STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G101	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/29/2014
NAME OF PROVIDER OR SUPPLIER CDC INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2906 N 400 E MONTICELLO, IN 47960	

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W000000	This visit was for a fundamental recertification and state licensure survey. Dates of survey: October 20, 21, 22, 24 and 29, 2014 Facility number: 000639 Provider number: 15G101 AIM number: 100234030 Surveyor: Christine Colon, QIDP The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed November 13, 2014 by Dotty Walton, QIDP.	W000000		
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 2 of 2 sampled clients and 2 additional clients (clients #1, #2, #3 and #4), the facility's governing body failed to exercise general policy and operating direction over the facility to 1. develop a policy and procedure on addressing	W000104	Ø a Bug Infestation procedure has been developed and staff have been trained by Group Supervisor on the procedure as of 11-4-2014. CDC Resources had Orkin personnel come out and do a training of staff on 10-30-2014 as what to look for an infestation of bed bug. Training will be done	12/02/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	infestation of bed bugs, 2. to ensure implementation of the facility's "Physician Orders and Medication Administration" policy in regard to proper administration of medications and disposal of medications, 3. to ensure implementation of the facility's "Procedure for Management of Consumer Finances" policy and to reimburse client #2's missing money. Findings include: 1. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident Reports (IR) and/or investigations was conducted on 10/21/14 at 11:30 A.M.. The facility's reports indicated the following: -BDDS report dated 7/7/14 indicated: "[Exterminator name] was called out to Group Home to check for bed bugs. Bed bugs were found in the living room that were dead. It was suggested that [Exterminator name] come back to do a heating treatment on the home and removal of the furniture. Consumers were relocated that day (7/7/14) to the CDC [city] facility and will remain relocated until it is ok to return to the home. [Exterminator name] is coming to the home on Friday 7/11/14 to treat it for		upon hire and annually thereafter. Monitoring of the training will be done by Group Home Supervisor. Monitoring of the procedure is being followed will be done by a team of Group Home Supervisor, Habilitative Coordinator and the Quality Assurance Specialist. Monitoring will begin with a weekly check of the home for 60 days by Group Home Supervisor, Habilitative Coordinator and Quality Assurance will start a monthly check of the homes for the first Quarter then continue monthly checks by the Quality Assurance Specialist. Group Home Supervisors will also do a monthly check after the 60 days. A Professional will be contracted to check the home Bi-Annually. Ø CDC Resources hired Agency Nurse on November 1, 2014. The agency nurse will complete supervised med pass upon hire of staff. Group Home Supervisor will complete a supervised med pass twice a month for 30 days then one a month for 60 days. The Agency nurse will monitor medication passes monthly. The Agency nurse will monitor medication passes and supervised disposal of medications monthly. A competency in regards to medication passing and disposal will be done annually to ensure staffs competency. Habilitation Coordinator and Day Service Supervisor will monitor bi-monthly. Quality Assurance	

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	bedbugs. Furniture has been removed from the home and will be replaced once [Exterminator name] has treated the home." An interview with administrative staff #1 was conducted on 10/29/14 at 2:00 P.M.. Administrative staff #1 indicated the facility had not developed a policy and procedure on how to address the infestation and prevention of bed bugs. 2. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident Reports (IR) and/or investigations was conducted on 10/21/14 at 11:30 A.M.. The facility's reports indicated the following: -Investigation record dated 12/13/13 indicated: "Staff called Group Home Supervisor into the med room and handed her an envelope. The envelope was supposed to contain a Xanax (anti anxiety medication) that had fallen on the floor on 11/27/13 that had not been disposed of. The envelope was sealed and a corner of the envelope had been opened and the pill was gone. This incident is substantiated that the pill cannot be located. It is unknown as to what happen (sic) to the pill. The envelope was sealed initially however it		Specialist will monitor medication errors monthly for trends. Ø Agency Nurse will review drug regimen of consumers at least quarterly, the Habilitation Coordinator will discuss drug regimen at the quarterly meetings. The agency nurse will review all consumers' psychotropic med reviews, pharmacy reviews and nutritional assessments at least quarterly and follow-up with any recommendations to the consumers. Habilitation Coordinator will review quarterly. Monitoring to ensure they are completed will be by Adult Service Manager or Quality Assurance Specialist quarterly. Ø Consumer was reimbursed. Money is counted daily by direct care staff. Group home Supervisor will monitor weekly to ensure counts are correct. Group Home Supervisor will do audit on receipts and documentation monthly. Habilitation Coordinator will do a monthly check to ensure counts are being completed.	

