

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G799	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2012
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NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940
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W0000	<p>This visit was for an extended recertification and state licensure survey. This visit included the investigation of complaint #IN00104090.</p> <p>Complaint #IN00104090: SUBSTANTIATED, Federal and State deficiencies related to the allegation(s) are cited at W132, W159, W210, W226, W249 and W322.</p> <p>Dates of Survey: March 14, 15, 22, 23 and 26, 2012.</p> <p>Provider Number: 15G799 Facility Number: 0012562 AIM Number: 201017540</p> <p>Surveyor: Susan Reichert, Medical Surveyor III</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/2/12 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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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview, and record review, for 1 of 2 sampled clients (client B) and two additional clients (clients C and D), the facility failed to allow and encourage independent access to food.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 3/14/12 from 3:45 PM until 6:15 PM and on 3/15/12 from 7:15 AM until 9:20 AM. During both observations, staff left the home to obtain food for the meal prepared during the observations.</p> <p>Staff #12 was interviewed on 3/14/12 at 7:40 AM. She indicated the home only kept limited supplies of food due to the food seeking behavior of client B. She indicated there was only enough meat, cheese, and bread in the home to prepare the next meal, and the remainder was kept in an agency owned group home nearby.</p>	W0125	<p>W125 Access to food – extra refrigerator is stored off site Corrective action for resident(s) found to have been affected The home has a refrigerator in the kitchen. The home's extra refrigerator will be moved back to the garage. The door from the home to the garage will be locked, and the three individuals without any need for food restriction will be given a key to access the garage without restriction. The BSP for the one individual will be modified to indicate that he is restricted from extra food in the garage, and this will be submitted for HRC approval. Originally, the IDT felt that having current food available in the kitchen refrigerator with extra food off-site was a non-restrictive way to address some behavioral issues that were associated with food. Because it was not considered restrictive (much like having one day's supply would occur right before grocery shopping), no HRC approval was sought. We will reverse this decision as noted above, and we will seek HRC approval at this time. How facility will identify other</p>	04/25/2012			

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	<p>When asked if the other clients in the group home wanted additional food or snacks, she indicated staff would need to take them to get the food at the nearby group home. She indicated the other clients in the home were not in need of the restriction of food in the group home.</p> <p>Client B's record was reviewed on 3/15/12 at 1:50 PM and did not include an assessed need for the restricted food. Client B's Individual Support Plan dated 10/30/11 and his BSP (Behavior Support Plan) dated 3/9/12 did not include evidence for the restricted food. There was no evidence in the record of consent for the restricted food.</p> <p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 3/23/12 at 3:11 PM. The QMRP stated when asked if clients B, C and D were in need of restricted food, "No, but they signed consents." She indicated the clients did not have the restriction of food in their plans and the IDT (interdisciplinary team) did not consider the locked food a restriction and the facility had not obtained approval for the practice from their Human Rights Committee.</p>		<p>residents potentially affected & what measures taken All residents potentially affected, and corrective measures address the needs of all clients. Specifically, the individuals who have no need for restriction on food will have access with keys. Measures or systemic changes facility put in place to ensure no recurrence Extra refrigerator returned to garage; garage restricted from one consumer; keys provided to other three individuals; restriction added to BSP for one individual and sent to HRC. How corrective actions will be monitored to ensure no recurrence The Behavior Clinician (BC) monitors restrictions and reports to the IDT. The IDT determines the need for restrictions. The BC submits HRC requests. Management staff complete home visit forms and will assist in monitoring restrictions. The Director supervises management staff, including the BC, and reviews home visit forms at regular staff meetings.</p>				

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	<p>Consents for the off site food storage were reviewed on 3/23/12 at 4:40 PM and indicated clients B, C and D signed on 1/18/12 they had been explained the details of the restricted food and agreed to the restrictions. "I understand that I may make reasonable requests for additional food items to be secured from the off-site refrigerator, as long as the items are within my dietary guidelines and/or restrictions. I also understand that I may request modifications and/or changes to the above listed provisions at any time, and that any such modifications/changes will require IDT consensus and approval prior to implementation." The consent indicated "The refrigerator inside the home will be kept stocked with the food items that are needed to prepare the next upcoming meal. No additional or extra food items will be kept in the in-home refrigerator. All additional and surplus food items will be kept in a second refrigerator that will be stored off-site at [name of site]. If a consumer makes a reasonable request to receive food items that are not located in the on-site refrigerator, staff will attempt to secure/obtain those food items from the off-site refrigerator within a reasonable time frame, provided that the food items are within any necessary dietary</p>			
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	<p>guidelines and/or restrictions. Consumers may make reasonable requests for off-site food items at any time. However, staff are to be given a reasonable length of time to located, obtain, and return the requested items to the home."</p> <p>9-3-2(a)</p>				

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W0132	<p>483.420(a)(8) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities.</p> <p>Based upon observation and interview for 1 of 2 sampled clients (client B) and for 1 additional client (client C), the facility failed to ensure they were paid prevailing wages commensurate with their abilities for painting their day service site.</p> <p>Findings include:</p> <p>Client C was interviewed on 3/14/12 at 4:00 PM during observation at the group home. Client C indicated he and client B had painted at day services that day. He stated, "I can paint without getting paint on my clothes."</p> <p>Client C was interviewed again on 3/15/12 at 7:30 AM during observation at the group home. He indicated he received public assistance checks, and was not paid for painting at day services. He stated, "I don't really need to. I just like to help clean up." He indicated he and client B took turns with an unidentified person to paint. When client C was asked if he had any money, he indicated he received money twice monthly and currently was out of money to carry.</p> <p>Client B was interviewed on 3/15/12 at 9:15 AM during observation at the group home. He indicated he had been painting at day services and was not paid for painting.</p>	W0132	<p>W 132</p> <p>Clients receiving pay for painting day program walls</p> <p>Corrective action for resident(s) found to have been affected</p> <p>All hours worked were documented, and clients will receive hourly pay for work completed.</p> <p>How facility will identify other residents potentially affected & what measures taken</p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>Clients will be paid for work completed.</p>	04/25/2012			

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	<p>Observation at day services was completed on 3/15/12 from 11:20 AM until 12:55 PM. During the observation, the Behavioral Clinician (BC), BC intern and client B painted the walls, while client D slept on the sofa. Client D was asked by staff #14 if he wanted to paint two times when he woke up, but did not engage in painting. Staff #14 asked client B if he liked painting and he stated, "Yes."</p> <p>The QMRP (Qualified Mental Retardation Professional) and Director were interviewed on 3/14/12 at 2:58 PM and indicated clients B and C were not being paid to paint. When asked who would paint the walls if clients didn't, the QMRP indicated staff would paint the walls. The QMRP indicated clients had asked if they could help paint the day services and expressed pride in their work. The Director indicated the facility would now pay clients to paint.</p> <p>This federal tag relates to complaint #IN00104090.</p> <p>9-3-2(a)</p>		<p>How corrective actions will be monitored to ensure no recurrence</p> <p>This has been a topic at the regularly scheduled management staff meeting. It is now understood that clients cannot perform work without compensation. The management staff are supervised by the Director who holds regularly-scheduled meetings with the management staff.</p>				

