

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G469	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/20/2015
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NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1111 S OAK ST BLUFFTON, IN 46714
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 11/9, 11/10, 11/12, 11/13, 11/16, 11/17, 11/18, and 11/20/2015.</p> <p>Provider Number: 15G469 Facility Number: 000983 AIM Number: 100244850</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/2/15.</p>	W 0000		
W 0125 Bldg. 00	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review, and interview, for 3 of 3 sampled clients (clients #1, #2, and #3) and 3 additional clients (clients #4, #5, and #6), the facility failed to ensure clients #1, #2, #3, #4, #5, and #6 were provided training and</p>	W 0125	<p>W125-Client Protections BCS must ensure the rights of allclients. We must allow and encourage individual clients to exercise theirrights as citizens of the United States, and as a person residing at BCS,</p>	12/20/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>encouraged to exercise their rights as United States citizens when their group home was used by the agency as a Day Services Site and to ensure unimpeded access to locked temperature controls and a locked refrigerator for clients who did not have documented assessments for the restricted access to the locked items.</p> <p>Findings include:</p> <p>1. On 11/09/15 from 3:10pm until 6:18pm and on 11/10/15 from 5:50am until 7:50am, clients #1, #2, #3, #4, #5, and #6's group home was visited. During both observation periods a sheet of paper was posted on the office area near the side entrance of the group home which identified two groups that held weekly visits to the group home. On 11/9/15 at 3:15pm, the Residential Manager (RM) provided and indicated a list of clients who attended the weekly day services at the group home. Group one, the "Dazzling Divas," included client #5 and four other ladies from outside the group home. Group two, the "Classy Ladies," included client #4 on the list with three other ladies from outside the group home. At 3:30pm, the RM indicated both groups replaced attending the day services site at the agency and was staffed by the agency. The RM indicated the clients who attended day services at the group home</p>		<p>including the right to file complaints, and the right to due process. BCS was found to be deficient in not meeting this standard as evidenced by failure to ensure that the six residents of the OAK group home were provided training and encouraged to exercise their rights as U.S. citizens when their group home was used by the agency as a Day Services (DS) site and to ensure unimpeded access to locked temperature controls & refrigerator for consumers not having documented assessments for the restricted access to locked items. A) Corrective Action and Follow-Up Specific to all six residents of the OAK group home & their rights regarding DS group concerns:</p> <p>1. A DS Alternative Program (AP) planning team was developed to explore options for alternative site/locations for special interest groups held at BCS residential group homes operated by BCS. This team is made up of administrative and management staff invested in providing consumer requested special interest AP groups as part of their DS program choice(s). The group includes the Quality Assurance Manager (QAM), DS Coordinator, Residential Administrator (RA), Administrative Assistant and Program Director (PD). Interviewing consumers, advocates, guardians,</p>				

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	<p>had access to clients #1, #2, #3, #4, #5, and #6's group home, watched television, ate meals, used the bathrooms, and used the group home equipment during day service times. During both observation periods a locked refrigerator located in the hallway between the dining room and the hallway to access client bedrooms was labeled for "Day Services."</p> <p>2. On 11/09/15 from 3:10pm until 6:18pm and on 11/10/15 from 5:50am until 7:50am, clients #1, #2, #3, #4, #5, and #6's group home was visited. During both observation periods a refrigerator located in the hallway between the dining room and client bedrooms was kept locked. On 11/9/15 at 5:10pm, GHS (Group Home Staff) #1 and client #6, retrieved the key to the locked refrigerator, unlocked the lock, client #6 was assisted to pick her flavored water from the locked refrigerator, and relocked the refrigerator. At 5:10pm, GHS #1 indicated the locked refrigerator was kept locked to secure the day services food. On 11/10/15 at 6:05am, GHS #1 unlocked the secured refrigerator to allow client #4 to access eggs, apple juice, and an Aloe Vera vitamin drink.</p> <p>During both observation periods the temperature control located in the living room had a cover that was locked. On</p>		<p>HealthCare Representatives (HCR) and other pertinent individuals in the consumers' lives was started in early December. This group will continue to meet regularly until such time as all concerns, requests and options for sites have been explored, decisions made and plans implemented. Thereafter the group will meet as needed &/or quarterly for additional consumer program requests and as part of the DS Program Evaluation and Outcome Measurement strategies for CARF.</p> <p>2. During the week of December 7th all six of the OAK residents received re-training on "Your Rights" which is a component of the Consumer Handbook and is reviewed annually. In addition to the review of rights, specific components related to their home environment such as personal privacy, feeling safe, & advocating when there are things that you don't like &/or things that are important to you were discussed. In particular we spent time talking about their thoughts/feelings regarding DS groups held in their home, as well as restrictions on access to things in their home (this will be addressed in section B). Two of the ladies had very strong, positive feelings regarding the Dazzling Diva's & Classy Ladies group being located at their home. As they stated loud and clear that this is their home and they like</p>				

