

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/08/2013
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 1/30/13, 1/31/13, 2/1/13, 2/4/13, 2/5/13, 2/7/13 and 2/8/13.</p> <p>Facility Number: 000979 Provider Number: 15G465 AIMS Number: 100244860</p> <p>Survey Team: Keith Briner, Medical Surveyor III/QMRP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/15/13 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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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W0149	<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 5 of 24 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed for 2 of 4 sampled clients (#1 and #2) plus 2 additional clients (#5 and #6), the facility failed to implement its policy and procedures to ensure the facility immediately notified BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an injury of unknown origin for client #5. The facility failed to implement its policy and procedures to ensure the facility completed a thorough investigation regarding one incident of a facility vehicle accident for client #1 and four separate incidents of injuries of unknown origin for clients #1, #2, #5 and #6. The facility failed to implement its policy and procedures to ensure the facility reported the results of an investigation of an allegation of staff leaving the scene of a vehicle accident involving client #1 and the group home van.</p> <p>Findings include:</p> <p>1. The facility's BDDS reports, investigations and incident reports were</p>	W0149	<p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically, the facility:</i></p> <p>1. The facility will retrain direct support staff regarding the need to immediately report all injuries to the nurse and supervisory staff and to complete appropriate documentation.</p> <p>2. <i>The facility must have evidence that all alleged violations are thoroughly investigated.</i> Specifically, an investigation was completed for the 10/10/12 van accident on 10/15/12 and the report will be provided at revisit. The facility will complete investigations for the following incidents: Client #2's injury of unknown origin discovered on 11/3/13, Client #5's injury of unknown origin discovered on 11/27/12, Client #6's injury of unknown origin discovered on 12/13/12 and Client #1's injury of unknown origin discovered on 12/18/12.</p> <p>3. The results of the investigation into the 10/10/12 van accident were reported to the administrator on 10/15/12 and the documentation will be provided at revisit. PREVENTION:</p> <p>4. Supervisory staff will review</p>	03/10/2013			

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	<p>reviewed on 1/30/13 at 12:42 PM. The review indicated the following:</p> <p>BDDS report dated 10/11/12 indicated on 10/10/12, "[Staff #1] and [client #1] was (sic) at [store] shopping, after loading up the group home van [staff #1] struck a car in the parking lot and not realizing she hit a car she drove off and was headed back to the group home. While driving back to the group home the van had a flat tire, police pulls (sic) in behind the van and told staff she was involved in a hit and run. At the group home staff checked [client #1] for injuries. None were noted. The facility nurse was notified of the incident. [Client #1] was taken to [hospital] emergency department for evaluation...."</p> <p>-Investigation dated 10/11/12 regarding the 10/11/12 BDDS report for client #1 did not indicate documentation of an interview or statement from staff #1 or client #1. The 10/11/12 investigation did not indicate documentation of a conclusion, findings and make recommendations for corrective actions. The 10/11/12 investigation did not indicate documentation the administrator was notified of the results of the investigation.</p> <p>2. BDDS report dated 11/29/12 indicated</p>		<p>all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Quality Assurance Manager who will in turn coordinate and follow-up with the facility Clinical Supervisor to assure appropriate follow-up occurs.</p> <p>5. Professional staff will be retrained regarding the criteria for conducting investigations at the facility and will receive guidance toward developing of a tracking system to assure thorough investigations are conducted within required timeframes. The QDDP will turn in copies of completed investigations to the Quality Assurance Manager to allow for appropriate oversight and follow-up. Additionally, the facility's Clinical Supervisor will meet with the Quality Assurance Manager weekly to review incidents that require follow-up and investigation to assure timely completion.</p> <p>6. Professional staff will be retrained regarding the need to provide documentation of investigation result reporting to medical surveyors and other appropriate parties on request... Members of the Operations team will remain in communication with medical surveyors throughout the survey process to assure available documentation is provided upon request.</p> <p>RESPONSIBLE PARTIES:</p>		

