AM indicated the QMRP should have conducted/documentated an investigation in regard to the 12/19/11 incident with client A. Administrative staff #2 indicated he did not have a documented investigation for the 12/19/11 incident.</p> <p>2. The facility's reportable incident reports and/or investigations were</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/17/2012
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330
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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>reviewed on 1/10/12 at 8:54 AM and on 1/11/12 at 9:48 AM. The facility's reportable incident reports indicated the following:</p> <p>-1/3/12 "[Client C] was assisting with carrying in groceries as he walked by [client D], he pushed [client C]. After being pushed [client D] laughed and stepped out of the way...Neither individual was injured as a result of the incident...."</p> <p>-12/26/11 "Staff was assisting [client C] with preparing breakfast when [client B] walked into the kitchen to refill his drink. [Client C] reached out and scratched [client B's] lower right arm...Neither individual was injured as a result of the incident...."</p> <p>-12/26/11 "Staff heard [client D] using profanity and when staff entered the room where [client D] was sitting, staff observed [client C] standing over [client D]. [Client D] said that [client C] had hit him on his cheek...."</p> <p>-12/25/11 "[Client C] had been agitated throughout the evening and at 7:30 PM, he began throwing objects. He threw a shoe which hit [client D] in the stomach...."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/17/2012
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330
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	<p>-12/23/11 "...[Clients B and C] were walking through the house together and without provocation, [client C] reached out and hit [client B] on the stomach...Neither individual was injured as a result of the incident..."</p> <p>-12/23/11 client C hit client D in the face twice when client D walked beside client C to look into the kitchen.</p> <p>-12/16/11 "...[Client B] took a seat at the table and [client C] hit him (client B) twice in the face in quick succession before staff could intervene...No one was injured as a result of the incident...." The 12/16/11 reportable incident report indicated "...The Team has initiated an investigation into the circumstances of the incident..."</p> <p>-12/15/11 "...[Client C] pushed [client B] twice..." when client B walked past client C to get to the laundry room.</p> <p>-12/11/11 "[Client C] was standing at the med room door. One of his housemates, [client B] walked beside [client C]. [Client C] reached out and smacked [client B] on the right arm...." The above mentioned reportable incident reports did not indicate the facility conducted an investigation in regard to the client to client allegations of abuse/aggression.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/17/2012
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330
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	<p>Interview with the QMRP on 1/10/12 at 12:16 PM indicated if the above mentioned client to client incidents were investigated they would be at the main office.</p> <p>Interview with administrative staff #2 on 1/11/12 at 9:55 AM indicated the QMRP was responsible for conducting investigations in regard to client to client aggression/incidents. Administrative staff #2 indicated the QMRP had not been conducting client to client investigations. Administrative staff #2 stated "[Name of QMRP] is still learning process and urgency."</p> <p>9-3-2(a)</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/17/2012	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330			
(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			
W0159	<p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on interview and record review for 1 of 2 sampled clients (B) and for 2 additional clients (C and D), the facility's Qualified Mental Retardation Professional (QMRP) failed to monitor clients' programs in regard to documenting/addressing identified needs in regard to client C targeting clients B and D. The QMRP failed to monitor the clients' Individual Support Plans (ISPs) to ensure all communication and/or interdisciplinary team (IDT) meetings were documented. The QMRP failed to monitor clients' programs to ensure a rights restriction/use of window alarms were part of a client's behavior plan with documentation the facility's Human Rights Committee (HRC) reviewed/approved, documented a client's guardian was informed of the restriction/gave written informed consent, and to ensure a plan to remove the restriction was developed.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 1/10/12 at 8:54 AM and on 1/11/12 at 9:48 AM. The facility's reportable incident reports indicated the</p>	W0159	<p>CORRECTION: <i>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</i> Specifically, the Program Coordinator/QDDP has received training on the following: Modification of ISP and Behavior supports to address Client A's physical aggression toward his housemates, the need to document the outcomes of interdisciplinary team meetings and the need to ensure due process –including human rights committee and guardian prior written informed consent— occurs when rights restrictions are necessary. PREVENTION: The Operations Team has enrolled the Program Coordinator/QDDP in a new supervisor training program designed to assist with developing the competencies necessary to integrate, coordinate and monitor clients' active treatment programs successfully. Members of the Operations Team will periodically perform quality assurance audits at the facility, on an ongoing basis to assure that active treatment programs meet internal and regulatory requirements. Responsible Parties:QDDP, Operations Team</p>	02/16/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/17/2012	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330			