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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.</p> <p>Based on record review and interview, the facility neglected to implement written policy and procedures to report injuries of unknown origin to the administrator, conduct investigations of injuries of unknown origin and investigate injuries during restraint for 1 of 14 reports reviewed affecting 1 of 2 sampled clients (client A), and one additional client, (client D).</p> <p>Findings include:</p> <p>1. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and reports of injury were reviewed on 3/14/12 at 1:25 PM. An injury report dated 6/12/11 indicated at 5:30 PM, client D had a cut to his face. There was no evidence the injury to client D had been reported to the administrator, assessed or investigated as to cause.</p> <p>The QMRP (Qualified Mental Retardation Professional) was interviewed on 3/15/12 at 2:28 PM. When asked about the injury to client D's face, she indicated it had occurred prior to her employment at the group home and she</p>	W0149	<p>W 149 Investigating unknown injuries & Injury during restraint Corrective action for resident(s) found to have been affected The group home's original QMRP was not sufficiently precise in reporting and investigating. Due to performance issues such as these, that QMRP no longer works for the agency. A highly experienced QMRP now works in the home and is responsible for reporting and investigating incidents. Since the time the cited incidents originally were reported, a number of trainings on reporting requirements have been conducted with staff, including management staff. Recently, the agency's Compliance Officer conducted a training with the QMRP and Director on agency policy for incident reporting and thorough investigating. Another similar training will take place focusing on the need to report and investigate all injuries of unknown origin and injuries caused during restraints. In addition to training as a corrective action, the Nurse now uses a home visit form to improve the accuracy and accessibility of documentation of all activity with clients. How facility will identify other</p>	04/25/2012			

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	<p>would need to check to see if it had been reported to the administrator, assessed or investigated. No further information was provided in regards to client D's injury to his face on 6/12/11.</p> <p>The Director was interviewed on 3/26/12 at 10:15 AM and indicated it was the agency's policy to report to the administrator and investigate all injuries of unknown origin.</p> <p>2. The facility's BDDS (Bureau of Developmental Disability Services) reports and reports of injury reviewed on 3/14/12 at 1:25 PM and indicated the following injuries during restraint for client A:</p> <p>A report of injury dated 7/25/11 (no time listed) completed by staff #13 indicated client A sustained a "rug burn" when he was restrained caused by attempted movement by client A during restraint. The report indicated the burn was around client A's left knee cap. The area for the nurse to complete assessment was blank of information, and an area to complete "What could be done to prevent this incident from occurring again" was also blank.</p> <p>A report of injury dated 7/26/11 at 11:00 AM completed by staff #1 indicated client</p>		<p>residents potentially affected & what measures taken All residents potentially affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence A new QMRP was hired who has significant experience with reporting and investigations. Trainings have been conducted. The Nurse has improved documentation. How corrective actions will be monitored to ensure no recurrence The Group Home Manager supervises DSP staff and ensures training needs are met. Staff report all incidents to Management Staff. The IDT reviews all incidents. An Incident Oversight Committee – consisting of the Director, an agency Vice President, and an agency Compliance Officer – also reviews all incidents and ensures that all investigations are completed, including the required investigations on injuries of unknown origin. Management staff meet regularly with the Director who monitors home-visit forms, including the new one recently implemented by the Nurse.</p>		

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	<p>A sustained a quarter inch spot on the top of his right wrist in which the skin "looked like it was rubbed a little raw...He had similar spots around the same size, on his elbows. The description of how the injuries occurred indicated, "Injuries occurred when [client A] had to be restrained,He was struggling when he was being restrained, causing the injuries." The area for the nurse to complete assessment was blank of information, and an area to complete "What could be done to prevent this incident from occurring again" was also blank.</p> <p>There were no corresponding BDDS reports of the incident provided to review upon entrance to the facility.</p> <p>The Behavior Consultant was interviewed on 3/14/12 at 2:47 PM. When asked if the injuries to client A were the result of being restrained, he stated, "Yes I think that's what he is implying." He indicated staff #13 was available to interview.</p> <p>Staff #13 was interviewed on 3/14/12 at 3:50 PM and when asked if the injuries to client A on 7/26/11 were caused by restraint, he stated he was "not sure." He indicated the injuries could possibly have occurred due to client A pounding the wall.</p>						

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	<p>BDDS reports for 7/25/11 and 7/26/11 were provided on 3/23/12 at 8:26 AM. The report dated 7/25/11 indicated the incident occurred at 7:00 PM and indicated client A was restrained using a one armed physical restraint after engaging in property destruction and was able to break free of the restraint and "punched staff in the face 4 times." There was no indication if client A was injured during the incident in the BDDS report. The BDDS report dated 7/26/11 indicated the incident occurred at 12:00 PM and client A was restrained 7 times for less than a minute after engaging in property destruction and physical aggression towards staff. The report indicated staff had observed a scratch on his left elbow and examined by a nurse who indicated medical treatment was unnecessary. There was no evidence of an investigation into the incidents causing injuries to client A documented on 7/25 and 7/26/11. There was no evidence documenting nursing assessments of client A's injuries available to review.</p> <p>The Director stated via an e-mail dated 3/23/12 at 8:26 PM, "It is likely" the reports were reported with information in error and missing information and the QMRP who completed the report was no longer employed at the agency due to</p>						