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	<p>on 11/28/12, "[Client #5] was receiving his 5:00 PM medications when staff noticed red mark/cut, 2 centimeters in size on the top of his head. When asked how the cut was received, [client #5] shared that on 11/27/12, he had hit his head on a door while bending down. Supervisor was in the home at the time of discovery and went back to review body checks that had been given at 9:00 PM on 11/27/12 and it was noted that the cut was present." The review did not indicate documentation staff had reported the injury of unknown origin to supervisory staff on 11/27/12 when they were aware of the injury. The 11/29/12 BDDS report indicated, "The [QMRP #1] will initiate an investigation into the injury of unknown origin." The review did not indicate an investigation had been initiated into the injury of unknown origin for client #5.</p> <p>-BDDS report dated 11/4/12 indicated on 11/3/12, "Staff was assisting [client #2] with evening hygiene. Staff noted a quarter size bruise on [client #2's] upper left buttock. Staff asked [client #2] if she knew how she got the bruise. [Client #2] said that she didn't." The 11/4/12 BDDS report indicated, "An investigation was also initiated into the origin of the bruise." The review did not indicate documentation an investigation had been</p>		Clinical Supervisor, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team				

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	<p>initiated regarding the injury of unknown origin for client #2.</p> <p>-BDDS report dated 12/13/12 indicated on 12/12/12, "Staff noticed that [client #6] had a small one inch scratch on the top of his right hand. When staff asked [client #6] how he received the scratch he was unable to communicate effectively as to where the scratch came (sic)." The 12/13/12 BDDS report indicated, "[QMRP #1] will conduct an investigation in an attempt to discover how (sic) cut was received." The review did not indicate documentation an investigation had been initiated regarding the injury of unknown origin for client #6.</p> <p>-BDDS dated 12/18/12 indicated on 12/18/12, "[Client #1] showed staff a 1 and 1/2 inch diameter bruise located on her inner thigh. [Client #1] was not sure of how she attained the bruise." The 12/18/12 BDDS indicated, "[QMRP #1] will initiate an investigation to determine how bruise was received." The review did not indicate documentation an investigation had been initiated regarding the injury of unknown origin for client #1.</p> <p>Interview with QMRP (Qualified Mental Retardation Professional) #1 on 2/1/13 at 10:30 AM indicated facility staff should report injuries of unknown origin to</p>						

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	<p>supervisory staff as soon as they become aware of the injury. QMRP #1 indicated injuries of unknown origin should be investigated and allegations of staff leaving the scene of an accident should be investigated. QMRP #1 indicated the results of investigations should be reported to the administrator within 5 business days.</p> <p>The facility's policy and procedures were reviewed on 2/4/13 at 3:03 PM. The facility's 9/14/07 policy and procedure entitled Abuse, Neglect, Exploitation operating standard 1.26 indicated, "Following ResCare protocol for the exact process to report incidents, once the suspicion has been reported to the supervisor and/or PD (Program Director), the PD will report, within 24 hours, the suspected abuse, neglect or exploitation as follows:</p> <p>G. "To the BDDS central office..."</p> <p>The facility's 9/14/07 policy and procedure entitled, Investigations indicated, "Practices: 3. (b) Ensure alleged incident of abuse, neglect, mistreatment, exploitation or injuries of unknown origin are fully investigated within 5 calendar days from the date the allegations were made and investigation was initiated."</p>						

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	9-3-2(a)				

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W0153	<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 1 of 24 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to immediately notify BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an injury of unknown origin for client #5.</p> <p>Findings include:</p> <p>The facility's BDDS reports, investigations and incident reports were reviewed on 1/30/13 at 12:42 PM. The review indicated the following:</p> <p>-BDDS report dated 11/29/12 indicated on 11/28/12, "[Client #5] was receiving his 5:00 PM medications when staff noticed red mark/cut, 2 centimeters in size on the top of his head. When asked how the cut was received, [client #5] shared that on 11/27/12, he had hit his head on a door while bending down. Supervisor was in the home at the time of discovery and went back to review body</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. Specifically, the facility will retrain direct support staff regarding the need to immediately report all injuries to the nurse and supervisory staff and to complete appropriate documentation.</i></p> <p>PREVENTION: Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Quality Assurance Manager who will in turn coordinate and follow-up with the facility Clinical Supervisor to assure appropriate follow-up occurs.</p> <p>RESPONSIBLE PARTIES: Clinical Supervisor, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	03/10/2013	