(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>following:</p> <p>-1/3/12 "[Client C] was assisting with carrying in groceries as he walked by [client D], he pushed [client C]. After being pushed [client D] laughed and stepped out of the way...Neither individual was injured as a result of the incident..." The 1/3/12 reportable incident report indicated client C's behavior "...followed a typical pattern..." as client C would aggress against others when the other person entered client C's personal space. The reportable incident report indicated staff should be encouraged to "...engineer the training environment by encouraging [client C's] housemates to avoid entering his personal space."</p> <p>-12/26/11 "Staff was assisting [client C] with preparing breakfast when [client B] walked into the kitchen to refill his drink. [Client C] reached out and scratched [client B's] lower right arm...Neither individual was injured as a result of the incident. [Client C's] behavior followed its typical pattern. When a housemate entered his personal space he reacted in a mildly physically aggressive manner. Staff will be trained regarding the need to engineer the training environment by encouraging [client C's] housemates to avoid his personal space."</p>						

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330
--	--

(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
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	<p>-12/26/11 "Staff heard [client D] using profanity and when staff entered the room where [client D] was sitting, staff observed [client C] standing over [client D]. [Client D] said that [client C] had hit him on his cheek..."</p> <p>-12/25/11 "[Client C] had been agitated throughout the evening and at 7:30 PM, he began throwing objects. He threw a shoe which hit [client D] in the stomach...Staff will monitor both individuals closely, implementing proactive and reactive behavior support strategies as needed. The team will continue to work with [client C's] behavioral clinician to assure adequate supports are in place...."</p> <p>-12/23/11 "...[Clients B and C] were walking through the house together and without provocation, [client C] reached out and hit [client B] on the stomach...Neither individual was injured as a result of the incident...Staff will continue to monitor [clients B and C] closely, implementing proactive and reactive behavior support strategies as needed."</p> <p>-12/23/11 client C hit client D in the face twice when client D walked beside client C to look into the kitchen.</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/17/2012	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330			
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	<p>-12/16/11 "...[Client B] took a seat at the table and [client C] hit him (client B) twice in the face in quick succession before staff could intervene...No one was injured as a result of the incident...." The 12/16/11 reportable incident report indicated "...Administrative Team members have communicated with to (sic) [clients C and B's] behavioral clinician (BC) to discuss current assessment data to assure that programmatic changes to [clients C and B's] behavior supports occur if indicated. The BC has assessed that [client C's] aggression occurs in response to his housemates' behavior and that [client B's] frequent episodes of verbal aggression, property destruction and threats have resulted in [client C's] targeting him. The team is working on adjustments to both individuals' formal supports and staff training toward proper implementation of these supports is ongoing."</p> <p>-12/15/11 "...[Client C] pushed [client B] twice..." when client B walked past client C to get to the laundry room. The reportable incident report indicated the "...Administrative Team members will speak to [client C's] behavioral clinician to discuss current assessment data to assure that programmatic changes to [client C's] behavior supports occur if</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/17/2012
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330
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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
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	<p>indicated."</p> <p>-12/11/11 "[Client C] was standing at the med room door. One of his housemates, [client B] walked beside [client C]. [Client C] reached out and smacked [client B] on the right arm...."</p> <p>Client C's record was reviewed on 1/10/12 at 8:56 AM. Client C's 12/20/11 Behavior Support Plan (BSP) indicated client C demonstrated physical aggression (scratching, spitting, hitting, slaps and kicking others). Client C's 10/11/11 ISP and/or record did not indicate the client's IDT met to review and/or address client C's targeting clients B and D. Client C's record indicated no IDT notes and/or documentation of communication with the client's IDT members.</p> <p>Client B's record was reviewed on 1/10/12 at 9:40 AM. Client B's 10/25/11 ISP and/or record indicated the client's IDT had not met to review and/or address client B's being a targeted by client C. Client B had no interdisciplinary team notes in his chart and/or documentation of communication between the QMRP and IDT members.</p> <p>Interview with the QMRP on 1/10/12 at 12:16 PM indicated client C targeted clients B and D. The QMRP stated client</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/17/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330		