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	appears that paperclip could have opened it and the pill fallen (sic) out in the medication area. (The pill is a size that could easily be concealed). There was no indication from staff that they were of (sic) or have information on anyone taking the pill out of the envelope." -BDDS report dated 10/13/13 involving client #4 indicated: "[Client #4] was not administered her 7:00 A.M. medication of Prednisone Acetate 1% (anti-inflammatory) drop in each eye for 1 week. Staff will be re-trained on medication administration and will complete three supervised med passes." -BDDS report dated 12/3/13 involving client #4 indicated: "Staff [Staff name] did not administer correct medication to [client #4]. [Client #4] was administered 1 Calcium Carb +D 600 mg (milligram) -400 IU (International Unit) tab (supplement) instead of 2 tabs....Staff observed the medication error on 12/4 when the medication was to be administered next. Staff will be unable to pass medications until they receive four supervised med passes before giving medications again." -BDDS report dated 1/8/14 involving client #4 indicated: "Staff did not administer to [client #4] her medication			

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	Citrucil (sic) 500 mg on (fiber) 1/8 at 7:00 A.M.. Staff did not observe the medication error until 1/9 at the next medication dose time. A second staff check of medications has been implemented." -BDDS report dated 1/22/14 involving client #4 indicated: "Residential manager went to classroom to check [client #4]. [Client #4] complained of a sore throat. Day service staff was informed to provide [client #4] PRN (as needed) medication. Staff Administered (sic) to [client #4] Acetaminophin (sic) (pain) 650 mg tab....Staff failed to administer to [client #4] Mi-Acid 1 tsp (teaspoon) for reflux or sore throat and gave Acetaminophen instead.....Staff was retrained on reading MAR (Medication Administration Record) and physician orders. Staff received verbal counseling." -BDDS report dated 9/6/14 involving client #1 indicated: "[Client #1] is ordered 3/125 mg caps of Divalproex (bipolar/seizures) twice daily. On 9/6/14 at 8:00 P.M. she was given 1 cap instead of 3....Plan of correction for the staff making the medication error is a supervised medication pass and staff making the medication pass will request a second check by another staff working at			

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	the home. Both staff working at the time of the medication error will receive verbal counseling." -BDDS report dated 9/12/14 involving client #3 indicated: "Staff noticed [client #3] had only been given 15 mg of Zyprexa (schizophrenia) 1 tab at bedtime on 9/12/14 and 9/13/14. [Client #3] is prescribed 20 mg 1 tab at bedtime....The staff making the error will be counseled, placed on a probation period, and be required to complete three supervised medication passes before administering medications. The staff will be monitored at least weekly for thirty days." -BDDS report dated 10/8/14 involving client #3 indicated: "[Client #3] is prescribed Diazepam (panic disorder) 1 tablet every morning at 7 A.M.. [Client #3] received this dose on 10/8/14 at 7 A.M.. Staff administered a second dose at 8:00 P.M. on 10/8/14....Staff making the error is prohibited from giving medications for thirty days, the staff will be required to complete three supervised medication passes, and will be required to be passed for medication administration by the health and safety personnel." -BDDS report dated 10/8/14 involving client #1 indicated: "[Client #1] is			

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	prescribed Xanax 1 tablet for anxiety. [Client #1] was given her 7 A.M., and 6 P.M. dose on 10/8/14 as prescribed. Staff administered a third dose at 8:00 P.M. on 10/8/14. Staff making the error is prohibited from giving medications for thirty days, the staff will be required to complete three supervised medication passes, and will be required to be passed for medication administration by the health and safety personnel." A review of the facility's "Physician Orders and Medication Administration" policy dated 5/24/13 was conducted on 10/23/14 at 12:30 P.M.. Review of the policy indicated: "Purpose: The purpose of this procedure is to ensure consumers are administered medication as prescribed by a physician....Drug Disposal: All unused drugs and medication will be disposed of by the following means: a. Complete the medication disposal form with at least one witness. b. Dispose of the medication, by returning them to the pharmacy, or by other appropriate route (controls to be taken to the Police Department for disposal). c. When possible return unused medications to the pharmacy for disposal.			

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	d. Submit the original form for filing in the master file; attach a copy. e. File a copy of the disposal form in the home book for residential services, to be filed and retained according to department guidelines. Procedures for administering medication: Preparing and administering medication requires staff to be diligent at all times. Proper handling and dispensing of medication ensures that the consumer is receiving the correct medication. Specific guidelines must be followed in the event that a medication is not given at the correct time or needs to be destroyed. All staff must be aware of the guidelines for controlled substances, storing medications, and maintaining medical asepsis. All staff is responsible for following directions given in Core A and Core B Curriculum (where applicable) and/or Medication Administration Curriculum. 2. When administering medication: ...c. Read the label 3 times. Confirm the '6 Rights' of medication administration. Remain with the consumer while he/she takes medication. Staff must remain until medication is taken....e. After giving the medication, initial the MAR to document all medications have been administered. This must be done immediately after the			

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	medication is given. Never chart before a medication is given-only immediately after....g. Medications may be given 1/2 hour before of 1/2 hour after the assigned time. That is administered outside the 1/2 hour before/after guideline but is still within label directions should be documented on the Med Error form to ensure that consistency is preserved, but such occurrences will not be considered significant medication errors." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/29/14 at 2:00 P.M.. The QIDP indicated staff are trained on the facility's medication administration upon hire and then annually. The QIDP indicated staff should pass medications as ordered by the physician and further indicated staff should follow the policy at all times. 3. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident Reports (IR) and/or investigations was conducted on 10/21/14 at 11:30 A.M.. The facility's reports indicated the following: -Investigation record dated 1/3/14 involving client #2 indicated: "Petty cash money was counted and staff found it			