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	<p>checks that had been given at 9:00 PM on 11/27/12 and it was noted that the cut was present." The review did not indicate documentation staff had reported the injury of unknown origin to supervisory staff on 11/27/12 when they were aware of the injury.</p> <p>Interview with QMRP (Qualified Mental Retardation Professional) #1 on 2/1/13 at 10:30 AM indicated facility staff should report injuries of unknown origin to supervisory staff as soon as they become aware of the injury.</p> <p>9-3-1(b)(5) 9-3-2(a)</p>				

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 5 of 24 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to complete a thorough investigation regarding one incident of a facility vehicle accident for client #1 and five separate incidents of injuries of unknown origin for clients #1, #2, #5 and #6.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, investigations and incident reports were reviewed on 1/30/13 at 12:42 PM. The review indicated the following:</p> <p>-BDDS report dated 10/11/12 indicated on 10/10/12, "[Staff #1] and [client #1] was (sic) at [store] shopping, after loading up the van [staff #1] struck a car in the parking lot and not realizing she hit a car she drove off and was headed back to the group home. While driving back to the group home the van had a flat tire, police pulls (sic) in behind the van and told staff she was involved in a hit and run. At the group home staff checked [client #1] for</p>	W0154	<p>CORRECTION: <i>The facility must have evidence that all alleged violations are thoroughly investigated. Specifically, an investigation was completed for the 10/10/12 van accident on 10/15/12 and the report will be provided at revisit. The facility will complete investigations for the following incidents: Client #2's injury of unknown origin discovered on 11/3/13, Client #5's injury of unknown origin discovered on 11/27/12, Client #6's injury of unknown origin discovered on 12/13/12 and Client #1's injury of unknown origin discovered on 12/18/12.</i></p> <p>PREVENTION: Professional staff will be retrained regarding the criteria for conducting investigations at the facility and will receive guidance toward developing of a tracking system to assure thorough investigations are conducted within required timeframes. The QDDP will turn in copies of completed investigations to the Quality Assurance Manager to allow for appropriate oversight and follow-up. Additionally, the facility's Clinical Supervisor will meet with the Quality Assurance Manager weekly to review incidents that require follow-up and investigation to assure timely completion.</p>	03/10/2013			

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	<p>injuries. None were noted. The facility nurse was notified of the incident. [Client #1] was taken to [hospital] emergency department for evaluation...."</p> <p>-Investigation dated 10/11/12 regarding the 10/11/12 BDDS report for client #1 did not indicate documentation of an interview or statement from staff #1 or client #1. The 10/11/12 investigation did not indicate documentation of a conclusion, findings and make recommendations for corrective actions.</p> <p>-BDDS report dated 11/29/12 indicated on 11/28/12, "[Client #5] was receiving his 5:00 PM medications when staff noticed red mark/cut, 2 centimeters in size on the top of his head. When asked how the cut was received, [client #5] shared that on 11/27/12, he had hit his head on a door while bending down. Supervisor was in the home at the time of discovery and went back to review body checks that had been given at 9:00 PM on 11/27/12 and it was noted that the cut was present." The 11/29/12 BDDS report indicated, "The [QMRP #1] will initiate an investigation into the injury of unknown origin." The review did not indicate an investigation had been initiated into the injury of unknown origin for client #5.</p>		<p>RESPONSIBLE PARTIES: Clinical Supervisor, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>		