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	<p>performance issues. He indicated in the e-mail staff had been trained since the incident regarding policy and reporting requirements.</p> <p>The Director was interviewed on 3/26/12 at 10:21 AM and indicated it was the agency's practice to conduct team meetings after a behavioral incident to determine cause and develop corrective action.</p> <p>A review of the facility's "Incident Reports/Indiana dated 3/12 was reviewed on 3/26/12 at 10:20 AM and indicated "Reportable Incidents are any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual...." Reportable incidents included "injury to an individual when the cause is unknown and the injury could be indicative of abuse, neglect or exploitation, and use of physical or manual restraint..." The policy indicated significant injuries and injuries of unknown origin were to be investigated.</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.</p> <p>Based on record review and interview, the facility failed to report to the administrator an injury of unknown origin for 1 of 14 reports reviewed affecting 1 of 4 clients (client D) in accordance to state law.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the BDDS and reports of injury were reviewed on 3/14/12 at 1:25 PM. A injury report dated 6/12/11 indicated at 5:30 PM, client D had a cut to his face. There was no evidence the injury to client D had been reported to the administrator or reported to BDDS.</p> <p>The QMRP (Qualified Mental Retardation Professional) was interviewed on 3/15/12 at 2:28 PM. When asked about the injury to client D's face, she indicated it had occurred prior to her employment at the group home and she would need to check to see if it had been reported to the administrator or to BDDS.</p>	W0153	<p>W 153</p> <p>Reporting injuries of unknown origin</p> <p>Corrective action for resident(s) found to have been affected</p> <p>All staff will be trained that injuries of unknown origin must be immediately reported to management staff – manager during regular hours, and on-call phone during other times. The agency's Compliance Officer will conduct a training with the QMRP and Director focusing on the need to report and investigate all injuries of unknown origin.</p> <p>How facility will identify other residents potentially affected & what measures taken</p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p>	04/25/2012			

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	<p>No further information was provided in regards to client D's injury to his face on 6/12/11.</p> <p>The Director was interviewed on 3/26/12 at 10:15 AM and indicated it was the agency's policy to report to the administrator all injuries of unknown origin.</p> <p>9-3-2(a)</p>		<p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>Staff training on reporting requirement for injuries of unknown origin; QMRP and Director training on investigating incidents of unknown origin.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The Group Home Manager supervises DSP staff and ensures training needs are met. Staff report all incidents to Management Staff. The IDT reviews all incidents. An Incident Oversight Committee – consisting of the Director, an agency Vice President, and an agency Compliance Officer – also reviews all incidents and ensures that all investigations are completed, including the required investigations on injuries of unknown origin.</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, the facility failed to investigate an injury of unknown origin for 1 of 14 reports reviewed affecting 1 of 4 clients (client D).</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and reports of injury were reviewed on 3/14/12 at 1:25 PM. A injury report dated 6/12/11 indicated at 5:30 PM, client D had a cut to his face. There was no evidence the injury to client D had been investigated as to the cause.</p> <p>The QMRP (Qualified Mental Retardation Professional) was interviewed on 3/15/12 at 2:28 PM. When asked about the injury to client D's face, she indicated it had occurred prior to her employment at the group home and she would need to check to see if it had been assessed or investigated. No further information was provided in regards to client D's injury to his face on 6/12/11.</p> <p>The Director was interviewed on 3/26/12</p>	W0154	<p>W 154 Did not investigate injury of unknown origin Corrective action for resident(s) found to have been affected Both professional staff members responsible to conduct investigations will receive training from the agency Compliance Officer on conducting investigations for all injuries of unknown origin. How facility will identify other residents potentially affected & what measures taken All residents potentially affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Training with both professionals responsible for investigations. How corrective actions will be monitored to ensure no recurrence All appropriate incidents will be investigated. The IDT reviews all incidents. An Incident Oversight Committee – consisting of the Director, an agency Vice President, and an agency Compliance Officer – also reviews all incidents and ensures that all investigations are completed as needed.</p>	04/25/2012			

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	at 10:15 AM and indicated it was the agency's policy to investigate all injuries of unknown origin. 9-3-2(a)				

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W0159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on observation, interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to provide oversight to integrate, coordinate, and monitor the development of 2 of 2 sampled clients (clients A and B) individual program plans within 30 days of client admissions and to ensure assessments and comprehensive functional assessments were completed. The QMRP failed to ensure that implementation of restrictive practices was implemented after clients, their representatives, and the facility's HRC (Human Rights Committee) had given consent. The QMRP failed to ensure recommendations made by the dietitian were acted upon (client A).</p> <p>Findings include:</p> <p>Please refer to W210. The facility failed to perform a comprehensive functional assessment (CFA) within 30 days of their admission for 2 of 2 sample clients (clients A and B) who were new admissions to the facility.</p> <p>Please refer to W226. The facility failed</p>	W0159	<p>W 159 QMRP failed to integrate and coordinate active treatment program for new admissions; HRC did not approve food restriction; no follow-up on dietician's recommendation Corrective action for resident(s) found to have been affected The group home's original QMRP implemented basic ISPs prior to client admission, but did not coordinate ongoing active treatment sufficiently with the individuals' IDTs. Due to performance issues such as these, that QMRP no longer works for the agency. A highly experienced QMRP now works in the home, coordinates ongoing IDT activity across individuals, and has revised all ISP goals in coordination with the IDTs. Keeping extra food off-site will be submitted for HRC approval (see W125). The primary health care provider was notified about the dietician's 2-10-12 recommendation for a lipid panel and has scheduled the screening. Her response was as follows when asked why the screen was scheduled in June rather than sooner: "Lipids last drawn 8/2011 and was actually low at that time - annual lipid recommended for seroquel usage</p>	04/25/2012			

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	<p>to develop an ISP (Individual Support Plan) within 30 days of admission to the facility for 2 of 2 sample clients (clients A and B).</p> <p>Please refer to W227. The facility failed to ensure a choking management plan was developed and implemented when a need was identified for 1 of 2 sampled clients (client A).</p> <p>Please refer to W263. The facility failed to ensure consent from the client or legally authorized representative was obtained for 2 of 2 sampled clients (clients A and B) with restrictive interventions in their plans.</p> <p>Please refer to W264. The facility's HRC (Human Rights Committee) failed to approve facility practices for restrictions of food for 2 of 2 sampled clients (clients A and B) and for two additional clients (clients C and D).</p> <p>Please refer to W322. The facility failed to ensure a choking management plan was developed and implemented when a need was identified for 1 of 2 sampled clients (client A).</p> <p>The Director was interviewed on 3/23/12 at 11:46 AM and indicated the facility had replaced a QMRP due to performance</p>		<p>and we are already drawing early in June. Dietitian only recommended lipids which we have done - no specific time frame" How facility will identify other residents potentially affected & what measures taken All residents potentially affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence A new QMRP was hired who has significant experience implementing ISPs and coordinating IDT activity. New ISPs have been implemented across clients based on IDT consensus. The QMRP will ensure that all new admissions include appropriate assessments and that IDT activity and ISP goals are developed within the required 30-day timeframe. Program plan implementation will include documentation of the need and approval for any restrictions, including guardian consent and IDT as well as HRC approval. HRC approval is being sought for the extra food stored off site. The primary health care provider has scheduled a lipid screening based on the dietician's recommendation. How corrective actions will be monitored to ensure no recurrence The QMRP coordinates the activity of the IDT, which is responsible for development of ISPs. For all new</p>				