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	was $20.00 short....This incident is Substantiated. However, when talking with all staff involved no one admitted to taking the money and no one shows knowledge of knowing where the money went. The petty cash is in a lock box that all staff have access to....Root Cause: Lack of follow through on money counts." Further review of the record failed to indicate the facility reimbursed client #2 for her missing money. A review of the facility's "Procedure for Management of Consumer Finances" dated 4/19/12 was conducted on 10/23/14 at 1:30 P.M. and indicated: Purpose: The purpose of this procedure is to ensure that CDC Resources, Inc. assists consumers with managing their personal finances in a way that is ethical, responsible,and adheres to Social Security Representative Payee regulations, where applicable. This procedure will be used throughout the course of service delivery for consumers who utilize CDC Resources, Inc.'s assistance with their finances. The outcome will be that consumers will be able to use their money as they chose with as much assistance as is needed to ensure it is managed responsibly." An interview with the Qualified			

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	Intellectual Disabilities Professional (QIDP) was conducted on 10/29/14 at 2:00 P.M.. The QIDP indicated the facility managed clients #2's finances and further indicated the facility was to keep an accurate account of her finances at all times. The AD indicated the facility reimbursed client #2 for the missing money. When asked if client #2 had been reimbursed, the QIDP indicated she did not know. 9-3-1(a)			
W000130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview, the facility failed for 1 of 2 sampled clients and 1 additional client observed during medication administration (clients #1 and #3) to ensure privacy during medication	W000130	As for Tag 130 Work orders have been submitted for enclosed areas that will ensure privacy during medication administration on 11-17-2014.Maintenance will ensure measurements, and purchase all needed supplies by	12/02/2014

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	administration. Findings include: An evening observation was conducted at the group home on 10/20/14 from 4:45 P.M. until 7:00 P.M.. At 5:55 P.M., Direct Support Professional (DSP) #2 began administering client #1's medications in the open dining/kitchen area while clients #2 and #3 were standing in the doorway, where client #1's medication information could be heard. As DSP #2 administered each of client #1's prescribed medications, she stated the names, dosage, reason for each medication and side effects for each medication. A morning observation was conducted at the group home on 10/21/14 from 6:15 A.M. until 8:30 A.M.. Beginning at 6:30 A.M., DSP #3 began administering client #3's morning medication in the open dining area while DSP #4 walked in and out of the dining area. Clients #1 and #4 sat at the dining table, where client #3's medication information could be heard. As DSP #3 administered each of client #3's prescribed medications, she stated the names, dosage, reason for each medication and side effects for each medication. At 6:46 A.M., DSP #3 began administering client #1's morning medication while she sat at the dining		11-18-2014. Completion of private medication areas will be potentially completed by 12-02-2014.Monitoring of work progress will be done by Quality Assurance Specialist. Quality Assurance Specialist will monitor progress of work orders progression weekly until completed.	

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	table, in the open dining area. DSP #4 walked in and out of the dining area and clients #2 and #3 sat at the dining table, where client #1's medication information could be heard. As DSP #3 administered each of client #1's prescribed medications, she stated the names, dosage, reason for each medication and the side effects of each medication. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/29/14 at 2:00 P.M.. The QIDP indicated while staff are administering client's medications, the other clients should be directed out of the area to ensure privacy. The QIDP further indicated all clients should have privacy during medication administration. 9-3-2(a)			
W000136	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities.	W000136	As for Tag 136 Staff will assist consumers in completing a	12/02/2014

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	Based on record review and interview, the facility failed to provide frequent opportunities for out of home social, religious and group activities for 2 of 2 sampled clients and 1 additional client (clients #1, #2 and 3). Findings include: 1. A review of the facility's "Community Outings" record dated 6/1/14 to 10/20/14 was conducted at the facility's administrative office on 10/22/14 at 3:30 P.M.. Review of the record did not indicate clients #1, #2 and #3 participated in frequent social, religious or community group activities. "October 2014 Community inclusions: [Client #1]: 10/3-[Store name], 10/11-Park, 10/20-Bank and Wal Mart [Client #2]: 10/9-Dinner, 10/11-Park, 10/18-Shop for purse, 10/20-Bank [Client #3]: 10/4-[Restaurant name], 10/9-Dinner, 10/10-Ice cream, 10/11-Park, 10/15-[Restaurant name], 10/20-Bank September 2014 Community inclusions: [Client #1]: 9/12-Hair cut, 9/23-Bank		monthly activity calendar based on consumer's wants and needs. Activity calendars will include social, religious, community group activities based on their preferences weekly. Staff will be retrained on documentation of community events by December 1, 2014.Monitoring will be done by Group Home Supervisor weekly and Habilitation Coordinator will review monthly.	