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	<p>11/9/15 at 4:35pm, clients #4 and #5 both indicated the clients at the group home did not have keys for the locked temperature control and had to ask staff to change the temperature.</p> <p>On 11/10/15 at 11:50am, client #1's record was reviewed. Client #1's 7/23/15 ISP (Individual Support Plan) and record did not indicate consent and/or notification which included information regarding the agency providing Day Services in the group home. Client #1's record did not indicate an assessed need and consent regarding the locked refrigerator and the locked temperature control.</p> <p>On 11/10/15 at 12:25pm, client #2's record was reviewed. Client #2's 3/1/15 ISP (Individual Support Plan) and record did not indicate consent and/or notification which included information regarding the agency providing Day Services in the group home. Client #2's record did not indicate an assessed need and consent regarding the locked refrigerator and the locked temperature control.</p> <p>On 11/10/15 at 10:30am and on 11/12/15 at 9:40am, client #3's record was reviewed. Client #3's 7/1/15 ISP (Individual Support Plan) and record did</p>		<p>having their friends there. For consumer's #4 & 5, especially, having their groups in their home is very important to them. Asconsumer #5's guardian stated to the QIDP, she was "a little upset about beingasked permission for something I already know about & support because she lovesgroup & loves that it is in her home". Of the other four ladies living inthe home, consumer's #1, 2 & 6 said that they think it is OK to have thetwo groups at OAK. Consumer #3 was not able to provide informed consent,however her guardian felt that having groups there is fine & she has no concerns.</p> <p>3. Over the course of December 1stthrough 11th, all of the BCS alternative DS program sites werevisited and all participants re-trained on rights, responsibilities andrespecting others. We provided information regarding potential changes insites/locations for some of our DS special interest alternative programsgroups. The Dazzling Diva's expressed they would prefer to stay at the currentsite at OAK, following the lead of consumer #5 who wants the group to stay ather home. They said that it feels homey and that they really like getting awayfrom the agency & coming to OAK. They said that they feel welcome. TheDazzling Divas have demonstrated that they respect</p>		

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	<p>not indicate consent and/or notification which included information regarding the agency providing Day Services in the group home. Client #3's record did not indicate an assessed need and consent regarding the locked refrigerator and the locked temperature control.</p> <p>On 11/10/15 at 11:05am, an interview was conducted with the Agency Program Director/Qualified Intellectual Disabilities Professional (APD/QIDP). The APD/QIDP indicated the agency had not notified clients #1, #2, #3, #4, #5, and #6 and/or their legally sanctioned representatives that Day Services were housed within the group home. The APD/QIDP indicated the agency allowed other agency clients, other agency staff, and visitors not associated directly with client #1, #2, #3, #4, #5, and #6's group home to have access to their group home, the living space, and equipment.</p> <p>On 11/12/15 at 9:40am, an interview was conducted with the APD/QIDP. The APD/QIDP indicated clients #1, #2, #3, #4, #5, and #6 had not been assessed as needing the refrigerator and group home air temperature controls locked. The APD/QIDP indicated no further information was available for review.</p> <p>9-3-2(a)</p>		<p>the home and the people who live there; there has never been any privacy invaded or misuse of property. They understood that changes in location may happen but they advocated for staying at OAK if possible. The Classy Ladies group also advocated staying in their current location at OAK. One of the group members cried when we discussed alternate locations and why that might have to happen. Again, consumer #4 was very adamant about having "our group at my home. These are my friends and I want them here". She feels that her rights are being "messed with" and has been upset about it.</p> <p>4. The week of December 7th all of the guardian & HCR's for the consumers living at OAK were contacted by the QIDP in order to provide information about the DS groups at OAK and to see what concerns, questions &/or support they might have in regards to their loved one and groups being held in their home. Many of the guardians/HCR were aware of the two groups held at the home and no one offered any concerns or criticisms of these groups. Two requested assurance that no one goes into anyone's bedrooms. They were assured that their concern has not been an issue & respecting the OAK ladies privacy while at group is a priority. Two felt that it has had a positive impact with their loved ones. For example, consumer #4 is learning</p>				