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	<p>issues who was responsible for completing assessments and ISPs upon client admission and the new QMRP had been off work due to illness for some weeks and was now working to correct problems to ensure plans were developed, recommendations implemented and client progress was monitored. He further indicated the facility was in the process of developing a system to ensure records were available for review. He indicated there was now a new process to ensure the HRC committee deliberated restrictive interventions in a timely manner.</p> <p>This federal tag relates to complaint #IN00104090.</p> <p>9-3-3(a)</p>		<p>admissions, the QMRP is responsible to ensure that the 30-day requirement is met for all appropriate assessments and for the development of the ISP. Other management staff, including the Nurse, the Behavior Clinician, and the Group Home Manager, take part in the process and will assist with appropriate appointments, assessments, and staff training as needed. The Director supervises the management staff and will monitor implementation of all plans during regularly scheduled meetings or more often, as necessary. A checklist will be used by the Director to monitor the status and appropriate scheduling of all required assessments for all new admissions.</p>		

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W0210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview, for 2 of 2 sample clients (clients A and B) who were new admissions to the facility, the facility failed to perform a comprehensive functional assessment (CFA) which included audio and vision assessments within 30 days of their admission.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Client A's record was reviewed on 3/15/12 at 2:30 PM. Client A's record indicated client A was admitted to the facility on 6/28/11. Client A's record did not include evidence of a comprehensive assessment identifying the functional abilities of client A had been completed in the following areas: sensorimotor development; speech and language development; auditory functioning; or vocational skills. Client B's record was reviewed on 3/15/12 at 1:50 PM. Client B's record indicated client B was admitted to the 	W0210	<p>W210 Assessments of Hearing and Vision in CFA Corrective action for resident(s) found to have been affected The group home's original QMRP did not ensure that the comprehensive functional assessments due within 30 days of admission included vision and hearing testing. Due to performance issues such as these, that QMRP no longer works for the agency. A highly experienced QMRP now works in the home, coordinates ongoing IDT activity across individuals, and is responsible for ensuring assessments are completed as needed. The QMRP and Nurse have made vision and hearing appointments for all clients who need them. How facility will identify other residents potentially affected & what measures taken All residents potentially affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Vision and Hearing assessments have been scheduled. A highly qualified QMRP was hired who will ensure that all new admissions include appropriate assessments,</p>	04/25/2012			

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	<p>facility on 5/13/11. Client B's record did not include evidence of a comprehensive assessment identifying the functional abilities of client B had been completed in the following areas: sensorimotor development; speech and language development; auditory functioning; or vocational skills.</p> <p>Client B was interviewed on 3/15/12 at 9:15 AM during observation at the group home. He indicated he had been painting at day services and was not paid for painting. Client B indicated he used to work at two paid jobs while living at another facility. When asked if he had been approached by staff regarding paid employment, he stated, "They say they are going to get me a job, but never did."</p> <p>The QMRP (Qualified Mental Retardation Professional) was interviewed on 3/14/12 at 3:00 PM and indicated vocational assessments had not been completed for the clients within 30 days.</p> <p>The Director was interviewed on 3/26/12 at 10:21 AM and indicated the QMRP was responsible for ensuring assessments were completed.</p> <p>This federal tag relates to complaint #IN00104090.</p> <p>9-3-4(a)</p>		<p>including hearing and vision, are completed within the required 30-day timeframe for all future admissions. A new checklist of needed assessments has been developed for this purpose.</p> <p>How corrective actions will be monitored to ensure no recurrence For all new admissions, the QMRP is responsible to ensure that the 30-day requirement is met for all appropriate assessments, including hearing and vision. Other management staff, including the Nurse, the Behavior Clinician, and the Group Home Manager, take part in the process and will assist with appropriate appointments, assessments, and staff training as needed. The Director supervises the management staff and will monitor implementation of all plans during regularly scheduled meetings or more often, as necessary. A checklist will be used by the Director to monitor the status and appropriate scheduling of all required assessments for all new admissions.</p>				

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W0226	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan.</p> <p>Based on interview and record review, for 2 of 2 sample clients (clients A and B), the facility failed to develop an ISP (Individual Support Plan) within 30 days of admission to the facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Client A's record was reviewed on 3/15/12 at 2:30 PM. Client A's record indicated he was admitted to the group home on 6/28/11. Client A's ISP was dated 10/30/11. Client B's record was reviewed on 3/15/12 at 1:50 PM. Client B was admitted to the group home on facility on 5/13/11. Client B's ISP was dated 7/12/11 and revised 10/30/11. <p>The Director and QMRP (Qualified Mental Retardation Professional) were interviewed on 3/15/12 at 2:58 PM. The Director stated, "This is all we have record of," when asked if there were ISPs developed within 30 days.</p>	W0226	<p>W226 ISP implemented within 30 days Corrective action for resident(s) found to have been affected The group home's original QMRP implemented basic ISPs prior to client admission that were based on pre-admission IDT meetings that went undocumented. The QMRP did not coordinate sufficiently with the individuals' IDTs to update and implement plans based on assessment within 30 days. Due to performance issues such as these, that QMRP no longer works for the agency. A highly experienced QMRP now works in the home, coordinates ongoing IDT activity across individuals, and has revised all ISP goals in coordination with the IDTs.</p> <p>How facility will identify other residents potentially affected & what measures taken All residents potentially affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence A new QMRP was hired who has significant experience implementing ISPs and coordinating IDT activity. New ISPs have been implemented across clients based on IDT consensus. The QMRP will ensure that all new</p>	04/25/2012			

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	This federal tag relates to complaint #IN00104090. 9-3-4(a)		admissions include appropriate assessments and that IDT activity and ISP goals are developed within the required 30-day timeframe. A new checklist has been developed for this purpose. How corrective actions will be monitored to ensure no recurrence The QMRP coordinates the activity of the IDT, which is responsible for development of ISPs. For all new admissions, the QMRP is responsible to ensure that the 30-day requirement is met for all appropriate assessments and for the development of the ISP. Other management staff, including the Nurse, the Behavior Clinician, and the Group Home Manager, take part in the process and will assist with appropriate appointments, assessments, and staff training as needed. The Director supervises the management staff and will monitor implementation of all plans during regularly scheduled meetings or more often, as necessary. A checklist will be used by the Director to monitor the status and appropriate scheduling of all required assessments for all new admissions.		