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	and store [Client #2]: 9/5-Dinner, 9/12-Hair cut, 9/14-Home visit, 9/16-Bowling, 9/23-Bank, 9/29-[Restaurant name] [Client #3]: 9/12-Hair cut, 9/14-Home visit, 9/16-[Restaurant name], 9/23-[Restaurant name] and Bank, 9/29-[Restaurant name] August 2014 Community inclusions: [Client #1]: 8/1-[Gas station], 8/20-Park [Client #2]: 8/1-[Gas station], 8/7-Dinner [Client #3]: 8/20-[Store name] July 2014 Community Inclusions: [Client #1]: No documented community inclusions [Client #2]: No documented community inclusions [Client #3]: No documented community inclusions June 2014 Community Inclusions: [Client #1]: 6/7-Ice cream, 6/11-Store,			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6/13-Bank, 6/14-Park, 6/29-[Restaurant name] [Client #2]: 6/7-Ice cream, 6/11-Store, 6/12-Dinner, 6/13-Bank, 6/14-Park, 6/28-Ice cream, 6/29-Church & Restaurant [Client #3] 6/7-Ice cream, 6/11-Store, 6/13-Bank, 6/14-Park, 6/28-Ice cream, 6/29-Park" An interview with Direct Support Professional (DSP) #6 was conducted on 10/21/14 at 7:30 A.M.. DSP #6 indicated the documented activities were the only times the clients got out into the community. DSP #6 indicated staff always documented on each client's calendar when the clients were taken out into the community. DSP #6 indicated the clients used to participate in other activities but did not do so now. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/29/14 at 2:00 P.M.. When asked how often the clients get out into the community, the QIDP stated "It depends on each client, but we try to get them out often." 9-3-2(a)			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CDC INC	2906 N 400 E MONTICELLO, IN 47960

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W000140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based upon record review and interview, the facility failed to maintain an accurate accounting system for 1 of 2 sampled clients (client #2), for whom the facility managed their personal funds accounts. Findings include: A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident Reports (IR) and/or investigations was conducted on 10/21/14 at 11:30 A.M.. The facility's reports indicated the following: -Investigation record dated 1/3/14 involving client #2 indicated: "Petty cash money was counted and staff found it was $20.00 short....This incident is Substantiated. However, when talking with all staff involved no one admitted to taking the money and no one shows knowledge of knowing where the money went. The petty cash is in a lock box that all staff have access to....Root Cause:	W000140	As for Tag 140 Staff has been retrained on Abuse, Neglect, and Exploitation on November 3, 2014. All abuse and neglect incidents will be reviewed by CDC's HRC team quarterly. Money is counted daily by direct care staff. Group home Supervisor will monitor weekly to ensure counts are correct. Group Home Supervisor will do audit on receipts and documentation monthly. Habilitation Coordinator will do a monthly check to ensure counts are being completed.	12/02/2014

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	Lack of follow through on money counts." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/29/14 at 2:00 P.M.. The QIDP indicated the facility managed clients #2's finances and further indicated the facility was to keep an accurate account of her finances at all times. The AD indicated the facility reimbursed client #2 for the missing money. 9-3-2(a)			
W000149	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 2 of 2 sampled clients and 2 additional clients (clients #1, #2, #3 and #4), the facility neglected to implement written policy and procedures to prevent alleged abuse/neglect regarding providing supervision and preventing staff abuse/neglect.	W000149	As for Tag 149 Staff has been retrained on Abuse, Neglect, and Exploitation on November 3, 2014.Monitoring to ensure issue doesn't arise again Group Home Supervisor will do weekly Quality Inspections along with Quality Assurance Specialist doing a Quality Inspection weekly for 60 days then monthly thereafter. Abuse and Neglect training will be	12/02/2014

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	Findings include: A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident Reports (IR) and/or investigations was conducted on 10/21/14 at 11:30 A.M.. The facility's reports indicated the following: -Investigation record dated 10/30/13 involving client #3 indicated: "Staff heard [client #3] yell 'get out of my way.' [Staff name] said 'you have the whose hallway, on one is near you (sic)..' [Staff name] then said to [client #3], 'you sound like a baby when you act like that.'" -Investigation record dated 11/24/13 involving clients #1, #2, #3 and #4 indicated: "Staff reported that [Staff #25] was abusive verbally during dinner time and kept yelling at all 4 consumers. She stated that [Staff #25] ate the consumer's snacks which included ice cream bars. Staff also reported that [Staff #25] was on her cell phone the entire shift texting way too much. Staff stated that [Staff #25] was very abusive verbally towards [client #2]. It was reported that [Staff #25] stated 'We go through this every day, 3 times a day, why can't you remember to cut up your food!'"		increased to bi-annually of staff. All abuse and neglect incidents will be monitored to ensure investigation completed and for trends by Quality Assurance Specialist monthly.	