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			<p>to be a role model & leader & is more confident and that consumer #1 has more opportunities to socialize with others in a less stimulating environment. All guardians/HCR's were agreeable to sign a consent form stating such agreement.</p> <p>5. Due to popular demand by consumers, consent agreement by the OAK residents & their guardians/HCR's, the two groups (Dazzling Diva's Classy Ladies) will remain at the current location at this time. There can be further discussion in the future, but for now the wishes of the consumers involved weigh strongly into the decision. Both groups are functional & focused with specific training/services provided. These are not groups where they are lounging around in someone's home watching TV and snacking. They are respectful of the home.</p> <p>6. All consumers at OAK will have addendums made to their ISP indicating notification and consent agreement to alternative DS groups being held in their home effective date of their consent as well as agreement by HCR &/or guardian. Should both groups continue to participate at the OAK setting in the future then agreement to such plan will be discussed at each consumer's annual case conference to assure that each individual continues to feel that same about consent to have groups in their home. This</p>		

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			<p>will be documented in the narrative portion of the ISP & signed off on by the consumer & their HRC/ guardian. Effective 12/20/15 and then ongoing.</p> <p>7. Starting the week of December 14th 2015, all DS AP's located in group homes &/or relocated to other sites/locations will receive training at least monthly on important advocacy issues involved with rights, responsibilities and the consumer grievance procedure ("What to Do If I Don't Like Something") from the Consumer Handbook. This is a starting point for exploring opportunities to allow & encourage consumers to learn more about exercising their rights & encouraging independence to the extent of their abilities. Training will be documented by use of the Consumer Inservice Training form with an outline of training focus attached & submitted to the QAM & PD for review by the end of each month. Consumer training documentation will be kept with the Administrative Assistant and monitored quarterly by the DS Alternative Program Planning Team.</p> <p>8. All direct care staff working with residential consumers across all settings will be retrained on items from the Consumer Handbook including "Your Rights" and the "The Grievance Procedure". Training will also include further discussion</p>	

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			<p>on consumerrights and encouraging advocacy.</p> <p>9.All RMT's & administrativeteam members will be trained on items A.1-8 to assure an understanding ofconsumer protections, programming involved and training staff & consumers. Persons responsible: OAK Management Team; Program Director (PD); Quality AssuranceManager (QAM); Residential Administrator (RA); DS Coordinator; AdministrativeAssistant and Alternative Program (AP) Trainers. Target completion date: 12/20/15</p> <p>B) Corrective Action as it relates to all sixOAK consumers and restricted access to locked items:</p> <p>1.Upon review at the OAK grouphome, the QIDP & Program Director deemed that the restricted items,including a locked refrigerator & thermostat were in violation of all sixladies rights as the restrictions were in place without due cause related tothem. They should be free to move about without limitations due to staffpreference or convenience.</p> <p>2.There is no need for any refrigeratorat OAK to be locked and/or identified as "Day Services". The lock was removed onNovember 12th 2015 and refrigerator is now accessible to the OAKladies. In the future DS alternative groups will bring any food supplies neededwith them</p>	

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			<p>for that day when coming for their weekly group sessions.</p> <p>3. The lock for the thermostat was removed on 11/12/15 as well. The lock had been placed on the thermostat due to staff & consumers adjusting it at random. The thermostat will be monitored throughout the day/night to assure that it is set at a temperature that is agreeable to the ladies living in the home. Should a need arise where specific teaching/training needs to be done with any specific consumer regarding maintaining temperature control for the home, then the QIDP will develop a programming goal to meet that need.</p> <p>4. All staff working with the OAK ladies across all settings will be retrained on individual rights and assisting the ladies to exercise their rights. Role modeling will be encouraged as a good training tool. Training will be completed by 12/20/15.</p> <p>5. All ladies living at the OAK group will be encouraged to exercise their rights to the best of their abilities. Teaching/training opportunities will be provided at least monthly as part of their Strengths Programming goals. The QIDP will add the "Your Rights" training to all six ladies Strengths programming by 12/20/15. This will be documented on their Strengths tracking form.</p> <p>6. All staff working with residential consumers across</p>		

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			<p>all settings will be trained on guidance related consumer protections and the W125 tag. The training will focus on the guidance provided on page #10 & 11 of the Interpretive Guidelines-Responsibilities of Intermediate Care Facilities with Individuals with Intellectual Disabilities(revised) by 12/20/15.</p> <p>7. Retraining will be provided to Medical Department, supervisory staff, administrative & management teams on restrictions as a violation of individual rights, including items B.1-6 above by 12/20/15. Person's responsible: PD; OAK QIDP; RMT's; RA & QAM. Target completion date: 12/20/15.</p> <p>C) Corrective Action for BCS practices agency wide:</p> <ol style="list-style-type: none"> All supervisory staff agency wide including Supported Living Management Team (SLMT) members will be retrained on protection of consumer rights in general and specifically items A.1-8 & B.1-6. All staff working with residential consumers across all settings will be trained on protection of rights; an overview of A.1-8 & B.1-6. All SL DCS will be retrained at the next scheduled house/staff meetings by the SLMT members. Persons responsible: PD; RA; QAM; RMT's; SLMT's; DS Coordinator and Administrative Assistant. Target completion 	