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	<p>C did not "hit hard." Client C indicated clients B and D would walk into the space of client C and get hit. The QMRP indicated client C's hits did not cause harm to others. The QMRP indicated he had discussed client C's behaviors and targeting clients B and D with the other IDT members. The QMRP indicated he did not document the conversations and/or document IDT meetings in regard to client C's behavior. The QMRP indicated staff were to "re-arrange the environment" to prevent client C from the targeting/hitting the other clients. When asked if the QMRP had documented/addressed client C's targeting clients B and D, the QMRP stated "No."</p> <p>Interview with administrative staff #2 on 1/11/12 at 9:55 AM indicated the QMRP was responsible for conducting client to client aggression investigations. Administrative staff #2 indicated client C's targeting clients B and D should be addressed by the QMRP with the IDT. Administrative staff #2 indicated the QMRP should document communication with the IDT and/or document IDT meetings in regard to the clients' behaviors.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 1/10/12 at 8:54 AM and on</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/17/2012	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330			
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	<p>1/11/12 at 9:48 AM. The facility's reportable incident reports indicated the following:</p> <p>-12/18/11 client B climbed out of his bedroom window after visiting with his mother. The reportable incident report indicated facility staff met the client outside.</p> <p>-12/16/11 "[Client B] had been agitated throughout the morning. He threw a cup of juice and other items and went into his bedroom and shut his door. While staff was cleaning up to (sic) spilled liquid, [client B] opened his window, climbed out and began walking in the direction of the [name of store]. Staff checked on [client B] and saw that he had exited the house. Staff caught up with [client B] before he left the property and walked with him while he calmed himself, per his Behavior Support Plan(BSP)...." The 12/16/11 reportable incident report indicated an alarm was installed on client B's bedroom windows and the client's guardian and the facility's HRC gave consent for the restrictions.</p> <p>Client B's record was reviewed on 1/10/12 at 9:40 AM. Client B's 10/25/11 ISP indicated client B had a guardian. Client B's 12/20/11 BSP indicated the client demonstrated "Runs/Wanders</p>						

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	<p>Away." Client B's 10/25/11 ISP and/or 12/20/11 BSP did not indicate the use of window alarms had been incorporated into the client's BSP in regard to the client's elopement behavior. Client B's ISP and/or BSP also did not indicate the QMRP obtained written informed consent in regard to the use of the window alarms prior to implementation and/or obtain HRC approval for the restrictive technique. Client B's 12/20/11 BSP did not indicate the QMRP convened the IDT to meet/review the client's elopement behavior as no IDT notes were present in the client's record.</p> <p>Interview with the QMRP on 1/10/12 at 12:16 PM indicated client B's IDT reviewed client B's elopement behavior of going out of the window. The QMRP indicated he did not document the communication with the client's IDT. The QMRP indicated he had not incorporated the use of the window alarms into client B's behavior plan with a plan of removal. The QMRP indicated he phoned client B's guardian and the facility's HRC to obtain consent for the window alarms. The QMRP indicated the consents were obtained by phone, but he had not documented when he obtained the consents/approvals. The QMRP indicated he still needed to document the information.</p>			
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	<p>Interview with administrative staff #2 on 1/11/12 at 9:55 AM indicated the QMRP was new to group homes. Administrative staff #2 indicated the QMRP contacted the facility's Human Rights Committee for approval of the window alarm for client B. Administrative staff #2 indicated the QMRP should document his contacts with the Human Rights Committee, and obtain documentation of consents. Administrative staff #2 indicated the QMRP should ensure the window alarm was part of the client's program plan with a plan of removal in place to indicate how/when the alarm would be removed.</p> <p>9-3-3(a)</p>			