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	-Investigation record dated 11/26/13 involving client #4 indicated: "Group home brought in [client #4] into day program and asked which class [client #4] was in today, staff told group home staff that [client #4] was in the class across the hall. Group home staff took [client #4] across the hall and left her in the class and there wasn't a staff in the class to be with [client #4]. Group home staff then left the building, leaving [client #4] unattended." -Investigation record dated 12/20/13 involving client #1 indicated: "Staff [Staff name], reported they felt the behavioral specialist, responded to [client #1]'s behaviors in a (sic) Abusive (sic) manner. Staff reported [Behaviorist] stated, '[Client #1] should be fed, and put in her room.' [Behaviorist] then stated, [Client #1] has had explosive behaviors this month.' [Behaviorist] had [client #1] to sit at the table, causing [client #1] to become upset, And (sic) scratching a staff member. This causing [client #1] to be placed in quiet time. [Client #1] slid to the floor, then [Behaviorist] reportedly grabbed under the arm area with his hands and guided [client #1] up, using his hands, pushing her with his body before she was in an upright standing position. It was reported by staff, that [client #1] still attempted to keep going to the floor.			

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	Staff reported that [Behaviorist] placed his knee between [client #1]'s shoulder blade to prevent her From (sic) sitting on the floor, and continues (sic) to use the pushing method through the door to the hallway." -Investigation record dated 1/2/14 involving client #1 indicated: "Staff came into classroom to assist with taking [client #1] to the bathroom. [Client #1] was not willing to go to the bathroom and dropped self to the floor. Staff stated to [client #1] 'if you rip my sweatshirt you're gonna get it.' Then staff yelled 'stop it.' [Client #1] kicked staff on their leg-Staff cursed 'f---k.' [Client #1] has a Behavior Support Plan (BSP) that addresses physical aggression in which staff followed for [client #1] to complete quiet time. During [client #1]'s quiet time staff told [client #1] to 'stop whinning (sic)." -Investigation record dated 1/4/14 indicated: "Group Home supervisor was arriving at the group home to do an inspection. She observed staff on shift sleeping in the chair upon arrival." -Investigation record dated 2/6/14 involving client #4 indicated: "[Client #4] was in the kitchen with and stated that male staff smacked her hard on her (buttocks). [Client #4] was asked a			

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	second time to repeat what she said. [Client #4] stated again that the male staff member smacked her on the (buttocks) and pointed to her right (buttock). Staff did not observe any marks on [client #4]'s (buttocks)." -Investigation record dated 2/26/14 involving client #3 indicated: "Staff was in the classroom waiting for [client #3] to finish her soda before going to her meeting. [Staff #22] asked [Staff #23] if [client #3] had her pop already. [Staff #23] stated 'I could kill her today.' Day Services coordinator was notified immediately. [Staff #23] was suspended. As [Staff #23] was leaving the classroom she stated 'I'm being sent home, guess I refused [client #3] of (sic) her damn coffee, oh well it's not the first time.'" -Investigation record dated 4/29/14 indicated: "Staff contacted group home supervisor on 4/30 at 11:47 P.M. and stated they hadn't slept and couldn't (sic) working awake. Supervisor informed staff to notify current staff working to see if she could stay longer so the other staff could get some sleep before coming in. The staff on shift reported to the supervisor that the other staff made the comment that she had fallen asleep during their overnight shift for an hour on 4/29. Supervisor wasn't notified until			

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	5/1/14 at 9:00 A.M.. The overnight shift because they were having trouble stay (sic)." Investigation record dated 7/11/14 involving clients #3 and #4 indicated: "Staff came out of office and observed [client #3] and [client #4] walking down the hallway without staff. Six minutes later staff from group home came down the hallway wondering where the consumers were." -Investigation record dated 8/23/14 involving client #1 indicated: "Staff was handing [client #1] her nightgown. [Client #1] waved her hands at staff and staff yelled '[Client #1], I'm just trying to hand you your d--n clothes, f--k.'" A review of the facility's "Policy on Abuse and Neglect", dated 4/22/14, was conducted on 10/23/14 at 8:30 P.M.. Review of the policy indicated: "Each person receiving services and supports from CDC Resources, Inc. will receive humane care and protection from harm. Services shall be provided in safe, secure and supportive environments. CDC Resources, Inc. shall provide services that are meaningful and appropriate and that comply with all applicable standards of professional			

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	practice, guidelines established by accredited professional organizations and budgetary constraints. Employees of CDC Resources, Inc. have a professional and legal mandate to report suspected abuse, neglect, or violation of civil rights....Abuse, neglect, exploitation, and mistreatment and violation of any rights of an individual are prohibited, including: Failure to provide appropriate supervision, care or training, according to the ISP (Individual Support Plan) ...The Adult Service Manager will assign someone to complete the investigation. The results of all investigations must be reported to the Executive Director or the Adult Services Manager if the Executive Director is not available or to other officials in accordance with State law within 5 working days of the incident." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/29/14 at 2:00 P.M.. The QIDP indicated staff should follow the facility's abuse/neglect policy. The QIDP indicated all clients should be free from abuse and neglect at all times. The QIDP indicated all staff are to provide supervision at all times to all clients. 9-3-2(a)			