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W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based upon record review and interview, the facility failed to ensure a choking management plan was developed and implemented when a need was identified for 1 of 2 sampled clients (client A).</p> <p>Findings include:</p> <p>Client A's record was reviewed on 3/15/12 at 2:30 PM. A choking risk assessment dated 7/23/11 indicated client A was at moderate risk for choking and included the recommendations to cue client A to take smaller bites and to swallow the previous bite before taking another. Client A was to be encouraged to drink fluids with meals. There was no evidence the dietitian's recommendations were discussed by the IDT (interdisciplinary team) or incorporated into a plan to address client A's choking risk.</p> <p>The group home nurse was interviewed on 3/15/12 at 4:20 PM and indicated she had recently become aware of the recommendation of the dietitian and had not yet developed a plan to address the dietitian's recommendations. She stated the plan was "in process."</p> <p>The Director was interviewed on 3/26/12 at 10:21 AM. He indicated it was the Qualified Mental Retardation Professional's (QMRP) role to ensure recommendations were acted upon and was to work with the nurse in developing a plan to address them.</p>	W0227	<p>W 227</p> <p>Choking Management Plan</p> <p>Corrective action for resident(s) found to have been affected</p> <p>The client's dysphasia and dining plans were updated by the nurse, including instructions to reduce the risk of choking.</p> <p>How facility will identify other residents potentially affected & what measures taken</p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>Dysphasia and Dining plans updated.</p>	04/25/2012	

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	9-3-4(a)		<p>How corrective actions will be monitored to ensure no recurrence</p> <p>The QMRP coordinates IDT activity and schedules intake assessments for new admissions. The QMRP also follows up on recommendations from those assessments. The original QMRP was replaced due to performance issues. The new QMRP is highly experienced and will work with the Nurse to ensure that all dysphasia and dining plans are consistent with recommendations resulting from assessments. The QMRP and Nurse are supervised by the Director, and they meet regularly.</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 upon observation, interview and record review for 1 of 2 sampled clients (client B) and for 1 additional client (client D), the facility failed to ensure their ISP (individual support plan) objectives were implemented as written.</p> <p>Findings include:</p> <p>Upon entrance to the facility on 3/14/12 at 12:42 PM, clients A, B, C and D were not present at day services.</p> <p>The Behavior Clinician was interviewed on 3/14/12 at 12:50 PM and indicated the clients had left for lunch and stated, "They might be back." He indicated clients normally prepared lunch at day services, but there was no can opener available that day and the clients normally stayed until 2 to 3 PM.</p> <p>The QMRP (Qualified Mental Retardation Professional) was interviewed on 3/14/12 at 1:15 PM and indicated clients normally arrived at day services at 9:00 AM to 9:30 AM.</p> <p>During administration of medication on 3/14/12 at 4:05 PM and again on 3/15/12 at 7:55 AM, client D was given his medications without being prompted to state one of his medications.</p>	W0249	<p>W249 Program implementation Corrective action for resident(s) found to have been affected Staff members have been trained on the essential aspect of proper implementation of all ISP goals and Physician Orders. Updates were being made to the day program at the time of survey, including new paint, which is now completed. Clients will be paid for their participation in this, and programs will be implemented at the day program per ISP plans. How facility will identify other residents potentially affected & what measures taken All residents potentially affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Training on implementation, paying clients for their work, and on-going implementation at the newly-repainted day program. How corrective actions will be monitored to ensure no recurrenceThe QMRP monitors</p>	04/25/2012

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	<p>Observation at day services was completed on 3/15/12 from 11:20 AM until 12:55 PM. Clients A and C were not present during the observation. During the observation, the Behavioral Clinician (BC), BC intern and client B painted the walls, while client D slept on the sofa. Client D was asked by staff #14 if he wanted to paint two times when he woke up, but did not engage in painting. Staff #14 asked client B if he liked painting and he stated, "Yes." Client D was prompted to assist with preparing lunch by the BC intern.</p> <p>Client B's record was reviewed on 3/15/12 at 1:50 PM. His ISP dated 10/30/11 indicated he was to assist with preparing a meal twice weekly, practice making change daily, plan activity with staff, turn in receipts after making a purchase, and practice writing his phone number daily.</p> <p>Client D's record was reviewed on 3/15/12 at 1:40 PM. Client D's ISP dated 10/30/11 indicated he was to state one medication daily, brush his teeth twice daily, identify one coin from change of a purchase, assist in preparing a meal.</p> <p>The QMRP (Qualified Mental Retardation Professional and Director were interviewed on 3/15/12 at 2:58 PM and indicated clients B and C were not being paid to paint. When asked who would paint the walls if clients didn't, the QMRP indicated staff would paint the walls. The QMRP indicated clients had asked if they could help paint the day services and expressed pride in their work.</p> <p>The QMRP was interviewed on 3/23/12 at 3:11 PM and indicated client D's goals should be implemented at day services and indicated client D should identify medications once daily. When asked if client D's self administration of medication goals should be implemented at every</p>		<p>program development and implementation. Management staff complete home visit forms and will assist in monitoring program implementation. The Director supervises management staff and reviews home visit forms at regular staff meetings.</p>				

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	<p>opportunity, she indicated they should be implemented. When asked about client D's goals to be implemented during day services, she indicated client D was to identify coins and complete toothbrushing.</p> <p>This federal tag relates to complaint #IN00104090.</p> <p>9-3-4(a)</p>						

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W0263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview, the facility failed to ensure consent from the client or legally authorized representative was obtained for 2 of 2 sampled clients (clients A and B) with restrictive interventions in their plans.</p> <p>Findings include:</p> <p>Client A's records were reviewed on 3/15/12 at 2:30 PM. Client A's record failed to include evidence client A or client A's legally authorized representative had signed consent for a BSP (Behavior Support Plan) dated 9/21/11 which included the use of physical restraint, restricted food access and psychotropic medications to manage his behavior. An update to his plan dated 3/10/12 was signed by client A on 3/21/12 and reviewed and approved by the facility's HRC (Human Rights Committee) on 3/19/12 two days prior to client A's signed consent.</p> <p>Client B's records were reviewed on 3/15/12 at 1:50 PM. Client B's record failed to include evidence client B or</p>	W0263	<p>W263 Written Consent for all BSPs and Restrictive Measures Corrective action for resident(s) found to have been affected Written consent will be obtained. The agency's Behavior Clinician will receive training on the need to obtain consent and HRC approval for all restrictive measures. How facility will identify other residents potentially affected & what measures taken All residents potentially affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Written consent will be obtained for all clients' BSPs and restrictions, and BC will receive training to ensure follow-through. Additionally, HRC procedures have changed and now require guardian approval with signature prior to consideration. How corrective actions will be monitored to ensure no recurrence Behavior Clinician is responsible for all BSPs, restrictions, and HRC applications. Any new intervention or restriction requires HRC approval, which now requires verification of signed</p>	04/25/2012	