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	<p>-BDDS report dated 11/4/12 indicated on 11/3/12, "Staff was assisting [client #2] with evening hygiene. Staff noted a quarter size bruise on [client #2's] upper left buttock. Staff asked [client #2] if she knew how she got the bruise. [Client #2] said that she didn't." The 11/4/12 BDDS report indicated, "An investigation was also initiated into the origin of the bruise." The review did not indicate documentation an investigation had been initiated regarding the injury of unknown origin for client #2.</p> <p>-BDDS report dated 12/13/12 indicated on 12/12/12, "Staff noticed that [client #6] had a small one inch scratch on the top of his right hand. When staff asked [client #6] how he received the scratch he was unable to communicate effectively as to where the scratch came (sic)." The 12/13/12 BDDS report indicated, "[QMRP #1] will conduct an investigation in an attempt to discover how (sic) cut was received." The review did not indicate documentation an investigation had been initiated regarding the injury of unknown origin for client #6.</p> <p>-BDDS report dated 12/18/12 indicated on 12/18/12, "[Client #1] showed staff a 1 and 1/2 inch diameter bruise located on her inner thigh. [Client #1] was not sure of how she attained the bruise." The</p>						

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	<p>12/18/12 BDDS report indicated, "[QMRP #1] will initiate an investigation to determine how bruise was received." The review did not indicate documentation an investigation had been initiated regarding the injury of unknown origin for client #1.</p> <p>Interview with QMRP (Qualified Mental Retardation Professional) #1 on 2/1/13 at 10:30 AM indicated injuries of unknown origin should be investigated and allegations of staff leaving the scene of an accident should be investigated.</p> <p>9-3-2(a)</p>						

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W0156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 24 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to report the results of an investigation of an allegation of staff leaving the scene of a vehicle accident involving client #1 and the group home van.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, investigations and incident reports were reviewed on 1/30/13 at 12:42 PM. The review indicated the following:</p> <p>-BDDS report dated 10/11/12 indicated on 10/10/12, "[Staff #1] and [client #1] was (sic) at [store] shopping, after loading up the van [staff #1] struck a car in the parking lot and not realizing she hit a car she drove off and was headed back to the group home. While driving back to the group home the van had a flat tire, police pulls (sic) in behind the van and told staff she was involved in a hit and run. At the</p>	W0156	<p>CORRECTION: <i>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Specifically, the results of the investigation into the 10/10/12 van accident were reported to the administrator on 10/15/12 and the documentation will be provided at revisit.</i></p> <p>PREVENTION: Professional staff will be retrained regarding the need to provide documentation of investigation result reporting to medical surveyors and other appropriate parties on request. Members of the Operations team will remain in communication with medical surveyors throughout the survey process to assure available documentation is provided upon request.</p> <p>RESPONSIBLE PARTIES: Clinical Supervisor, Residential Manager, Quality Assurance Team, Operations Team</p>	03/10/2013			

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	<p>group home staff checked [client #1] for injuries. None were noted. The facility nurse was notified of the incident. [Client #1] was taken to [hospital] emergency department for evaluation...."</p> <p>-Investigation dated 10/11/12 regarding the 10/11/12 BDDS report for client #1 did not indicate documentation of an interview or statement from staff #1 or client #1. The 10/11/12 investigation did not indicate documentation the administrator was notified of the findings.</p> <p>Interview with QMRP (Qualified Mental Retardation Professional) #1 on 2/1/13 at 10:30 AM indicated the results of investigations should be reported to the administrator within 5 business days.</p> <p>9-3-2(a)</p>				

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W0186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#4), the facility failed to ensure there were adequate staff to implement client #4's one to one staffing protocol.</p> <p>Findings include:</p> <p>Interview with DSP (Direct Support Professional) #1 on 2/1/13 at 6:15 AM indicated client #4 was on a one to one supervision protocol. DSP #1 stated, "The clients usually begin getting up in the morning around 5:00 AM. There are a few that have to take their medications at 5:00 AM because they have to wait a half an hour after them before they can eat. So, we start getting them up at 5:00 AM. From 5:00 AM I am usually checking on clients in bedrooms, starting medications in the office and trying to get everyone ready for breakfast. We head out for day services around 8:00 AM." DSP #1 stated, "Typically, there is only one staff working from 12:00 AM to 8:00 AM. Sometimes</p>	W0186	<p>CORRECTION: <i>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Specifically, the facility has added additional direct support staff to facilitate implementation of Client #4's one to one staffing plan.</i></p> <p>PREVENTION: The Operations Team will monitor facility staff schedules to assure adequate direct support staff are assigned to all shifts. Additionally, on an ongoing basis, members of the Operations and Quality Assurance Teams will spot check time and attendance records to assure hours worked match the facility schedule.</p> <p>RESPONSIBLE PARTIES: Clinical Supervisor, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	03/10/2013	

