

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/08/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203		
(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	
W0000	<p>This visit was for the fundamental recertification and state licensure survey.</p> <p>Survey dates: January 2, 3, 4 and 8, 2013</p> <p>Facility Number: 003184 Provider Number: 15G697 AIM Number: 200368720</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/11/13 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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W0104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the front and garage doors were repainted.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/2/13 from 3:47 PM to 6:00 PM and 1/3/13 from 5:56 AM to 7:25 AM. During the observations, the garage and front doors were missing paint. The doors were missing paint in a two foot by 5 inches section on the doors near the door handles. The missing paint exposed the metal on the doors. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/4/13 at 11:07 AM. The QMRP indicated the doors needed to be repainted. The QMRP indicated there was no work order submitted for the doors.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/4/13 at 11:40 AM. AS #1 indicated the doors and</p>	W0104	<p>W104</p> <p>Work order has been submitted for painting needs at this home. SGL Manager and Division Director have met with Property Manager to discuss procedures for reporting, scheduling, and completion of maintenance needs at the group homes. Group homes have been notified of the proper procedures. Work orders will be tracked by Property Manager, SGL Manager, and Division Director at this time to ensure timely completion or work.</p> <p>Responsibility for QA: QIDP, SGL Manager, Property Manager, Division Director</p>	02/07/2013			

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	house needed to be repainted. 9-3-1(a)				

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W0126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients accessed their client funds on a regular basis.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 1/2/13 at 1:32 PM. Client #1 had not accessed his funds since 10/23/12. Clients #2 and #3 had not accessed their funds since 9/21/12. Client #4 had not accessed his funds his 10/20/12. Client #4 had no money in his account from 7/3/12 to 10/19/12. Client #5 did not access his funds since 9/21/12. Client #5 did not access his funds from 7/3/12 to 9/20/12. Client #6 had not accessed his funds since 10/20/12.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/4/13 at 11:40 AM. AS #1 indicated the clients should access their funds at least one time per month. AS #1 did not know why the clients had not accessed their funds. AS #1 indicated the staff had been told to</p>	W0126	<p>W126</p> <p>SGL Manager has retrained the QIDP's on the importance of clients accessing their petty cash routinely. QIDP's will retrain their staff in this area. QIDP will review this at house meetings. QIDP or designee will review petty cash expenditures at least monthly to ensure compliance in this area.</p> <p>Responsible for QA: SGL Manager, QIDP</p>	02/07/2013			

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	ensure the clients accessed their money on a monthly basis. 9-3-2(a)				

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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 3 of 26 incident and investigative reports reviewed affecting clients #1, #3, #4, #5 and #6, the facility failed to implement their policies and procedures to conduct a thorough investigation of client #6's missing money within 5 working days, prevent client to client abuse, submit reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, and conduct an investigation of client to client abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/2/13 at 1:12 PM.</p> <p>1) On 11/19/12 at 12:45 PM, workshop staff discovered money missing from an unlocked desk drawer. Client #6 was missing \$4.00. The facility's investigation, dated 12/17/12, did not indicate client #6 was interviewed for the investigation. The investigation indicated several staff were interviewed however there was no documentation any clients were interviewed. The investigation indicated, "Upon interviewing each staff,</p>	W0149	<p>W149 Agency policy and procedures on prohibiting mistreatment, neglect, or abuse of clients, reporting of incidents to the state, and investigations were reviewed and determined appropriate. SGL manager has retrained QIDP's on timely reporting of incidents and completing investigations per agency policy. QIDP's will retrain staff on policy for reporting of incidents. SGL manager will review internal incident reports to ensure state reports and investigations are completed as required.</p> <p>Responsible for QA: SGL Manager, QIDP</p>	02/07/2013			