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W 0149 Bldg. 00	<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 1 of 3 sampled clients (client #1), the facility neglected to implement their policy to prevent abuse, neglect, and/or mistreatment to ensure client #1 received immediate medical attention after her PEG (a feeding tube) had been dislodged.</p> <p>Findings include:</p> <p>On 11/9/15 at 2:00pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations from 11/2014 through 11/9/15 were reviewed and indicated the following for client #1: -A 11/3/14 BDDS report for an incident on 11/2/14 at 10:45am indicated "An abuse/neglect investigation is being currently conducted. The staff allegedly accused is currently suspended pending completion of the investigation." -A 11/10/14 Follow Up BDDS report indicated "The allegation is neglect...After interviewing all the DCS (Direct Care Staff) involved with this incident and discussing our findings with</p>	W 0149	<p>date: 12/20/15</p> <p>W149-Staff Treatment of Consumers The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the consumer. BCS neglected to implement the Abuse, Neglect, Exploitation and Violation of Individual Rights policy to ensure consumer #1 received immediate attention after her PEG feeding tube had been dislodged. A) Corrective Action and Follow-Up Specific to Consumer #1 (hereafter referred to as C1): 1. Neglect was substantiated for C1 following a thorough and timely investigation process. All recommendations were followed and completed in a timely manner including: a) written warnings with specific expectations to be met immediately & continually or employment is in jeopardy; b) thorough 4 hour training provided to identified staff as well as all staff working at OAK (abuse/neglect policy, team work, communication, consumer safety, peg tube care & protocols as well as following all medical orders & directives); c) all directives by C1's PCP were followed through on as</p>	12/20/2015

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	<p>each other, it has been the decision of the (agency) staff that the allegation of neglect are (sic) substantiated." The follow up report indicated "all the staff" at the group home were neglectful for not following client #1's PEG tube protocol to seek medical treatment at the ER (Emergency Room) and "a lack of communication."</p> <p>-The 11/3/14 "Neglect Investigation" indicated "After interviewing all DCS involved with this incident...the allegations of neglect are substantiated...Staff not having [client #1] ready to go when [GHS (Group Home Staff) #8] arrived, or not taking [client #1] immediately to the ER and by taking a housemate to her sister's home, the neglect resulted in not getting [client #1] to the ER until 3 hours after the incident. Because of the lack of communication, lack of teamwork, not following medical orders, or communication, and putting [client #1] at risk for complications...all staff received written warnings...."</p> <p>-The 11/3/14 investigation indicated "On 11/2/14 at approximately 7:10am, client #1's feeding tube had fallen out. The medical department was not notified until 7:45am. Staff was instructed at that time to take the consumer to the Emergency</p>		<p>well as a proactive appointment with woundcare physician who found no problems and d) consideration of staff suspensions due to negligence . There have been no further incidents of consumer mistreatment by the identified staff and they all remain employed by BCS.</p> <p>2. We will continue to monitor staff treatment of consumers through the Home Observation process, management and medical On-Call support system as well as administrative team random drop-in's at OAK, as well as all other residential settings. Follow-up on any concerns will be completed.</p> <p>3. Although we cannot change what previously occurred we will take this opportunity to provide all staff working with C1 across all settings to be retrained on the agency A/N policy, as well as review of the BDDS Reportable Incident Criteria.</p> <p>4. All staff working with residential consumers across all settings will be retrained on item A.3.</p> <p>5. All residential support staff, DS Coordinator, RMT's and administrative program team members will be retrained on item A.3 above, as well as a review of the components of the W149 tag interpretive guidelines, practices and probes in order to better understand the significance</p>		