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	<p>client B's legally authorized representative had signed consent for a BSP dated 9/2/11 that included the use of physical restraint, locked sharps, and door alarms. An updated plan dated 3/9/12 included psychotropic medications including Cogentin (side effects), Risperidone (psychosis), Topamax (mood stabilizer) and staff assigned to him at all times when female clients are in the immediate area. The plan was signed by client B on 3/21/12 and reviewed and approved by the HRC on 3/19/12, two days prior to client B's consent.</p> <p>The behavior clinician was interviewed on 3/15/12 at 4:30 PM and indicated obtaining client consent was an oversight, and no consent was available to review for the clients' BSPs dated 9/21/11.</p> <p>9-3-4 (a)</p>		<p>consent prior to consideration. Additionally, at a minimum, BSPs (which include the restrictions) are renewed on an annual basis and submitted for HRC approval.</p>		

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W0264	<p>483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, interview, and record review, for 1 of 2 sampled clients (client B) and two additional clients (clients C and D), the facility failed to ensure the facility's Human Rights Committee reviewed and approved the practice of limiting food access in the home.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 3/14/12 from 3:45 PM until 6:15 PM and on 3/15/12 from 7:15 AM until 9:20 AM. During both observations, staff left the home to obtain food for the meal prepared during the observations.</p> <p>Staff #12 was interviewed on 3/14/12 at 7:40 AM. She indicated the home only kept limited supplies of food due to the food seeking behavior of client B. She</p>	W0264	<p>W 264 HRC approval for extra refrigerator is stored off site Corrective action for resident(s) found to have been affected The home has a refrigerator in the kitchen. The home's extra refrigerator will be moved back to the garage. The door from the home to the garage will be locked, and the three individuals without any need for food restriction will be given a key to access the garage without restriction. The BSP for the one individual will be modified to indicate that he is restricted from extra food in the garage, and this will be submitted for HRC approval. Originally, the IDT felt that having current food available in the kitchen refrigerator with extra food off-site was a non-restrictive way to address some behavioral issues that were associated with food. Because it was not considered restrictive (much like having one day's supply would occur right before grocery shopping), no HRC approval was sought. We will reverse this decision as noted</p>	04/25/2012	

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	<p>indicated there was only enough meat, cheese, and bread in the home to prepare the next meal, and the remainder was kept in an agency owned group home nearby. When asked if the other clients in the group home wanted additional food or snacks, she indicated staff would need to take them to get the food at the nearby group home. She indicated clients B, C and D were not in need of restricted access to food.</p> <p>Client B's record was reviewed on 3/15/12 at 1:50 PM and did not include an assessed need for the restricted food. There was no evidence in the record of consent for the restricted food.</p> <p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 3/23/12 at 3:11 PM. The QMRP stated when asked if clients B, C and D were in need of restricted food, "No, but they signed consents." She indicated the clients did not have the restricted access to food in their plans and the IDT (interdisciplinary team) did not consider the off site storage of food restricted access and the facility had not obtained approval for the practice from their Human Rights Committee (HRC).</p>		<p>above, and we will seek HRC approval at this time. How facility will identify other residents potentially affected & what measures taken All residents potentially affected, and corrective measures address the needs of all clients. Specifically, the individuals who have no need for restriction on food will have access with keys. Measures or systemic changes facility put in place to ensure no recurrence Extra refrigerator returned to garage; garage restricted from one consumer; keys provided to other three individuals; restriction added to BSP for one individual and sent to HRC. How corrective actions will be monitored to ensure no recurrence The Behavior Clinician (BC) monitors restrictions and reports to the IDT. The IDT determines the need for restrictions. The BC submits HRC requests. Management staff complete home visit forms and will assist in monitoring restrictions. The Director supervises management staff, including the BC, and reviews home visit forms at regular staff meetings.</p>				

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	<p>The QMRP stated, "It's like the day before going to the grocery store."</p> <p>Consents for the off site food storage were reviewed on 3/23/12 at 4:40 PM and indicated clients B, C and D signed on 1/18/12 they had been explained the details of the restricted food and agreed to the restrictions. "I understand that I may make reasonable requests for additional food items to be secured from the off-site refrigerator, as long as the items are within my dietary guidelines and/or restrictions. I also understand that I may request modifications and/or changes to the above listed provisions at any time, and that any such modifications/changes will require IDT consensus and approval prior to implementation." The consent indicated "The refrigerator inside the home will be kept stocked with the food items that are needed to prepare the next upcoming meal. No additional or extra food items will be kept in the in-home refrigerator. All additional and surplus food items will be kept in a second refrigerator that will be stored off-site at [name of site]. If a consumer makes a reasonable request to receive food items that are not located in the on-site refrigerator, staff will attempt to secure/obtain those food items from the off-site refrigerator within a reasonable</p>						

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	<p>time frame, provided that the food items are within any necessary dietary guidelines and/or restrictions. Consumers may make reasonable requests for off-site food items at any time. However, staff are to be given a reasonable length of time to located, obtain, and return the requested items to the home." There was no evidence to review of the facility's HRC review and approval of the practice of storing food off site.</p> <p>9-3-4(a)</p>			

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W0304	<p>483.450(d)(5) PHYSICAL RESTRAINTS Restraints must be designed and used so as not to cause physical injury to the client.</p> <p>Based on record review and interview, for 1 of 2 sampled clients (client A), the facility failed to ensure client A was not injured during physical restraints applied by the facility staff.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disability Services) reports and reports of injury were reviewed on 3/14/12 at 1:25 PM and indicated the following injuries during restraint for client A:</p> <p>A report of injury dated 7/25/11 (no time listed) completed by staff #13 indicated client A sustained a "rug burn" when he was restrained caused by attempted movement by client A during restraint. The report indicated the burn was around client A's left knee cap. The area for the nurse to complete assessment was blank of information, and an area to complete "What could be done to prevent this incident from occurring again" was also blank.</p> <p>A report of injury dated 7/26/11 at 11:00</p>	W0304	<p>W 304</p> <p>Injury during physical restraints</p> <p>Corrective action for resident(s) found to have been affected</p> <p>A certified trainer provided specific training to staff on how to safely implement restraint without injuring clients. This includes proper hand placement to prevent bruising.</p> <p>How facility will identify other residents potentially affected & what measures taken</p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>Staff training took place.</p>	04/25/2012			