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W000153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, the facility failed for 2 of 2 sampled clients and 2 additional clients (clients #1, #2, #3 and #4), to report an allegation of verbal abuse immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law. Findings include: A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident Reports (IR) and/or investigations was conducted on 10/21/14 at 11:30 A.M.. The facility's reports indicated the following: -BDDS report dated 11/24/13...Date of Knowledge: 11/25/14...Submitted Date: 11/26/13 indicated: "A staff in training	W000153	As for Tag 153 Abuse and Neglect training will be increased to bi-annually of staff. All abuse and neglect incidents will be reviewed by CDC's HRC team quarterly. All abuse and neglect incidents will be monitored to ensure investigation completed and for trends by Quality Assurance Specialist monthly. Staff will be retrained on reporting all allegations of abuse and neglect and reporting injuries of unknown origins on December 1, 2014. Monitoring to ensure all allegations reported bi-weekly by Group Home Supervisor or Habilitation Coordinator.	12/02/2014

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	reported to group home supervisor that staff [Staff name] was yelling at all four consumers (#1, #2, #3 and #4) during dinner time. Staff also reported that [Staff name] had eaten some consumers (sic) snacks. Incident occurred on 11/24 but informed group home supervisor on 11/25 at 1:45 P.M.." Further review of the report failed to indicate the incident of verbal abuse was immediately reported to the administrator and BDDS. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/29/14 at 2:00 P.M.. The QIDP indicated the incident should have been immediately reported to the administrator and within 24 hours to BDDS. 9-3-2(a)			
W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for	W000154	As for Tag 154. Investigators and	12/02/2014

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	17 of 37 incidents, involving 2 of 2 sampled clients and 2 additional clients (clients #1, #2, #3 and #4), the facility failed to provide written evidence thorough investigations were conducted in regard to injuries of unknown origin. Findings include: A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident Reports (IR) and/or investigations was conducted on 10/21/14 at 11:30 A.M.. The facility's reports indicated the following: Incidents involving client #1 indicated: -Investigation record dated 12/11/13 involving client #1 indicated: "Staff noticed a bruise on [client #1]'s right leg just above the knee. This incident is substantiated. However, after speaking with staff involved, as to how the bruise got there is unknown." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 1/11/14 involving client #1 indicated: "Staff		Department Coordinators, Supervisors were trained by ISDH personnel, Steve Corya on September 10, 2014. CDC will revise the investigation training to ensure staff are competent in obtaining community reports of Abuse, Neglect, and Exploration by December 1, 2014. Monitoring to ensure investigations are complete will be by Adult Service Manager monthly.	

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	noticed small bruises on the back of [client #1]'s right arm." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 1/12/14 involving client #1 indicated: "Staff noticed small bruises on the back of [client #1]'s right arm." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 1/19/14 involving client #1 indicated: "Staff was assisting [client #1] with a shower and observed a 6.5 cm (centimeter) bruise on [client #1]'s lower left arm below her elbow which was documented as purple/red in color and round in size. Also, staff noticed on 1/18/14 that [client #1] had 2 bruises on her buttocks." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 2/4/14			

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	involving client #1 indicated: "Staff noticed a bruise on [client #1]'s right breast and multiple scratches on her lower back and right side of her neck." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 3/30/14 involving client #1 indicated: "3/30/14 Staff assisting [client #1] with her shower noticed a bruise on her left body, side/back, higher than waist area and lower than breast, described as 2 1/2 by 1 centimeters in size and purple in color. 3/31/14 Staff noticed a bruise on [client #1]'s left arm." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 4/23/14 involving client #1 indicated: "[Client #1] was eating lunch and belched. Staff told [client #1] to say excuse me. [Client #1] did not motion excuse me. Staff yelled '[Client #1], I said to say excuse me.' [Client #1] growled and was getting upset. Staff grabbed [client #1]'s are (sic) and pulled it, pushing her back and then			

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	sternly told [client #1] 'say excuse me.' [Client #1] motioned by patting her leg; excuse me. Staff then sat down." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 4/23/14 involving client #1 indicated: "Staff was assisting [client #1] with a shower and observed three bruises on [client #1]'s body. Bruise 1 noted as 1 centimeter, round, black on left breast/Bruise 2 noted as 6 centimeter, round, black on left side by waist/Bruise 3 noted as 1 centimeters round, brown on left buttock." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 5/8/14 involving client #1 indicated: "Staff was assisting [client #1] with a shower and observed two bruises on [client #1]'s left arm. Bruise 1 noted on upper arm near armpit area which had a 1 1/2 inch long cut and bruise around it. Bruise 2 noted on inner arm just above elbow bend 2 inch diameter both noted as black in color." Review of the record failed to			

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	indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 6/2/14 involving client #1 indicated: "Staff was assisting [client #1] getting dressed this morning and observed a 3 centimeter round blue/purple bruise on her outer left thigh." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 8/4/14 involving client #1 indicated: "Staff was assisting [client #1] with a shower and observed two bruises on [client #1]'s inner left arm measuring 1 centimeter and another bruise on her upper left thigh measuring 4 centimeters. All bruises round in shape and purple in color." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. Incidents involving client #2 indicated: -Investigation record dated 12/11/13 involving client #2 indicated: "Staff			