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	<p>room. Without any discussion about what needed to be done or how it was going to get done, the staff went about helping other consumers with their morning routine. From the time that staff was notified to take the consumer to the Emergency room, there should have been an urgent effort to do so. Instead, the consumer was not taken to the Emergency room until 11:00am. At that point the opening that the tube was to be reinserted had closed to the point that would require a doctor's evaluation before any more action was taken. You're (sic) actions were neglectful and put a consumer's health and safety at risk."</p> <p>On 11/10/15 at 9:15am, an interview was conducted with the Agency Program Director/Qualified Intellectual Disabilities Professional (APD/QIDP). The APD/QIDP indicated the facility followed the BDDS reporting guidelines for abuse, neglect, and/or mistreatment. The APD/QIDP indicated the facility staff neglected to implement client #1's plan correctly on 11/2/14 which indicated immediate medical attention should have been sought at the Emergency room for client #1's PEG tube to be reinserted.</p> <p>Client #1's record was reviewed on 11/10/15 at 10:50am. Client #1's 7/23/15</p>		<p>of assuring that consumers are free from abuse, neglect, exploitation and violation of their rights. Person's responsible: PD; QAM; RA and OAK RMT. Target completion date: 12/20/15</p> <p>B) Corrective Action as it relates to BCSpractices agency wide: 1.All SLMT & any other identified supervisory staff will be trained on A.3 & A.5 above to ensure that all consumers receiving services are free from mistreatment consistently across all settings. They will then be responsible for training SL DCS on A.3& A.5 at their next staff/house meetings. Person's Responsible: PD, RA, QAM& SLMT's Target completion date: 12/20/15</p>		

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	<p>ISP (Individual Support Plan) and 11/6/14 "Protocol in Case PEG tube needs to be replaced" indicated client #1 "Call medical on call immediately...Follow all medical orders...take immediately to Emergency room...[client #1] is priority #1 at this point. Everything else can wait..." Client #1's record indicated a 11/13/14 "Medical Note" which indicated client #1 "was very ill and weak. She was diagnosed with Adult Failure to thrive and had on going issues with her gallbladder and pancreas. She was ordered an at home hospital bed with a pressure relieving mattress. She also had a PEG tube for nutritional support...." Client #1's record indicated the PEG tube was discontinued after the 11/2/14 incident and was not reinserted. Client #1's 9/1/15 Physician's Orders indicated she was on a pureed diet and eating and drinking by mouth.</p> <p>On 11/9/15 at 1:45pm, the undated facility's policy on "Abuse and Neglect" was reviewed and indicated the facility prohibited abuse, neglect, and/or mistreatment by all persons including facility staff. The policy indicated "Neglect is a failure to provide necessary supports needed to avoid physical harm and/or mental suffering."</p>						

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W 0193 Bldg. 00	<p>On 11/9/15 at 1:45pm, a record review was completed of the 6/11/2002 BDDS "Incident Reporting" policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...."</p> <p>9-3-2(a)</p> <p>483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. Based on observation, record review, and interview, for 1 of 3 sampled clients (client #3) who had behaviors of touching other people's property, the facility failed to ensure staff were able to demonstrate skills and consistently implement supervision techniques for client #3's behaviors.</p> <p>Findings include:</p> <p>On 11/09/15 from 3:10pm until 6:18pm and on 11/10/15 from 5:50am until 7:50am, client #3 was at the group home. During both observation periods client #3 paced throughout the group home living room, kitchen, dining room, and hallways. On 11/9/15 at 4:25pm, client #3 repeatedly touched the surveyor's hair,</p>	W 0193	<p>W193-Staff Training Program Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage inappropriate behavior of consumers. BCS failed to ensure staff were able to manage the inappropriate behavior of Consumer #3. A) Corrective Action and Follow-Up Specific to Consumer #3 (hereafter referred to as C3):</p> <p>1. Guidelines for Respecting Other's Personal Space have been developed by the QIDP to address strategies & interventions for C3 to interact with others in an appropriate manner and allow her to become more independent & inclusive in all her environments.</p> <p>2. The Guidelines provide clarification for staff on understanding what respecting</p>	12/20/2015			