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	<p>AM completed by staff #1 indicated client A sustained a quarter inch spot on the top of his right wrist in which the skin "looked like it was rubbed a little raw...He had similar spots around the same size, on his elbows. The description of how the injuries occurred indicated, "Injuries occurred when [client A] had to be restrained,He was struggling when he was being restrained, causing the injuries." The area for the nurse to complete assessment was blank of information, and an area to complete "What could be done to prevent this incident from occurring again" was also blank.</p> <p>There were no corresponding BDDS reports of the incident provided to review upon entrance to the facility.</p> <p>The Behavior Consultant was interviewed on 3/14/12 at 2:47 PM. When asked if the injuries to client A were the result of being restrained, he stated, "Yes I think that's what he is implying." He indicated staff #13 was available to interview.</p> <p>Staff #13 was interviewed on 3/14/12 at 3:50 PM and when asked if the injuries to client A on 7/26/11 were caused by restraint, he stated he was "not sure." He indicated the injuries could possibly have occurred due to client A pounding the</p>		<p>How corrective actions will be monitored to ensure no recurrence</p> <p>All staff members are supervised by the Group Home Manager who is responsible to ensure that staff receive proper training. The Manager is supervised by the Director. Training needs are reviewed during regular management team meetings.</p>				

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	<p>wall.</p> <p>BDDS reports for 7/25/11 and 7/26/11 were provided on 3/23/12 at 8:26 AM. The report dated 7/25/11 indicated the incident occurred at 7:00 PM and indicated client A was restrained using a one armed physical restraint after engaging in property destruction and was able to break free of the restraint and "punched staff in the face 4 times." There was no indication if client A was injured during the incident in the BDDS report. The BDDS report dated 7/26/11 indicated the incident occurred at 12:00 PM and client A was restrained 7 times for less than a minute after engaging in property destruction and physical aggression towards staff. The report indicated staff had observed a scratch on his left elbow and examined by a nurse who indicated medical treatment was unnecessary. There was no evidence of an investigation into the incidents causing injuries to client A documented on 7/25 and 7/26/11. There was no evidence documenting nursing assessments of client A's injuries available to review.</p> <p>The Director stated via an e-mail dated 3/23/12 at 8:26 PM, "It is likely" the reports were reported with information in error and missing information and the QMRP completed the report was no</p>						

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	longer employed at the agency due to performance issues. 9-3-5(a)				

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W0322	<p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.</p> <p>Based upon record review and interview, the facility failed to ensure preventative care/lab work was conducted after recommended for 1 of 2 sampled clients (client A).</p> <p>Findings include:</p> <p>Client A's record was reviewed on 3/15/12 at 2:30 PM. A Quarterly Nutritional Review dated 2/10/12 included a recommendation to check client A's lipid panel in light of Seroquel use and rapid weight gain. "May also want to consider HGBA1c check (lab test)." There was no evidence of the testing recommendations having been completed in client A's record.</p> <p>The Director was interviewed on 3/23/12 at 11:46 AM and indicated he would need to check on the results of the lab work.</p> <p>An e-mail regarding the status of lab test recommendations made by the dietitian was received on 3/23/12 at 2:45 PM by the Director and indicated client A's primary healthcare provider informed the facility she wanted to wait until June (year not specified) to complete the lipid panel.</p> <p>The Director was interviewed on 3/26/12 at 10:21 AM. He indicated the recommendations had not been acted upon prior to the surveyor asking about the results of the testing, and client A's doctor had just been made aware of the recommendations on 3/23/12 and wanted to wait until other lab work was completed in June 2012. He further indicated it was the Qualified Mental Retardation</p>	W0322	<p>W 322</p> <p>Lipid panel recommended by dietician</p> <p>Corrective action for resident(s) found to have been affected</p> <p>The primary health care provider was notified about the dietician's 2-10-12 recommendation for a lipid panel and has scheduled the screening. Her response was as follows when asked why the screen was scheduled in June rather than sooner: "Lipids last drawn 8/2011 and was actually low at that time - annual lipid recommended for seroquel usage and we are already drawing early in June. Dietitian only recommended lipids which we have done - no specific time frame"</p> <p>How facility will identify other residents potentially affected & what measures taken</p> <p>All residents potentially affected, and corrective measures address</p>	04/25/2012			

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	<p>Professional's (QMRP) role to ensure recommendations were acted upon and was to work with the nurse in addressing them.</p> <p>This federal tag relates to complaint #IN00104090.</p> <p>9-3-6(a)</p>		<p>the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>Lipid panel will be conducted in June, as scheduled.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The group home Nurse monitors healthcare and coordinates with community providers. The Nurse is supervised by the Director, and they meet regularly.</p>		

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based upon record review and interview, the facility failed to ensure 4 of 4 clients living in the group home (clients A, B, C and D) were were provided nursing assessment and care in accordance to their needs.</p> <p>Findings include:</p> <p>1. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and reports of injury were reviewed on 3/14/12 at 1:25 PM and included the following reports that failed to include documentation the injuries were assessed by the nurse:</p> <p>-A report dated 5/21/11 indicated client B bumped his head on a van door as he was getting into the van (no visible injury).</p> <p>-A report of injury dated 6/12/11 at 5:30 PM, documented client D had a cut to his face. There was no documentation available to review to indicate the injury to client D had been assessed by the nurse.</p> <p>-A report dated 7/15/11 indicated client B was cut on his right ring finger by</p>	W0331	<p>W 331</p> <p>Nursing assessment</p> <p>Corrective action for resident(s) found to have been affected</p> <p>Training will be conducted with the nurse on the importance of documenting follow-up actions and assessments, including signing forms after review.</p> <p>How facility will identify other residents potentially affected & what measures taken</p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>Training will occur. The group home Nurse does an excellent job of follow-up when injuries occur or other health care needs are identified. Documentation</p>	04/25/2012			

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	<p>bumping into a mixer blade.</p> <p>-A report of injury dated 7/25/11 (no time listed) completed by staff #13 indicated client B sustained a "rug burn" when he was restrained caused by attempted movement by client B during restraint. The report indicated the burn was around client B's left knee cap.</p> <p>-A report of injury dated 7/26/11 at 11:00 AM completed by staff #1 indicated client B sustained a quarter inch spot on the top of his right wrist in which the skin "looked like it was rubbed a little raw...He had similar spots around the same size, on his elbows."</p> <p>-A report of injury dated 9/22/11 indicated client A sustained cut on his right "pinky finger red and very small." The report indicated he sustained the cut during "a behavior was throwing and hitting things. Staff contacted nurse [name]. She said OK and thanks."</p> <p>-A report of injury dated 12/12/11 indicated client B cut his middle finger on a can.</p> <p>-A report of injury dated 12/14/11 indicated client D was hit in the stomach by a plate thrown by client B.</p>		<p>has been inconsistent, so a new form has been adopted for home visits, which also can be used at other locations. This form will be available to her for easier documentation of follow-up actions and assessments.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The group home Nurse is responsible for health care monitoring, including follow-up assessment. The Nurse is supervised by the Director. They meet regularly with other management staff. During these visits, home visit forms will be monitored by the Director.</p>		