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W0189	<p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on interview and record review for 1 of 2 sampled clients (B) and for 1 additional client (C), the facility failed to ensure all staff knew when to call the nurse in regard to low and/or high blood sugars and/or failed to ensure all staff were retrained in regard to reporting allegations of abuse/neglect.</p> <p>Findings include:</p> <p>1. Client C's record was reviewed on 1/10/12 at 8:56 AM. Client C's 12/31/11 Medical Notes indicated "[Client C's] blood sugar was 298 and staff [staff #1] checked again on different finger and it was 293." Client C's 12/31/11 Medical Note and/or record did not indicate what was done in regard to client C's blood sugar reading and/or indicate the facility's nurse was notified.</p> <p>Client C's 11/30/11 physician's order indicated client C's diagnosis included, but was not limited to, Type II Diabetes. Client C's 11/30/11 physician's orders indicated client C's blood sugar levels were monitored/taken two times a day.</p> <p>Interview with staff #2 on 1/10/12 at 8:15 AM indicated staff #2 did not know what</p>	W0189	<p>CORRECTION: <i>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Specifically, the facility has retrained all direct support staff regarding the need to report all allegations of abuse, neglect, mistreatment and exploitation immediately to their direct supervisor and to continue reporting, following the chain of command until the situation is addressed. In addition, the facility nurse will train staff on abnormal blood sugar reporting procedures as directed on the Medication Administration Record.</i></p> <p>PREVENTION: The Program Coordinator/QDDP received training on 1/19/11 regarding the need to provide and document ongoing training to direct support staff regarding all aspects of service delivery. Members of the Operations Team will review documentation to assure ongoing training occurs and will perform periodic observations of active treatment sessions on an ongoing basis to monitor the outcome and effectiveness of training provided by facility professional staff.</p> <p>Responsible Parties: QDDP, Health Services Team, Support Associates, Operations Team</p>	02/16/2012			

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	<p>was considered high and/or low blood sugar levels for client C. Staff #2 indicated he would call the nurse if client C's blood sugar level was above 245.</p> <p>Interview with staff #3 on 1/10/12 at 11:35 AM indicated the facility nurse should be called when client C's blood sugar level was below 80 or above 180.</p> <p>Interview with the Qualified Mental Retardation professional (QMRP) on 1/10/12 at 12:16 PM indicated the nurse told him staff should be calling the nurse when client C's blood sugar level readings were below 80 and/or above 180. The QMRP indicated he was not able to locate documentation where the facility nurse was called on 12/31/11 in regard to client C's blood sugar reading of 298. The QMRP indicated the nurse should have been called. The QMRP indicated he inserviced staff on when to call the nurse at an inservice on 12/30/11.</p> <p>The facility's inservice record were reviewed on 1/10/12 at 1:07 PM. The facility's 12/30/11 Inservice Sign-in Sheet indicated the following was trained/inserviced: "FATAL 4 (Aspiration, Constipation, Dehydration, Seizures), Procedures of a Med Pass, Controlled substance procedure, 911 & Nurse Notification guidelines, Emergency</p>			
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	<p>Room Procedure, Buddy Check." The 12/30/11 inservice record indicated staff #2 was present at the 12/30/11 training.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 1/10/12 at 8:54 AM and on 1/11/12 at 9:48 AM. The facility's 12/25/11 reportable incident report indicated "A co-worker reported seeing staff [staff #6] slap [client C] in (sic) the hand twice and hit him in the head with a pillow in response to an episode of physical aggression."</p> <p>The facility's undated Investigation Summary indicated the facility staff did not immediately report the allegation of abuse to their supervisor and/or the administrator immediately as the staff reported the incident the next day on 12/26/11. The facility's undated investigation indicated staffs' witness statements indicated staff #6 had cut the ends of client C's jump rope off to prevent the client from hitting her with them on 12/23/11, the staffs' witness statements indicated staff #6 had "forced" client C down to the ground in the past when restraining, and "poking him (client B) in the stomach..., [staff #6] was also sitting in the med room and banging on the med room window at [client B] and then made faces at him which made him angry..." in</p>			
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	<p>the past. The undated investigation summary indicated staffs' witness statements indicated staff #6 had turned the TV off on clients in the past and removed/took client C's pop away from him when he made a mess. The facility's undated investigation summary did not indicate the above mentioned allegations had been immediately reported to the administrator.</p> <p>The facility's 1/7/12 Adept Investigation Peer Review sheet indicated "...2. Retrain staff on Immediate reporting." The 1/7/12 peer review sheet did not indicate facility staff had been retrained in regard to reporting.</p> <p>Interview with administrative staff #2 on 1/11/12 at 9:55 AM indicated facility staff still needed to be retrained in regard to immediately reporting allegations of abuse and/or neglect to the administrator.</p> <p>3. The facility's reportable incident reports and/or investigations were reviewed on 1/10/12 at 8:54 AM. The facility's 12/26/11 reportable incident report indicated "Staff was assisting [client C] with preparing breakfast when [client B] walked into the kitchen to refill his drink. [Client C] reached out and scratched [client B's] lower right arm...Neither individual was injured as a</p>						