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	<p>took papers off a clipboard, pen, and attempted to place her hand inside the zipper pocket of the surveyor's jacket. At 4:25pm, GHS (Group Home Staff) #2 retrieved the items, did not redirect client #3, and stated client #3 "does that" with other people. On 11/10/15 from 5:50am until 7:50am, client #3 took papers off a clipboard, placed her hands inside the zipped pockets of a visitor's jacket, touched the visitor's hair, attempted to unzip a visitor's pants, and attempted to remove a visitor's right shoe. During both observation periods no staff redirection was observed when client #3 attempted to touch visitors and had taken items not belonging to her.</p> <p>On 11/10/15 at 10:30am and on 11/12/15 at 9:40am, client #3's record was reviewed. Client #3's ISP (Individual Support Plan) indicated a goal/objective that client #3 will not touch other's property. Client #3's record did not include a Behavior Support Plan.</p> <p>On 11/10/15 at 9:15am, an interview with the Agency Program Director/Qualified Intellectual Disabilities Professional (APD/QIDP) was conducted. The APD/QIDP indicated client #3 did not have a documented Behavior Support Plan. The APD/QIDP stated client #3 should have been redirected when "she</p>		<p>others personal spacemeans; providing consistent strategies for using active treatment as the focus for setting & role modeling expectations, setting clear boundaries for what is and is not acceptable interactions.</p> <p>3. Staff will be trained on not only implementing the Guidelines, but also clearly understanding that these strategies are a priority for C3 to have more dignity, be safe and to have increased opportunities to interact & form relationships with others not only at home & DS, but in the community. We need to train them to understand that by not following the guidelines she is isolated from opportunities to interact more with others in meaningful & purposeful ways. Focus will also target their role of teaching her skills as opposed to "taking care of her". We need to train on changing that mind set of "oh that's just C3" rather than teaching & redirecting.</p> <p>4. C3's goal of not touching other's property will be reviewed and revised if needed by the QIDP to assure that it is still appropriate for her identified needs.</p> <p>5. All staff working with C3 across all settings will be trained on her Guidelines for Respecting Other's Personal Space & any revisions made to her touching others property goal. They will also be trained on all</p>				

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	<p>touches strangers inappropriately." The APD/QIDP indicated client #3 did not recognize strangers.</p> <p>9-3-3(a)</p>		<p>components of A. 1-3 above.</p> <p>6. Once the training has occurred the RMT will be responsible for monitoring to assure that the guidelines are being implemented as written. The QIDP will review data & documentation on the guidelines and make revisions as necessary to assure that there is outcome & progress.</p> <p>7. All residential support staff, RMT's, DS Coordinator & administrative program team will be trained on assessing & monitoring that staff demonstrate the skills & techniques necessary to manage inappropriate behaviors that keep consumers from having meaningful relationships, becoming as independent as possible & having dignity & worth in their home and community. Persons Responsible: OAK QIDP & Manager; PD; QAM and RA. Target Completion Date: 12/20/15.</p> <p>B) Corrective Action as it relates to BCS practices agency wide:</p> <p>1. All SLMT & any other identified supervisory staff will be trained on items A.3 & 7 above. They will then provide monitoring of their DCS and train them on the importance of demonstrating skills necessary to intervene to manage inappropriate behaviors and follow BSP's. Persons Responsible: PD; RA; QAM & SLMT's. Target completion date: 12/20/15</p>	

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W 0331 Bldg. 00	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 1 of 3 sampled clients (client #1), the nursing services failed to include specific guidelines for client #1's toileting and repositioning needs for the facility staff to implement.</p> <p>Findings include:</p> <p>On 11/09/15 from 3:10pm until 6:18pm, client #1 was at the group home and was not assisted by the facility staff to go to the bathroom. During the observation period client #1 sat in her wheelchair in the living room covered with a blanket watching television and staff moved client #1's wheelchair. During the observation period client #1's body positioning in the wheelchair was not changed. At 5:00pm, GHS (Group Home Staff) #2 pushed client #1's wheelchair into the kitchen to assist with cooking. At 6:18pm, client #1 sat in her wheelchair in the same seating position and was not observed to have used the bathroom.</p> <p>On 11/10/15 at 11:50am, client #1's record was reviewed. Client #1's 7/23/15 ISP (Individual Support Plan) indicated client #1 was assisted by staff to transfer</p>			W 0331	<p>W331-Nursing Services BCS must provide consumers with nursing services in accordance with their needs.</p> <p>BCS failed to include specific guidelines for consumer #1 toileting and repositioning needs for staff to implement.</p> <p>A) Corrective Action and Follow-Up Specific to Consumer #1 (hereafter referred to as C1):</p> <ol style="list-style-type: none"> 1. The QIDP has revised C1's Restroom Protocol for home & DS to include time frames for using the restroom and additional steps/directions for how she is to be assisted to the restroom including transfer(s) to and from the toilet. 2. C1 has a pressure relieving aircushion for her wheelchair which fits her and her chair to provide support & decrease need to continually change her seating position. 3. The agency RN has revised C1's Acute Care Protocol to address position changing & avoiding pressure areas to her buttocks. 4. All staff working with C1 across all settings will be trained on revisions to C1's Restroom and Acute Care Protocols. 5. C1's health care protocols have been revised &/or updated 		12/20/2015