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	<p>-A report of injury dated 12/14/11 indicated client B "was punching cabinets." The report indicated there was no noticeable injury at the time of the incident.</p> <p>-A report of injury dated 1/13/12 indicated client A sustained a cut on the left forearm with a "small" scratch and client A used his fists to punch doors, cabinets, walls and windows, and used his feet to kick walls, desk and doors. The report indicated client A also threw "multiple" glass items.</p> <p>The LPN (licensed practical nurse) was interviewed on 3/14/12 at 2:47 PM and indicated there was no additional documentation regarding nursing assessments of the clients detailed in the reports of injury. She indicated she usually is notified by text or phone call of incidents involving injury and some of the reports were prior to her employment at the facility.</p> <p>The Director was interviewed on 3/23/12 at 10:11 AM and indicated the nurse should be documenting assessments of injuries.</p> <p>9-3-6(a)</p>						

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W0336	<p>483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>Based on record review and interview, for 2 of 2 sampled clients (clients A and B), the facility failed to document a quarterly nursing assessment.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 3/15/12 at 2:30 PM. Client A's record indicated he was admitted to the facility on 6/28/11. There were no nursing assessments available for review from 6/28/11 through 12/1/11, or after 12/1/11.</p> <p>Client B's record was reviewed on 3/15/12 at 1:50 PM. Client B was admitted on 5/13/11. Client B had a nursing assessment dated 2/12/12. There was no other evidence of nursing assessments.</p> <p>The facility's Licensed Practical Nurse (LPN) was completed on 3/15/12 at 2:30 PM. She indicated there were no other nursing assessments available to review.</p> <p>9-3-6(a)</p>	W0336	<p>W 336</p> <p>Nursing quarterlies</p> <p>Corrective action for resident(s) found to have been affected</p> <p>Nursing quarterlies are being completed at this time. The most recent quarterlies were not in the chart at the time of survey. Nursing quarterlies will be presented to the IDT on a quarterly basis and placed in the chart as required.</p> <p>How facility will identify other residents potentially affected & what measures taken</p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p>	04/25/2012			

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			<p>Nursing quarterlies will be written by the group home nurse, presented to the IDT on a quarterly basis, and placed in the appropriate chart as required. The nurse also is revising and improving the home's record keeping to enhance record retention and provide easy access for review.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The group home nurse is a member of the IDT and creates a quarterly report that is presented to the team. The Director supervises the nurse.</p>		

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W0369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview, the facility failed to assure medications were administered without error according to physician's orders for 1 of 16 medications administered affecting client D.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 3/14/12 from 3:45 PM to 6:15 PM. Client D was not observed to have a snack prior to his medication administration at 4:05 PM. Staff #5 gave client D two Metformin ER (extended release) 750 mg (milligrams) tablets. The label on the medication indicated, "Give every evening before supper snack." Client D was offered an apple at 5:15 PM by staff #5 who stated, "Do you want an apple to hold you over?"</p> <p>Staff #5 was interviewed on 3/14/12 at 5:15 PM and indicated client D had not had a snack since her arrival at the group home at 3:00 PM. She indicated client D normally receives a snack at shift change but did not on this day and he should have</p>	W0369	<p>W 369</p> <p>Medication administered per Physician Order</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>Staff members were trained to follow Physician Orders (POs) precisely in order to correctly administer medications. Additionally, staff will receive training specific to the medication not administered correctly during the time of survey. It should have been given with a snack.</p> <p>How facility will identify other residents potentially affected & what measures taken</p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure</p>	04/25/2012	

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	<p>a snack with his Metformin.</p> <p>Client D's record was reviewed on 3/15/12 at 1:50 PM. Physician's orders dated 2/12 indicated client D was to receive Metformin 1500 mg orally every evening before supper with snack for diabetes.</p> <p>The Licensed Practical Nurse (LPN) was interviewed on 3/15/12 at 3:00 PM and indicated client D was to receive a snack with the administration of his Metformin.</p> <p>9-3-6(a)</p>		<p>no recurrence</p> <p>Staff were trained on specific medications cited (Metformin) as well as a more general instruction to precisely follow POs.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The Group Home Nurse coordinates healthcare and is responsible for medication administration training. The Director supervises the Group Home Nurse.</p>	

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W0393	<p>483.460(n)(1) LABORATORY SERVICES</p> <p>If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter.</p> <p>Based on observation, record review, and interview, the facility failed to provide Clinical Laboratory Improvement Act (CLIA) certification documentation for 1 of 1 client (client D) who received injectable medication.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 3/15/12 from 7:15 AM until 9:20 AM. Client D was given an injection of Victoza 1.2 mg (diabetes) during medication administration at 7:55 AM. There was not a CLIA waiver document visible in the area of medication administration.</p> <p>The Director was interviewed on 3/23/12 at 11:41 AM and indicated there was not a CLIA waiver on file for the group home and he was in the process of obtaining a waiver.</p> <p>9-3-6(a)</p>	W0393	<p>W 393 CLIA waiver needed</p> <p>Corrective action for resident(s) found to have been affected An application will be made for a waiver of the Clinical Laboratory Improvement Act based on the fact that only the very simple blood glucose monitoring is performed at the home (this is one of the criteria for obtaining a waiver). How facility will identify other residents potentially affected & what measures taken Only one resident receives injections. Measures or systemic changes facility put in place to ensure no recurrence Waiver application to be made. How corrective actions will be monitored to ensure no recurrence The group home Nurse monitors health care in the home. The Director supervises the Nurse and meets with her regularly.</p>	04/25/2012	

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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.</p> <p>Based on interview and record review, for 4 of 4 clients (clients A, B, C, and D) living in the group home, the facility failed to ensure evacuation drills were conducted every ninety (90) days for each shift of personnel.</p> <p>Findings include:</p> <p>The facility evacuation drills for clients A, B, C, and D were reviewed on 3/15/12 at 4:45 PM and indicated the following:</p> <p>Evacuation drills for second shift personnel were completed on 7/29/11 at 7:33 PM and not again until 12/29/11 at 5:21 PM.</p> <p>The Director indicated on 3/22/12 at 4:09 PM there were no additional evacuation drills to review.</p> <p>9-3-7(a)</p>	W0440	<p>W 440</p> <p>Quarterly evacuation drills</p> <p>Corrective action for resident(s) found to have been affected</p> <p>Evacuation drills will be conducted for each shift.</p> <p>How facility will identify other residents potentially affected & what measures taken</p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>Evacuation drills will be conducted across shifts, and a new drill schedule will be put in place to ensure that they continue to be conducted in the future.</p>	04/25/2012	

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			<p>How corrective actions will be monitored to ensure no recurrence</p> <p>The Group Home Manager is responsible to ensure that drills are conducted as required. The Director supervises the Group Home Manager.</p>		