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	noticed [client #2] had a quarter size bruise on the lower inside of her left leg just below the knee." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 5/20/14 involving client #2 indicated: "[Client #2] showed staff a bruise documented as 2 1/4 by 2 inches, purple in color on her upper left thigh." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. Incident involving client #3 indicated: -Investigation record dated 3/5/14 involving client #3 indicated: "Staff was assisting [client #3] with a shower and observed a bruise on her back right upper arm documented as 1.5 centimeters in size, round in shape, and light purple in color. [Client #3] could not recall what caused the bruise and stated that it did not hurt." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at			

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	the group home were interviewed. Incidents involving client #4 indicated: -Investigation record dated 10/30/13 involving client #4 indicated: "While staff was assisting [client #4] in shaving her legs, staff noticed a large bruise on backside just above her knee and a small bruise on her backside just above her knees." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 11/13/13 involving client #4 indicated: "While staff was assisting [client #4] in washing up staff noticed a 1 centimeter round black bruise on the back upper thigh above the back of the knee on [client #4]'s right leg." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. An interview with administrative staff #4 was conducted on 10/29/14 at 2:15 P.M.. Administrative staff #4 indicated all allegations of abuse and neglect and injuries of unknown origin should be			

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	thoroughly investigated. When asked if the above incidents were thoroughly investigated, administrative staff #4 indicated if the incidents were investigated the investigations would have been submitted. When asked if all staff who work with the clients are interviewed during an investigation, administrative staff #4 indicated the staff who are involved in the documented incident are interviewed. When asked if all clients who reside at the group home are interviewed when an investigation is conducted, administrative staff #4 indicated only the client/clients involved in the documented incident are interviewed. 9-3-2(a)			
W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 2 sampled clients and 2 additional clients (clients #1, #3 and #4), the facility failed to take sufficient/effective corrective measures in regard to 1.	W000157	As for Tag 157 ¿Supervisor will review MAR and meds weekly to ensure medications were administered ¿Agency Nurse will monitor med errors for any trends monthly. ¿Quality Assurance	12/02/2014

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	addressing a pattern of medication errors and 2. preventing injuries of unknown origin. Findings include: 1. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident Reports (IR) and/or investigations was conducted on 10/21/14 at 11:30 A.M.. The facility's reports indicated the following: -BDDS report dated 10/13/13 involving client #4 indicated: "[Client #4] was not administered her 7:00 A.M. medication of Prednisone Acetate 1% (anti-inflammatory) drop in each eye for 1 week. Staff will be re-trained on medication administration and will complete three supervised med passes." -BDDS report dated 12/3/13 involving client #4 indicated: "Staff [Staff name] did not administer correct medication to [client #4]. [Client #4] was administered 1 Calcium Carb +D 600 mg (milligram) -400 IU (International Units) tab (supplement) instead of 2 tabs....Staff observed the medication error on 12/4 when the medication was to be administered next. Staff will be unable to pass medications until they receive		Specialist will complete recommendations to Habilitation Coordinator within 5 working days. ¿Recommendations will be monitored by Quality Assurance Specialist and Habilitation Coordinator monthly	

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	four supervised med passes before giving medications again." -BDDS report dated 1/8/14 involving client #4 indicated: "Staff did not administer to [client #4] her medication Citrucil (sic) 500 mg on (fiber) 1/8 at 7:00 A.M.. Staff did not observe the medication error until 1/9 at the next medication dose time. A second staff check of medications has been implemented." -BDDS report dated 1/22/14 involving client #4 indicated: "Residential manager went to classroom to check [client #4]. [Client #4] complained of a sore throat. Day service staff was informed to provide [client #4] PRN (as needed) medication. Staff Administered (sic) to [client #4] Acetaminophin (sic) (pain) 650 mg tab....Staff failed to administer to [client #4] Mi-Acid 1 tsp (teaspoon) for reflux or sore throat and gave Acetaminophen instead.....Staff was retrained on reading MAR (Medication Administration Record) and physician orders. Staff received verbal counseling." -BDDS report dated 9/6/14 involving client #1 indicated: "[Client #1] is ordered 3/125 mg caps of Divalproex (bipolar/seizures) twice daily. On 9/6/14			

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	at 8:00 P.M. she was given 1 cap instead of 3....Plan of correction for the staff making the medication error is a supervised medication pass and staff making the medication pass will request a second check by another staff working at the home. Both staff working at the time of the medication error will receive verbal counseling." -BDDS report dated 9/12/14 involving client #3 indicated: "Staff noticed [client #3] had only been given 15 mg of Zyprexa (schizophrenia) 1 tab at bedtime on 9/12/14 and 9/13/14. [Client #3] is prescribed 20 mg 1 tab at bedtime....The staff making the error will be counseled, placed on a probation period, and be required to complete three supervised medication passes before administering medications. The staff will be monitored at least weekly for thirty days." -BDDS report dated 10/8/14 involving client #3 indicated: "[Client #3] is prescribed Diazepam (panic disorder) 1 tablet every morning at 7 A.M.. [Client #3] received this dose on 10/8/14 at 7 A.M.. Staff administered a second dose at 8:00 P.M. on 10/8/14....Staff making the error is prohibited from giving medications for thirty days, the staff will be required to complete three supervised medication passes, and will be required			