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	<p>to/from her wheelchair and was recovering from a fractured right leg. Client #1's 7/1/15 "Restroom Protocol" indicated "Due to [client #1's] frequency of UTI's (Urinary Tract Infections) which can and do affect her physical and mental health the following protocol has been implemented...will be allowed to use the restroom as necessary..." Client #1's 7/1/15 "Health/Risk Plan" indicated client #1 was at risk for falls and "will also be given the opportunity to stand/change positions when sitting in her wheelchair for long periods of times...[client #1] requires 24 hour supervision to assure her safety." Client #1's plans did not include how often client #1 was to be assisted to the bathroom and change her wheelchair seating position.</p> <p>On 11/20/15 at 1:00pm, an interview was conducted with the Agency Program Director/Qualified Intellectual Disabilities Professional (APD/QIDP). The APD/QIDP indicated client #1 should have been taken to the bathroom and repositioned in client #1's wheelchair every two (2) hours. The APD/QIDP indicated client #1 had limited mobility and required staff assistance to transfer to the toilet and reposition her body in the wheelchair. The APD/QIDP indicated the nursing protocols did not include the</p>		<p>as changes in health status occur as indicated by revisions since her readmission to OAK following rehabilitation after orthopedic surgery in June 2015. Her health care is closely monitored and the medical department works very closely with her PCP Dr. Miller, who is very happy with her care.</p> <p>Person's responsible: RN, QIDP, Residential Manager & PD Target completion date: 12/20/15</p> <p>B) Corrective Action as it relates to BCS practices agency wide: 1. Residential consumers continue to receive quality nursing services through the Health Care Monitoring System. SL Waiver consumers with the Community Integration & Habilitation waiver receive Wellness Coordination. Family Support waiver consumers have a medication monitoring and management system in place at DS & sheltered workshops. 2. Review teams are in place monitor health & safety concerns as Injury/Illness Reports, medication error reports and Incident Reports are submitted, reviewed and recommendations made.</p> <p>Persons responsible: PD, RA, QAM, Residential & Wellness Coordination RN's. Target Completion date: ongoing</p>				

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W 0391 Bldg. 00	<p>length of time for toileting and repositioning client #1.</p> <p>9-3-6(a)</p> <p>483.460(m)(2)(ii) DRUG LABELING</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation, record review, and interview, for 1 of 6 medications administered in the evening (for client #2), the facility failed to remove from use the medication containers without labels from the supply.</p> <p>Findings include:</p> <p>On 11/9/15 at 3:25pm, GHS (Group Home Staff) #1 asked client #2 to the medication area. GHS #1 selected client #2's unlabeled "Tussin DM Cough and Chest" syrup for cold symptoms, poured 10ml (milliliters) into a medication cup, and client #2 took the medication. At 3:25pm, GHS #1 indicated the medication was an over the counter medication, did not have a pharmacy label on the medication, and did not have client #2's name on the medication. GHS #1 indicated the bottle belonged to client #2. At 3:25pm, client #2's 11/2015 MAR (Medication Administration Record)</p>	W 0391	<p>W391-Drug Labeling</p> <p>BCS must remove from use drug containers with worn, illegible or missing labels.</p> <p>BCS failed to remove from use the medication containers without labels from the supply.</p> <p>A) Corrective Action as it relates to Consumer #2 (hereafter referred to as C2):</p> <ol style="list-style-type: none"> Effective 11/11/15 C2's unlabeled Over the Counter (OTC) Tussin DM Cough & Chest syrup for cold symptoms has a pharmacy label with her name on it. Effective 11/11/15 all medications at the OAK group home were assessed to assure that all meds were relabeled. All residential group home consumers medications will be assessed to assure that all meds are labeled as per Core Lesson 2 of the Living in the Community medication administration training indicates as well as meet the drug labeling regulation of the SDOH. 	12/20/2015			