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	<p>no conclusion was able to be reached on who the money was taken by. The money was kept in a locked drawer. Upon investigating, the lock had to be cut off because the key was missing. A new lock was to be purchased, but the money was taken before a new lock made it onto the drawer. The money came up missing between 3:30 PM on Friday and 11:00 AM on Monday."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/4/13 at 11:07 AM. The QMRP indicated investigations should be completed within 5 working days of the incident.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/4/13 at 11:40 AM. AS #1 indicated investigations should be completed within 5 working days of the incident.</p> <p>2) On 9/14/12 at 8:15 AM, client #3 bit client #4 while in the van after the staff took a sharp turn and client #4 fell onto client #3. There was no documentation indicating where client #4 was bitten or if there was an injury. The facility did not report the incident to BDDS. The facility did not conduct an investigation.</p> <p>3) On 12/24/12 at 5:30 PM, client #5</p>				

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	<p>pinched client #4 and hit client #1. The incident was reported to BDDS on 12/27/12.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/4/13 at 11:07 AM. The QMRP indicated the staff should prevent client to client abuse as much as they physically were able to. The QMRP indicated BDDS reports should be submitted within 24 hours. The QMRP indicated the facility should investigate incidents of client to client abuse. The QMRP indicated she failed to document her investigation of client #3 biting client #4. The QMRP indicated upon investigating the incident, client #3 did not make contact with client #4's skin due to client #4 wearing a coat.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/4/13 at 11:40 AM. AS #1 indicated the staff should prevent client to client abuse. AS #1 indicated the facility should investigate client to client abuse. AS #1 indicated BDDS reports should be submitted within 24 hours of the incident and investigations should be completed within 5 working days of the incident. AS #1 indicated, on 1/2/13 at 2:10 PM, a BDDS report and investigation were not completed for client #3 biting client #4</p>			

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	<p>since she did not feel like it was aggression. AS #1 indicated there was no willful attempt to harm. AS #1 indicated she did not document her investigation into the incident.</p> <p>A review of the facility's policy and procedure for Identifying and Reporting Violations of Client Rights, dated 4/12/06, was reviewed on 1/2/13 at 2:26 PM. The policy indicated rights violations included abuse, neglect, exploitation and mistreatment. Abuse was defined as, "the intentional or willful infliction of physical injury, the unnecessary use of physical or chemical restraints or isolation, punishment that results in physical harm or pain." Verbal/Emotional Abuse was defined as "includes oral, written, and/or gestured language that includes disparaging or derogatory remarks. Also includes demeaning tones or harsh language. Includes unreasonable confinements, intimidation or humiliation." Neglect was defined as, "Placing an individual in a situation that may endanger his or her life or health; includes failure to provide appropriate care, food, medical care, shelter, or supervision." Exploitation was defined as, "Unauthorized use of a person or his or her resources for one's own profit or advantage. Includes any deliberate misplacement or use of an</p>						

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	<p>individual's belongings or money." The policy indicated, in part, "1. The staff person should document their concern or the reason for suspicion and submit to their supervisor/QMRP within 24 hours. The supervisor/QMRP is responsible to complete the state incident report and submit to the appropriate entities: Bureau of Developmental Disabilities/Bureau of Quality Improvement Services/Bureau of Aging and In Home Services." The facility's Protocol for Completing Investigations, dated 1/3/06, indicated, "The investigation must be initiated within 24 hours and completed within 5 working days." The policy indicated, in part, "...will be investigated immediately and thoroughly."</p> <p>9-3-2(a)</p>			

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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 2 of 26 incident and investigation reports reviewed affecting clients #1, #3, #4 and #5, the facility failed to submit reportable incidents of client to client aggression to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/2/13 at 1:12 PM.</p> <p>1) On 9/14/12 at 8:15 AM, client #3 bit client #4 while in the van after the staff took a sharp turn and client #4 fell onto client #3. There was no documentation indicating where client #4 was bitten or if there was an injury. The facility did not report the incident to BDDS.</p> <p>2) On 12/24/12 at 5:30 PM, client #5 pinched client #4 and hit client #1. The incident was reported to BDDS on 12/27/12.</p>	W0153	<p>w153 Agency policy and procedures on prohibiting mistreatment, neglect, or abuse of clients, reporting of incidents to the state, and investigations were reviewed and determined appropriate. SGL manager has retrained QIDP's on timely reporting of incidents and completing investigations per agency policy. QIDP's will retrain staff on policy for reporting of incidents. SGL manager will review internal incident reports to ensure state reports and investigations are completed as required.</p> <p>Responsible for QA: SGL Manager, QIDP</p>	02/07/2013	