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	<p>at 8:00 AM [HM #1 (Home Manager)] comes in but it's usually one person here working from the time they get up at 5:00 AM through 8:00 AM when they leave for day services." When asked how client #4's one to one protocol was implemented while she administered medications in the medication office, DSP #4 stated, "We can't. While we are in the office giving medications the door is shut and there is no staff out there helping the others." When asked how often there was only one staff on duty from 5:00 AM to 8:00 AM, DSP #1 stated, "Most all the time. We used to have someone but they quit. I think [PD #1 (Program Director)] has tried to get people but they keep quitting. I don't think they have found anyone for the position. One person is not enough."</p> <p>The facility's Time Detail Sheets (TDS) dated from 1/1/13 through 1/31/13 were reviewed on 2/7/13 at 3:05 PM. The review indicated one staff was on duty from 12:00 AM through 8:00 AM from 1/1/13 through 1/18/13. The review indicated one staff was on duty from 12:00 AM through 8:00 AM from 1/19/13 through 1/31/13.</p> <p>Client #4's record was reviewed on 1/31/13 at 12:41 PM. Client #4's Comprehensive High Risk Health Plan (CHRHP) dated 10/17/12 indicated, "One</p>						

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	<p>to one staff at all times." Client #4's IDT (Interdisciplinary Team) form dated 8/24/12 indicated, "One on one will make sure that [illegible] are always close to [client #4] to prevent her from falling." Client #4's IDT dated 1/13/13 indicated client #4 was to have one to one supervision to prevent falls.</p> <p>QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 2/1/13 at 9:10 AM. QMRP #1 indicated client #4 was on one to one supervision. QMRP #1 indicated client #4's one to one staff should remain near her while she walked and ensure the environment around her was clear of tripping hazards. When asked how the morning staff was able to provide client #4 with one on one supervision while administering medications in the medication administration room during the morning hours, QMRP #1 indicated there should be two staff working during the morning hours. QMRP #1 indicated one staff working in the morning from 5:00 AM when the clients began getting up through 8:00 AM when the clients began transport to day services was not sufficient to implement client #4's one to one supervision.</p> <p>9-3-3(a)</p>			

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W0218	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on record review and interview for 1 of 4 sampled clients (#2), the facility failed to ensure client #2 had a recommended sensorimotor assessment.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, investigations and incident reports were reviewed on 1/30/13 at 12:42 PM. The review indicated the following:</p> <p>-BDDS report dated 10/19/12 indicated on 10/19/12, "[Client #2] was awakened by staff to take morning medications when she fell out of bed, hitting the side of her head on the night stand in her bedroom. Staff noted no redness or bleeding. [Client #2] did complain of pain in the area she hit. Nurse on call was notified and [client #2] was taken to [hospital] emergency room for evaluation. At the emergency room, the area was checked as well as the wound from 10/18/12. No changes to wound, staples still intact...."</p> <p>-Incident report dated 10/18/12 indicated on 10/18/12 at 5:05 AM, "[Client #2] come (sic) into medication room and told</p>	W0218	<p>CORRECTION: <i>The comprehensive functional assessment must include sensorimotor development. Specifically, the facility has scheduled and will assist Client #2 with obtaining a physical therapy assessment.</i></p> <p>PREVENTION: Professional staff will be retrained regarding the need to obtain appropriate assessments to facilitate the development of needed supports for all clients across environments. Members of the Operations, Quality Assurance and/or Health Services Teams will review assessment data and incident documentation to assure assessments occur as needed and required. RESPONSIBLE PARTIES: Clinical Supervisor, Residential Manager, Direct Support Staff, Nursing Team, Quality Assurance Team, Operations Team</p>	03/10/2013			