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	<p>result of the incident. [Client C's] behavior followed its typical pattern. When a housemate entered his personal space he reacted in a mildly physically aggressive manner. Staff will be trained regarding the need to engineer the training environment by encouraging [client C's] housemates to avoid his personal space."</p> <p>The facility's inservice records were reviewed on 1/10/12 at 1:07 PM. The facility's 12/11 inservice records indicated the facility had not retrained staff in regard to engineering the environment to prevent client C from hitting the other clients.</p> <p>Interview with the QMRP on 1/10/12 at 12:16 PM indicated facility staff had received training in regard to engineering the environment on 12/30/11. The QMRP indicated the inservice/training was not documented.</p> <p>9-3-3(a)</p>			
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W0331	<p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on interview and record review for 1 additional client (C), the facility's nursing services failed to ensure staff were trained when to call the nurse in regard to a client's blood sugar levels.</p> <p>Findings include:</p> <p>Client C's record was reviewed on 1/10/12 at 8:56 AM. Client C's 12/31/11 Medical Notes indicated "[Client C's] blood sugar was 298 and staff [staff #1] checked again on different finger and it was 293." Client C's 12/31/11 Medical Note and/or record did not indicate what was done in regard to client C's blood sugar reading and/or indicate the facility's nurse was notified.</p> <p>Client C's 11/30/11 physician's order indicated client C's diagnosis included, but was not limited to, Type II Diabetes. Client C's 11/30/11 physician's orders indicated client C's blood sugar levels were monitored/taken two times a day.</p> <p>Client C's 10/27/11 Comprehensive High Risk Health Plan indicated the client had a high risk plan for his diabetes. The 10/27/11 plan indicated a section entitled "Triggers to Notify Nurse." The documented triggers indicated the staff</p>	W0331	<p>CORRECTION: <i>The facility must provide clients with nursing services in accordance with their needs.</i> Specifically, for Client C, parameters specifying notification protocols for abnormal blood sugar have been included on Client C's Medication Administration Record. The Operations Team has verified that the notification procedures are in place. Professional and direct support staff will be retrained on when to contact the facility nurse including but not limited to when client C's blood sugar is outside of normal limits.</p> <p>PREVENTION: Staff will be retrained regarding nurse notification protocols including but not limited to abnormal blood sugar. Additionally, on 1/19/12 the Program Coordinator/QDDP received additional training on the need to coordinate, integrate and monitor all aspects of client care and support to further assure an appropriate level of healthcare. The training session emphasized the need for follow-up and review of Medication and Treatment Administration Records to assure all needs are addressed. Members of the Health Services and Operations teams will monitor home systems on an ongoing basis providing guidance and support as needed to ensure health care requirements are met.</p> <p>Responsible Parties:Health</p>	02/16/2012			

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	<p>should notify the nurse when symptoms of high and/or low blood sugars were seen/observed exemplified by "Frequent urination, Unusual thirst, Extreme hunger, Unusual weight loss, ...Shakiness, Dizziness, Sweating, Hunger, Headache, Sudden moodiness or behavior changes..." The 10/27/11 high risk plan did not indicate when the facility staff should call the nurse in regard to high and/or low blood sugar readings.</p> <p>Interview with staff #2 on 1/10/12 at 8:15 AM indicated staff #2 did not know what was considered high and/or low blood sugar levels for client C. Staff #2 indicated he would call the nurse if client C's blood sugar level was above 245.</p> <p>Interview with staff #3 on 1/10/12 at 11:35 AM indicated the facility nurse should be called when client C's blood sugar level was below 80 or above 180.</p> <p>Interview with the Qualified Mental Retardation professional (QMRP) on 1/10/12 at 12:16 PM indicated the nurse told him staff should be calling the nurse when client C's blood sugar level readings were below 80 and/or above 180. The QMRP indicated he was not able to locate documentation where the facility nurse was called on 12/31/11 in regard to client C's blood sugar reading of 298. The</p>		Services Team, QDDP, Support Associates, Operations Team		

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	<p>QMRP indicated the nurse should have been called. The QMRP indicated he inserviced staff on when to call the nurse at an inservice on 12/30/11. The QMRP indicated the facility's nurse was on medical leave. The QMRP indicated client C's high risk plan for the client's diabetes still needed to be updated in regard to when staff were to call the nurse regarding client C's blood sugar levels.</p> <p>Interview with administrative staff #2 on 1/11/12 at 9:55 AM indicated the group home nurse had been on medical leave and had just returned. Administrative staff #2 indicated the facility's Director of Health Services was aware client C's risk plan for diabetes needed to be updated in regard to when staff were to call the nurse in regard to the client's blood sugar level readings.</p> <p>This deficiency was cited on 11/21/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>						