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	<p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/4/13 at 11:07 AM. The QMRP indicated BDDS reports should be submitted within 24 hours.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/4/13 at 11:40 AM. AS #1 indicated BDDS should be submitted within 24 hours of the incident.</p> <p>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 2 of 26 incident and investigation reports reviewed affecting clients #3, #4 and #6, the facility failed to conduct a thorough investigation of client #6's missing money and an investigation of client to client abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/2/13 at 1:12 PM.</p> <p>1) On 11/19/12 at 12:45 PM, workshop staff discovered money missing from an unlocked desk drawer. Client #6 was missing \$4.00. The facility's investigation, dated 12/17/12, did not indicate client #6 was interviewed for the investigation. The investigation indicated several staff were interviewed however there was no documentation any clients were interviewed. The investigation indicated, "Upon interviewing each staff, no conclusion was able to be reached on who the money was taken by. The money was kept in a locked drawer. Upon investigating, the lock had to be cut off because the key was missing. A new lock</p>	W0154	<p>W154 Agency policy and procedures on prohibiting mistreatment, neglect, or abuse of clients, reporting of incidents to the state, and investigations were reviewed and determined appropriate. SGL manager has retrained QIDP's on timely reporting of incidents and completing investigations per agency policy. QIDP's will retrain staff on policy for reporting of incidents. SGL manager will review internal incident reports to ensure state reports and investigations are completed as required.</p> <p>Responsible for QA: SGL Manager, QIDP</p>	02/07/2013			

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	<p>was to be purchased, but the money was taken before a new lock made it onto the drawer. The money came up missing between 3:30 PM on Friday and 11:00 AM on Monday."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/4/13 at 11:07 AM. The QMRP indicated the investigation was not thorough since clients were not interviewed.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/4/13 at 11:40 AM. AS #1 indicated the investigator should have interviewed clients for the investigation. AS #1 indicated the investigation was not thorough since clients were not interviewed.</p> <p>2) On 9/14/12 at 8:15 AM, client #3 bit client #4 while in the van after the staff took a sharp turn and client #4 fell onto client #3. There was no documentation indicating where client #4 was bitten or if there was an injury. The facility did not conduct an investigation.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/4/13 at 11:07 AM. The QMRP indicated the facility should investigate incidents of client to client</p>			

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	<p>abuse. The QMRP indicated she failed to document her investigation of client #3 biting client #4. The QMRP indicated upon investigating the incident, client #3 did not make contact with client #4's skin due to client #4 wearing a coat.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/4/13 at 11:40 AM. AS #1 indicated the facility should investigate client to client abuse. AS #1 indicated, on 1/2/13 at 2:10 PM, an investigation were not completed for client #3 biting client #4 since she did not feel like it was aggression. AS #1 indicated there was no willful attempt to harm. AS #1 indicated she did not document her investigation into the incident.</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 26 incident/investigative reports reviewed affecting client #6, the facility failed to ensure an investigation of client #6's missing money from the facility-operated workshop was conducted within 5 working days.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 1/2/13 at 1:12 PM.</p> <p>On 11/19/12 at 12:45 PM, workshop staff discovered money missing from an unlocked desk drawer. Client #6 was missing \$4.00. The facility's investigation, dated 12/17/12, did not indicate client #6 was interviewed for the investigation. The investigation indicated several staff were interviewed however there was no documentation any clients were interviewed. The investigation indicated, "Upon interviewing each staff, no conclusion was able to be reached on who the money was taken by. The money was kept in a locked drawer. Upon</p>	W0156	<p>w156 Agency policy and procedures on prohibiting mistreatment, neglect, or abuse of clients, reporting of incidents to the state, and investigations were reviewed and determined appropriate. SGL manager has retrained QIDP's on timely reporting of incidents and completing investigations per agency policy. QIDP's will retrain staff on policy for reporting of incidents. SGL manager will review internal incident reports to ensure state reports and investigations are completed as required.</p> <p>Responsible for QA: SGL Manager, QIDP</p>	02/07/2013			