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	<p>staff she had fallen again out of bed." The 10/18/12 incident report indicated, "I checked [client #2] head (sic) which she had both dry and wet blood, bigger than a quarter, (sic) hurt when touched. Called [nurse #1] and she told us to take [client #2] to the emergency room."</p> <p>Client #2's record was reviewed on 1/31/13 at 11:28 AM. Client #2's Record of visit forms indicated client #2 had been to the emergency room following incidents of falls on 10/18/12, 10/19/12 and 12/9/12. Client #2's IDT (Interdisciplinary Team) form dated 10/24/12 indicated a recommendation for a PT (Physical Therapy) evaluation. Client #2's record indicated the most recent PT evaluation was completed on 11/19/09.</p> <p>QMRP #1 (Qualified Mental Retardation Professional) was interviewed on 2/1/13 at 10:30 AM. QMRP #1 indicated client #2 had not had an PT evaluation since 11/19/09. QMRP #1 indicated client #2 had been scheduled for a PT evaluation on 11/12/12 that was canceled and not rescheduled.</p> <p>9-3-4(a)</p>						

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W0247	<p>483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management.</p> <p>Based on observation, record review and interview for 3 of 4 sampled clients (#1, #2 and #4), the facility failed to ensure client #4 had choice in community outings. The facility failed to ensure clients #1 and #2 had choice of food and drink during meal time.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/30/13 from 4:22 PM through 5:45 PM. At 5:10 PM client #1 and DSP (Direct Support Professional) #2 were standing in the group home kitchen preparing the evening meal. Client #1 stated to DSP #2, "I wish we could do more activities. We go out to eat and stuff but we never do more active things. Like, I want to go to the movies or go bowling. Maybe go to a park and play basketball and walk." DSP #2 indicated client #1 should talk to QMRP #1 (Qualified Mental Retardation Professional) to plan outings/activities. At 5:15 PM client #2 entered the group home kitchen where DSP #2 and clients #1 and #8 were preparing the evening meal. Client #2 stated to DSP #2, "I want to have coffee with my meal." DSP #2 replied to client</p>	W0247	<p>CORRECTION: <i>The individual program plan must include opportunities for client choice and self-management. Specifically, the facility will conduct monthly meetings with all clients to determine preferences for community outings and professional staff will develop an activity calendar based on the results of the meetings. Additionally, direct support staff will be retrained regarding the need to offer suitable substitution options prepared food items when Clients request something to eat that is not on the day's menu.</i></p> <p>PREVENTION: Professional staff will monitor documentation and perform active treatment observations on all shifts no less than weekly and members of the Operations and Quality Assurance Teams will review documentation and observe active treatment no less than monthly to assure opportunities for choice and self management are supported.</p> <p>RESPONSIBLE PARTIES: Clinical Supervisor, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	03/10/2013			

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	<p>#2, "Coffee is not part of your meal. It's not on the menu." Client #2 stated, "I am allowed to have coffee." Client #2 opened the kitchen cabinet to get a package of coffee. DSP #2 redirected client #2 to put the coffee back in the cabinet. Client #2 was not offered the choice to have coffee with her evening meal. At 5:23 PM client #4 was seated at the dining room table participating in the group home family style meal. Client #4 was non verbal in that she communicated her wants and needs with gestures and non articulated vocal sounds. Client #4 sat down at the dining room table and pointed to the bowl of broccoli. Client #4 began waving her hands and arms in an "X" pattern with vocal sounds. CS #1 (Clinical Supervisor) stated, "[Client #4] doesn't want any of that broccoli." Client #4 was not offered an alternative food choice to broccoli.</p> <p>Client #1 was interviewed on 2/1/13 at 7:20 AM. When asked if she had been bowling or to the movies, client #1 stated, "We don't do that here. I would like to but we don't do that. We haven't been bowling or to the movies."</p> <p>Client #1's record was reviewed on 2/1/13 at 8:56 AM. Client #1's Progress notes dated from 1/31/13 through 11/1/12 indicated client #1 had not been to the movies, bowling or to a park.</p>						