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	<p>indicated "Robafen DM (Tussin DM), give 10ml by mouth every 4 hours as needed."</p> <p>On 11/10/15 at 12:25pm, client #2's record was reviewed. Client #2's 9/1/15 Physician's Order indicated "Robafen DM (Tussin DM), give 10ml by mouth every 4 hours as needed."</p> <p>On 11/10/15 at 8:30am, an interview was conducted with the Agency Program Director/Qualified Intellectual Disabilities Professional (APD/QIDP). The APD/QIDP indicated the facility followed Core A/Core B medication administration training for medication administration. The APD/QIDP indicated each medication should have a pharmacy label which could be read including: the client's name, name of the medication, dosage, and directions for the medication's use.</p> <p>On 11/10/15 at 12:30pm, a record review was conducted of the facility's undated policy and procedure "Medication Administration." The policy and procedure indicated the facility followed Core A/Core B Living in the Community for medication administration.</p> <p>On 11/10/15 at 10:00am, a review of the 2004 "Living in the Community"</p>		<p>4. The OAK Medication Administration Mentor (MAM) will be responsible for assuring in the future that all medications are labeled. The Residential Manager will be responsible for monitoring of drug labels in group homes where there is no MAM.</p> <p>5. All residential DCS passing medications will be trained on assuring that medications are labeled and notifying the medical department should they have questions/concerns.</p> <p>6. All RMT's, administrative program team members and medical department will be provided a review of the labeling regulations to assure that this practice is being completed.</p> <p>Persons Responsible: RMT's, MAM's, Medical Department</p> <p>Target completion date: 12/20/15</p> <p>B) Corrective Action as it relates to BCS practices agency wide:</p> <p>1. All supervisory staff working with DCS passing medications agency wide will be provided with a review of the labeling requirements & provide their staff with that information. For SL staff, their supervisors will provide them with the labeling review at their next scheduled staff/house meetings.</p> <p>Persons Responsible: PD, QAM</p>		

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W 0412 Bldg. 00	<p>medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be labeled.</p> <p>9-3-6(a)</p> <p>483.470(b)(1)(iv) CLIENT BEDROOMS Bedrooms must measure at least 60 square feet per client in multiple client bedrooms. Based on observation, record review, and interview, for 1 of 3 sampled clients (client #3) and 1 additional client (client #6), the facility failed to ensure client #3 and #6's bedroom measured at least 60 square feet for each client.</p> <p>Findings include:</p> <p>During observations on 11/09/15 from 3:10pm until 6:18pm and on 11/10/15 from 5:50am until 7:50am, clients #1, #2, #3, #4, #5, and #6's group home was visited. During both observation periods clients #3 and #6 shared a single bedroom.</p> <p>On 11/10/15 at 10:00am, an interview with the Agency's Maintenance Director (MD) was conducted. The MD stated he had measured client #3 and #6's shared bedroom which measured "ten and one half feet by ten feet (10 1/2' x 10') to</p>	W 0412	<p>& SLMT's.</p> <p>Target Completion date: 12/20/15</p> <p>W412-Client Bedrooms Bedrooms must measure at least 60square feet per client in multiple client bedrooms.</p> <p>BCS failed to ensure thatconsumers #3 & 6's bedroom measured at least 60 square feet for eachclient.</p> <p>A) Corrective action and follow-up as itrelates to Consumers #3 & 6 (hereafter referred to as C3 &C6); 1.On November 11th 2015C3 & C6 moved to a larger bedroom that meets the criteria set forth of atleast 60 square feet per consumer following interviews with each of theconsumers and their agreement to move to a larger bedroom to better meet theirneeds and comfort. They have been very happy with the move to the largerbedroom. 2.C4 indicated at the time of the interviewsthat she would like a smaller private room and asked to switch rooms with C3& 6 so she could have the smaller room.</p>	12/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G469	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/20/2015
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 S OAK ST BLUFFTON, IN 46714		
(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>equal 106 square feet" of living space. The MD stated the staff had "said the clients moved rooms less than a year ago." The MD stated he and the group home staff were "looking into" moving client bedrooms.</p> <p>On 11/10/15 at 5:00pm, an interview was conducted with the Agency Program Director/Qualified Intellectual Disabilities Professional (APD/QIDP). The APD/QIDP indicated clients #3 and #6 shared a small bedroom and clients #3 and #6 were going to be moving into a larger bedroom which would allow for at least 60 square feet for each client. The APD/QIDP provided a 11/10/15 "Choices for Bedroom Changes" which indicated clients #3 and #6 were going to change bedrooms with client #4 because the existing bedroom clients #3 and #6 shared was not 60 square feet per client.</p> <p>9-3-7(a)</p>		<p>The move went smoothly with C4happy with her choice of a smaller, private room.</p> <p>3. Interview notes regarding the choices for bedroom changes at OAK were provided to the surveyor explaining the discussion that took place as well as recommendations/observations.</p> <p>4. All RMT's and administrative program teams will be provided with the bedroom measurement criteria of 60 square feet per client in multiple client bedrooms at scheduled training for the OAK POC so as to be informed for future reference.</p> <p>Persons responsible: Maintenance supervisor; PA; RA and RMT's</p> <p>Target completion date: 12/20/15</p> <p>B) Corrective action as it relates to BCSpractices agency wide: 1. Reference A.4 above. 2. The maintenance supervisor will assure that his staff are aware of the measurement regulations for residential bedrooms.</p> <p>Person's responsible: Maintenance Supervisor, RA& PD</p>		