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	<p>investigating, the lock had to be cut off because the key was missing. A new lock was to be purchased, but the money was taken before a new lock made it onto the drawer. The money came up missing between 3:30 PM on Friday and 11:00 AM on Monday."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/4/13 at 11:07 AM. The QMRP indicated investigations should be completed within 5 working days of the incident.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/4/13 at 11:40 AM. AS #1 indicated investigations should be completed within 5 working days of the incident.</p> <p>9-3-2(a)</p>			

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W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 1 of 3 clients in the sample (#6), the facility failed to ensure client #6's Behavior Support Plan (BSP) contained reactive strategies for his targeted behavior of inappropriate expression of anger for the group home setting.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/2/13 from 3:47 PM to 6:00 PM and 1/3/13 from 5:56 AM to 7:25 AM. On 1/2/13 at 3:58 PM, client #6 was prompted to get his medications by staff #4. Client #6 walked into the room, extended his middle finger at the surveyor and walked out. At 4:07 PM, client #6 indicated he did not want the surveyor to observe his med pass. Client #6 waved his fists in the surveyor's face and went with staff #4 to get his medications. At 4:12 PM, client #6 broke staff #1's fingernail by grabbing her hand. At 5:22 PM when prompted to get up for dinner, client #6 stated, "No! No!" At 5:24 PM, client #6 exited his room and extended his middle finger toward staff #4. Client #6 spit at the surveyor as the surveyor</p>	W0240	<p>W240 QIDP contacted Client #6's BC and the BSP has been revised to include reactive strategies for the targeted behavior of inappropriate expression of anger in the group home setting. Staff will be trained on the revision to the plan. QIDP will review behavior tracking information for client #6 and QIDP or designee will document observations in the home at least monthly to ensure compliance in this area.</p> <p>Responsible for QA: QIDP</p>	02/07/2013			

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	<p>walked past client #4. At 5:28 PM, client #6 refused to pour his milk. At 5:32 PM, client #6 hit client #5 and then hugged client #5. At 5:25 PM, client #6 indicated he was not going to eat dinner. He sat down in a recliner in the living room and turned on the television. Client #6 turned the television off and went to wash his hands. At 5:37 PM, client #6 smacked client #5 in the face as client #5 walked past client #6. On 1/3/13 at 6:31 AM, client #6 and client #2 hit each other in the arms. At 6:36 AM, client #6 took a lunch box out to the van in the garage. When redirected it was not time to go by staff #2, client #6 stated, "F--- you, d---!"</p> <p>A review of client #6's record was conducted on 1/3/13 at 11:18 AM. Client #6's BSP, dated 8/12/12, indicated client #6 had a targeted behavior of inappropriate expression of anger. This was defined as sticking out his tongue at others, obscene gestures, calling derogatory names, throwing items, attempting to get out of his seatbelt while a vehicle was moving, hitting others, spitting at others, or leaving the work area before time. The Reactive Measure section of the BSP addressing inappropriate expression of anger did not address this behavior at the group home. The BSP addressed the behavior at the workshop but not at the group home.</p>			

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	<p>There was nothing in client #6's BSP addressing inappropriate expression of anger while at the group home.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/4/13 at 11:07 AM. The QMRP indicated client #6's plan should address the behavior at the group home.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/4/13 at 11:40 AM. AS #1 indicated client #6's plan should address the behavior at the group home.</p> <p>An interview with the Behavior Consultant (BC) was conducted on 1/4/13 at 2:53 PM. The BC indicated the plan did not address the behavior at the group home. The BC indicated the plan needed to be revised to address the behavior while at the group home. The BC indicated historically, the behavior occurred at the workshop and not at the home however the behavior did occur at the home.</p> <p>9-3-4(a)</p>						

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W0248	<p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 2 of 3 clients in the sample (#5 and #6), the facility failed to ensure the group home staff had access to the clients' current Behavior Support Plans (BSP) at the group home.</p> <p>Findings include:</p> <p>A review of client #5's record was conducted on 1/3/13 at 10:44 AM. Client #5's current BSP, dated 9/11/12, was not in his records obtained and reviewed from the group home. The group home records contained a plan dated 8/12/11.</p> <p>A review of client #6's record was conducted on 1/3/13 at 11:18 AM. Client #6's current BSP, dated 8/12/12, was not in his records obtained and reviewed from the group home. The group home records contained a plan dated 9/12/11.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/4/13 at 11:07 AM. The QMRP indicated the group home staff should have access in the clients' records</p>	W0248	<p>W248 QIDP will ensure that an audit is completed of each client's records at the home and that current program plans and behavior support plans are in place. QIDP will conduct random audits at least monthly to ensure compliance continues in this area.</p> <p>Responsible for QA: QIDP</p>	02/07/2013			