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	<p>Client #2's record was reviewed on 1/31/13 at 11:28 AM. Client #2's Behavior Support Plan (BSP) dated 1/14/13 and ISP (Individual Support Plan) dated 1/14/13 did not indicate client #2 should be restricted from coffee.</p> <p>Interview with QMRP (Qualified Mental Retardation Professional) #1 on 1/31/13 at 12:28 PM indicated client #2 was not given coffee on 1/30/13. QMRP #1 indicated client #2 was not on a coffee restriction. QMRP #1 indicated client #2's BSP/ISP did not include being restricted from coffee. QMRP #1 indicated clients should be offered alternative food choices when they do not want an item from the menu. QMRP #1 indicated client #1 should be offered choices for outings and activities.</p> <p>9-3-4(a)</p>				

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W0250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to provide an active treatment schedule for staff to follow.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 2/1/13 at 8:56 AM. Client #1's ATS (Active Treatment Schedule) dated 10/26/12 did not indicate a schedule of activities from 9:00 AM to 4:00 PM Monday through Friday.</p> <p>Client #1 was interviewed on 2/1/13 at 7:20 AM. Client #1 indicated she did not attend day services or work during the day. Client #1 indicated she stayed at the group home with staff during the day while her peers were at work.</p> <p>Interview with QMRP (Qualified Mental Retardation Professional) #1 on 1/31/13 at 12:28 PM indicated client #1 did not attend day services or have a job during the day. QMRP #1 indicated the 10/26/12 ATS should indicate a schedule for staff to follow for client #1 for the hours of 9:00 AM through 4:00 PM Monday</p>			W0250	<p>CORRECTION: <i>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Specifically, Client #1's Active Treatment Scheduled will be revised to reflect Client B's current daily training activities.</i></p> <p>PREVENTION: Professional staff will be trained regarding the need to revise Active Treatment Schedules when the team changes a client's active treatment program. Members of the Quality Assurance and Operations Teams will review assessment data during routine visits to the facility which will occur no less than monthly as part of the agency's formal internal audit process.</p> <p>RESPONSIBLE PARTIES: Clinical Supervisor, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>		03/10/2013

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W0322	<p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 1 of 4 sampled clients (#2), the facility failed to provide an annual physical examination for client #2.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 1/31/13 at 11:28 AM. Client #2's record indicated no documentation of an annual physical examination.</p> <p>Interview with QMRP (Qualified Mental Retardation Professional) #1 on 2/1/13 at 10:30 AM indicated there should be documentation of an annual physical examination for client #2.</p> <p>Interview with AS (Administrative Staff) #1 on 2/1/13 at 10:49 AM indicated he would contact the facility nurse to obtain documentation of an annual physical for client #2.</p> <p>Electronic correspondence dated 2/1/13 at 11:18 AM from AS #1 indicated, after consultation with the facility nurse, no documentation could be located regarding client #2's annual physical examination.</p> <p>9-3-6(a)</p>	W0322	<p>CORRECTION: <i>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</i> Specifically, the facility has facilitated obtaining repairs eyeglasses.</p> <p>PREVENTION: Facility professional staff will be expected to review adaptive equipment cleaning/repair checklists no less than weekly to assure all adaptive equipment is in good repair. Additionally, members of the Operations and Quality Assurance Teams will conduct periodic active treatment observations on as needed but no less than monthly to assure that prescribed adaptive equipment is available and clients are utilizing it as recommended.</p> <p>RESPONSIBLE PARTIES: Clinical Supervisor, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	03/10/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/08/2013
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W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on record review and interview for 1 of 7 clients with adaptive equipment, the facility failed to provide client #3 with a pair of recommended eyeglasses.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 2/1/13 at 9:44 AM. Client #3's vision record of visit form dated 6/29/11 indicated, "picking out glasses, not eligible until 9/29/12."</p> <p>Interview with QMRP #1 (Qualified Mental Retardation Professional) #1 and AS (Administrative Staff) #1 on 2/1/13 at 10:49 AM indicated client #3's 6/29/11 vision exam recommended new prescription eyeglasses. QMRP #1 and AS #1 indicated client #3 had not received new glasses due to medicaid funding ineligibility. AS #1 indicated the facility should pay for new eyeglasses if medicaid would not provide funding.</p> <p>9-3-7(a)</p>	W0436	<p>CORRECTION:</p> <p><i>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Specifically, the facility has facilitated obtaining repairs eyeglasses.</i></p> <p>PREVENTION:</p> <p>Facility professional staff will be expected to review adaptive equipment cleaning/repair checklists no less than weekly to assure all adaptive equipment is in good repair. Additionally, members of the Operations and Quality Assurance Teams will conduct periodic active treatment observations on as needed but no less than monthly to assure that prescribed adaptive equipment is available and clients are utilizing it as recommended.</p> <p>RESPONSIBLE PARTIES:</p> <p>Clinical Supervisor, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	03/10/2013			