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	<p>to the current BSPs.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/4/13 at 11:40 AM. AS #1 indicated the group home staff should have access in the clients' records to the current BSPs.</p> <p>9-3-4(a)</p>						

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 3 of 3 clients in the sample (#4, #5 and #6) and one additional client (#1), the facility failed to implement the clients' program plans, as written.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 1/2/13 from 3:47 PM to 6:00 PM and 1/3/13 from 5:56 AM to 7:25 AM.</p> <p>On 1/2/13 at 3:54 PM, client #1 received his medication (Risperidone for schizophrenia) from staff #4. Staff #4 did not inform client #1 of the name, purpose or side effects of the medication. Staff #4 did not prompt client #1 to identify his medication or the possible side effects using picture symbols.</p> <p>On 1/2/13 at 4:02 PM, client #5 received his medications (Valproic acid for epilepsy and Artificial Tears for chronic</p>	W0249	<p>W249</p> <p>Staff will be retrained on implementation of each client's individual program plans. Specific training will include but not be limited to the implementation of medication training objectives during each med pass for each client, dining plan for Client #6, and line of sight supervision for Client #6. QIDP or designee will observe at least weekly for one month then monthly thereafter in the home and at the workshop to ensure compliance in these areas.</p> <p>Responsible for QA: QIDP</p>	02/07/2013

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	<p>dry eyes) from staff #4. Client #5 was not prompted to get his water for his medications or identify the side effects of his medications.</p> <p>On 1/3/13 at 5:58 AM, client #1 received his medications (Folic Acid for anemia, Vitamin D-3 as a supplement, Ferrous Sulfate for anemia, Gemfibrozil for cholesterol, Metoprolol for hypertension, Risperidone for schizophrenia, Senna for constipation, Uramaxin for dry skin) from staff #5. Staff #5 did not inform client #1 the name, purpose or side effects of the medication. Staff #4 did not prompt client #1 to identify his medication or the possible side effects using picture symbols.</p> <p>On 1/3/13 at 6:11 AM, client #4 received his medications (Advair for chronic obstructive pulmonary disease, Diltiazem for epilepsy, Ferrous Sulfate for anemia, Levetiracetam for epilepsy, Olanzapine for schizophrenia, Primidone for epilepsy, Risperidone for schizophrenia, Sertraline for schizophrenia, Vitamin B-12 for vitamin deficiency and Vitamin D-3 for vitamin deficiency) from staff #5. Staff #5 asked client #4 to name his medications however client #4 indicated he forgot. Staff #5 did not inform client #4 of the name, purpose or side effects of his medications. Staff #5 did not</p>						

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	<p>encourage client #4 to try to remember the names of his medications. Staff #5 did not ask client #4 to identify the side effects of his medications.</p> <p>A review of client #1's record was conducted on 1/3/13 at 11:15 AM. Client #1's Individual Program Plan (IPP), dated 1/12 - 1/13, indicated he had medication training objectives to identify the side effects of his medications using picture symbols and his medications.</p> <p>A review of client #4's record was conducted on 1/3/13 at 10:12 AM. Client #4's IPP, dated 2/12 - 2/13, indicated he had medication training objectives to identify the side effects and names of his medications.</p> <p>A review of client #5's record was conducted on 1/3/13 at 10:44 AM. Client #5's IPP, dated 2/12 - 2/13, indicated he had medication training objectives to get his water for the medication administration and to identify his medication's side effects.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/4/13 at 11:07 AM. The QMRP indicated the staff should implement the clients' medication administration training goals at each</p>						

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	<p>medication pass.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/4/13 at 11:40 AM. AS #1 indicated the staff should implement the clients' medication administration training goals at each medication pass.</p> <p>2) Observations were conducted at the group home on 1/2/13 from 3:47 PM to 6:00 PM and 1/3/13 from 5:56 AM to 7:25 AM. On 1/2/13 at 5:43 PM, dinner started. During dinner, client #6 did not receive prompts from staff #1 and #4 to take small bites and sips or double swallow prior to his next bite. On 1/3/13 at 6:28 AM, client #6 ate breakfast sitting at the dining room table by himself. There was no staff sitting at the table and the staff did not prompt client #6 during breakfast.</p> <p>A review of client #6's record was conducted on 1/3/13 at 11:18 AM. Client #6's Dining Plan, dated 6/21/12, indicated client #6, "Should have a double swallow prior to next bite. Should be given verbal cues to take small bites, small sips. Staff should be seated at eye level within arm's length - 100% supervision."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was</p>						

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	<p>conducted on 1/4/13 at 11:07 AM. The QMRP indicated the plan should be implemented as written.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/4/13 at 11:40 AM. AS #1 indicated the plan should be implemented as written.</p> <p>3) Observations were conducted at the group home on 1/2/13 from 3:47 PM to 6:00 PM and 1/3/13 from 5:56 AM to 7:25 AM. On 1/2/13 at 3:58 PM, client #6 was prompted to get his medications by staff #4. Client #6 walked into the room, extended his middle finger at the surveyor and walked out. At 5:24 PM, client #6 exited his room and extended his middle finger toward staff #4. Client #6 spit at the surveyor as the surveyor walked past client #4. Staff was not present to observe. At 5:32 PM, client #6 hit client #5 and then hugged client #5. At 5:25 PM, client #6 indicated he was not going to eat dinner. He sat down in a recliner in the living room and turned on the television. Client #6 turned the television off and went to wash his hands. At 5:37 PM, client #6 smacked client #5 in the face as client #5 walked past client #6. Staff was not present to observe. On 1/3/13 at 6:31 AM, client #6 and client #2 hit each other in the arms. Staff was not present to observe. Staff were not</p>			

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	<p>observed to wear a card with a plastic "C" during the observations at the group home. Staff were not observed to notify another staff member to assume the responsibility of client #6 during the observations.</p> <p>A review of client #6's record was conducted on 1/3/13 at 11:18 AM. Client #6's BSP, dated 8/12/12, indicated client #6 had a targeted behavior of inappropriate expression of anger. This was defined as sticking out his tongue at others, obscene gestures, calling derogatory names, throwing items, attempting to get out of his seatbelt while a vehicle was moving, hitting others, spitting at others, or leaving the work area before time. The plan indicated, "[Client #6] will have LINE OF SIGHT SUPERVISION by staff AT ALL TIMES during waking hours, and nightly bed checks every 1/2 hour at home." The plan indicated, "Given every shift, 24/7, one staff member will be 'assigned' line of sight supervision for [client #6]. If the staff member needs to use the restroom, or leave line of sight supervision for any reason, they will notify another staff member present to assure line of sight supervision until their return, and then 'assume' their responsibility."</p> <p>An interview, in an email, with the</p>			

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	<p>Qualified Mental Retardation Professional (QMRP) was conducted on 1/4/13 at 7:14 PM. The QMRP indicated, in part, "...The plan should be implemented as written. The staff are trained by the behaviorist on the BSP when they are hired and periodically by the Q (QMRP) at team meetings regarding line of sight supervision. There is not a sign off sheet for staff but there is a clip on plastic 'C' card that staff are to wear and pass off to other staff when they need to leave supervision."</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/4/13 at 5:55 PM by email. AS #1 indicated the staff should implement client #6's plan as written. AS #1 indicated, in part, "Staff should have a card that identifies they are the line of sight supervision. They need to pass this off to another staff should they need to leave this supervision."</p> <p>9-3-4(a)</p>						