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W9999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division (15. A fall resulting in injury, regardless of the severity of the injury.).</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 10 allegations of abuse, neglect, mistreatment and exploitation reviewed, the facility failed to immediately notify BDDS (Bureau of Developmental Disabilities Services) regarding two separate incidents of falls with injuries regarding clients #1 and #2.</p> <p>Findings include:</p> <p>The facility's BDDS reports, investigations and incident reports were reviewed on 1/30/13 at 12:42 PM. The review indicated the following:</p> <p>-BDDS report dated 10/19/12 indicated on 10/19/12, "[Client #2] was awakened by staff to take morning medications when she fell out of bed, hitting the side of her head on the night stand in her bedroom. Staff noted no redness or</p>	W9999	<p>CORRECTION: <i>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division (15. A fall resulting in injury, regardless of the severity of the injury). Specifically, the facility will submit BDDS Incident Reports for Client #1's fall with injury on 12/9/12 and Client #2's fall with injury on 12/18/12.</i></p> <p>PREVENTION: Direct Support staff will be retrained regarding the need to report incidents to supervisory staff immediately and complete appropriate documentation. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Quality Assurance Manager who will in turn coordinate and follow-up with the facility Clinical Supervisor to assure incidents are reported to state agencies as required.</p> <p>RESPONSIBLE PARTIES: Clinical Supervisor, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	03/10/2013	

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	<p>bleeding. [Client #2] did complain of pain in the area she hit. Nurse on call was notified and [client #2] was taken to [hospital] emergency room for evaluation. At the emergency room, the area was checked as well as the wound from 10/18/12. No changes to wound, staples still intact...."</p> <p>-Incident report dated 10/18/12 indicated on 10/18/12 at 5:05 AM, "[Client #2] come (sic) into medication room and told staff she had fallen again out of bed." The 10/18/12 incident report indicated, "I checked [client #2] head (sic) which she had both dry and wet blood, bigger than a quarter, (sic) hurt when touched. Called [nurse #1] and she told us to take [client #2] to the emergency room." The review did not indicate the 10/18/12 fall with injury for client #2 had been reported to BDDS.</p> <p>-Incident report dated 12/9/12 at 1:50 AM indicated client #1, "Fell in her bedroom. Staff was at (sic) the living room hold on getting to the consumer room (sic). I met [client #1] on the floor as she had a swelling on the back of her head." The review did not indicate documentation the 12/9/12 fall with injury had been reported to BDDS.</p> <p>Interview with QMRP (Qualified Mental Retardation Professional) #1 on 2/1/13 at 10:30 AM indicated indicated falls with injury should be reported to BDDS.</p> <p>9-3-1(b)</p>				