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W0440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure quarterly evacuation drills were conducted for each shift.</p> <p>Findings include:</p> <p>A review of the evacuation drills was conducted on 1/3/13 at 8:36 AM. On day shift (7:00 AM to 3:00 PM), there were no drills conducted from 5/6/12 to 11/22/12. On night shift (11:00 PM to 7:00 AM), there were no drills conducted from 1/2/12 to 5/10/12.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/4/13 at 11:07 AM. The QMRP indicated the facility scheduled evacuation drills to occur one time per quarter for each shift. The QMRP indicated the staff did not implement the schedule.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/4/13 at 11:40 AM. AS #1 indicated there should be one evacuation drill per shift per quarter.</p> <p>9-3-7(a)</p>	W0440	<p>W440 QIDP will retrain staff on the requirements for regular evacuation drills. A schedule of the drills will be posted in the home. Staff will turn in monthly documentation to the QIDP of the evacuation drills completed that month. QIDP will compare with the drill schedule to ensure compliance in this area.</p> <p>Responsible for QA: QIDP</p>	02/07/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/08/2013
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W0488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, interview and record review for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients were involved with dinner preparation, breakfast clean up, pouring their own drinks at the group home and facility-operated day program and packing their own lunches.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/2/13 from 3:47 PM to 6:00 PM. At 5:18 PM, staff #1 used the food processor to chop and puree chicken. At 5:32 PM, staff #1 used scissors to cut up chicken into bite size pieces. Clients #1, #3, #4, #5 and #6 were in the group home and available to assist. None of the clients was asked to assist staff #1.</p> <p>An observation was conducted at the group home on 1/3/13 from 5:56 AM to 7:25 AM. At 6:19 AM, staff #1 loaded the dishwasher. At 6:26 AM, staff #1 continued to clean up after breakfast. At 6:28 AM, staff #1 wiped off the counters and hand washed the food processor pieces. At 6:31 AM, staff #2 indicated to</p>	W0488	<p>W488</p> <p>QIDP will retrain staff in how to support each client in the meal preparation and clean up, and in dining that is consistent with their skill level and as identified in their IPP's both at home and in the day program. The QIDP or designee will observe mealtime procedures at least weekly for one month to ensure compliance in this area. Random observations will continue at least monthly.</p> <p>Responsible for QA: QIDP</p>	02/07/2013			

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	<p>staff #1 that staff #5 prepared the clients' lunches. Staff #2 asked staff #5 if the vegetable juice on the counter went into the clients' lunches. Staff #2 then put the vegetable juice in the clients' lunches. At 6:42 AM, staff #1 put dishwasher detergent in the dishwasher. At 6:50 AM, staff #1 warmed up coffee for client #5 and then took the coffee to him. At 6:55 AM, staff #2 put two cups of coffee into the microwave for clients #1 and #4. At 6:59 AM, client #5 walked up to staff #1, pulled on her and she asked what he wanted. Staff #1 took client #5's cup to the sink, filled it with water and gave it to client #5. At 7:02 AM, client #5 put his cup in the sink. Staff #2 picked it up and put it into the dishwasher. Clients #1, #2, #3, #4, #5 and #6 were present and available to assist with breakfast clean up and getting their own coffee. None of the clients were prompted to assist with the tasks. The clients were not observed to prepare their own lunches.</p> <p>An observation was conducted at the facility-operated day program on 1/3/13 from 9:07 AM to 9:50 AM. At 9:26 AM, staff #8 gave clients #2 and #5 a cup of coffee. Staff #8 poured client #3 a cup of coffee and gave it to client #2 to take to client #3. Clients #2, #3 and #5 were not prompted to pour their own coffee.</p>			

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	<p>An interview with staff #1 was conducted on 1/2/13 at 5:09 PM. Staff #1 indicated the overnight staff pack the clients' (#1, #2, #3, #4, #5 and #6) lunches.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/4/13 at 11:07 AM. The QMRP indicated she did not know why the staff were doing the tasks for the clients. The QMRP indicated she thought the staff were assisting the clients. The QMRP indicated the clients were capable of doing the tasks. The QMRP indicated the staff were not trained to pack the clients' lunches. The QMRP indicated the clients should be as independent as possible at all times.</p> <p>An interview with Administrative staff #1 (AS #1) was conducted on 1/4/13 at 11:40 AM. AS #1 indicated the clients should pack their own lunches to the best of their ability. AS #1 indicated the clients should participate in all aspects of clean up after meals and serving themselves.</p> <p>9-3-8(a)</p>				