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	to be passed for medication administration by the health and safety personnel." -BDDS report dated 10/8/14 involving client #1 indicated: "[Client #1] is prescribed Xanax 1 tablet for anxiety. [Client #1] was given her 7 A.M., and 6 P.M. dose on 10/8/14 as prescribed. Staff administered a third dose at 8:00 P.M. on 10/8/14. Staff making the error is prohibited from giving medications for thirty days, the staff will be required to complete three supervised medication passes, and will be required to be passed for medication administration by the health and safety personnel." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/29/14 at 2:00 P.M.. The QIDP indicated staff are trained on medication administration upon hire, as needed and annually. The QIDP indicated staff should pass medications as ordered by the physician. No documentation was available for review to indicate the facility took sufficient/effective corrective action to prevent recurrence of medication errors. 2. A review of the facility's Bureau of Developmental Disabilities Services			

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	(BDDS) reports, Internal Incident Reports (IR) and/or investigations was conducted on 10/21/14 at 11:30 A.M.. The facility's reports indicated the following: -Investigation record dated 12/11/13 involving client #1 indicated: "Staff noticed a bruise on [client #1]'s right leg just above the knee. This incident is substantiated. However, after speaking with staff involved, as to how the bruise got there is unknown." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home. -Investigation record dated 1/11/14 involving client #1 indicated: "Staff noticed small bruises on the back of [client #1]'s right arm." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 1/12/14 involving client #1 indicated: "Staff noticed small bruises on the back of [client #1]'s right arm." Review of the record failed to indicate all staff who			

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	worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 1/19/14 involving client #1 indicated: "Staff was assisting [client #1] with a shower and observed a 6.5 cm (centimeter) bruise on [client #1]'s lower left arm below her elbow which was documented as purple/red in color and round in size. Also, staff noticed on 1/18/14 that [client #1] had 2 bruises on her buttocks." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 2/4/14 involving client #1 indicated: "Staff noticed a bruise on [client #1]'s right breast and multiple scratches on her lower back and right side of her neck." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 3/30/14 involving client #1 indicated: "3/30/14 Staff assisting [client #1] with her shower			

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	noticed a bruise on her left body, side/back, higher than waist area and lower than breast, described as 2 1/2 by 1 centimeter in size and purple in color. 3/31/14 Staff noticed a bruise on [client #1]'s left arm." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 4/23/14 involving client #1 indicated: "[Client #1] was eating lunch and belched. Staff told [client #1] to say excuse me. [Client #1] did not motion excuse me. Staff yelled '[Client #1], I said to say excuse me.' [Client #1] growled and was getting upset. Staff grabbed [client #1]'s are (sic) and pulled it, pushing her back and then sternly told [client #1] 'say excuse me.' [Client #1] motioned by patting her leg; excuse me. Staff then sat down." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 4/23/14 involving client #1 indicated: "Staff was assisting [client #1] with a shower and observed three bruises on [client #1]'s			

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	body. Bruise 1 noted as 1 centimeter, round, black on left breast/Bruise 2 noted as 6 centimeters, round, black on left side by waist/Bruise 3 noted as 1 centimeter round, brown on left buttocks." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 5/8/14 involving client #1 indicated: "Staff was assisting [client #1] with a shower and observed two bruises on [client #1]'s left arm. Bruise 1 noted on upper arm near armpit area which had a 1 1/2 inch long cut and bruise around it. Bruise 2 noted on inner arm just above elbow bend 2 inch diameter both noted as black in color." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 6/2/14 involving client #1 indicated: "Staff was assisting [client #1] getting dressed this morning and observed a 3 centimeter round blue/purple bruise on her outer left thigh." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review			

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	failed to indicate all clients who reside at the group home were interviewed. -Investigation record dated 8/4/14 involving client #1 indicated: "Staff was assisting [client #1] with a shower and observed two bruises on [client #1]'s inner left arm measuring 1 centimeter and another bruise on her upper left thigh measuring 4 centimeters. All bruises round in shape and purple in color." Review of the record failed to indicate all staff who worked at the group home were interviewed. Further review failed to indicate all clients who reside at the group home were interviewed. A review of client #1's record was conducted on 10/22/14 at 2:15 P.M.. Review of client #1's Behavior Support Plan (BSP) dated 7/8/14 indicated: "Behaviors to be Decreased/Target Behaviors: Physical aggression: pinching, bitting (sic), slapping, or other physical contact directed towards another person with the intent of causing harm....This behavior has been an ongoing concern since [client #1] has been with CDC. This behavior has been addressed through the BSP since October 2005." No documentation was available for review to indicate the facility took			

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	sufficient/effective corrective action to prevent recurrence. There was documentation submitted to indicate the facility made any program revisions, increase of monitoring or checking for falls. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/29/14 at 2:00 P.M.. When asked if the facility addressed the documented incidents the QIDP indicated staff were retrained on the client's BSP. 9-3-2(a)			
W000159	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. Based on observation, record review and interview for 2 of 2 sampled clients (client #1 and #2), and two additional	W000159	As for Tag 159: ¿QIDP will be retrained on December 1, 2014 on ISDH regulations. Monitoring will be	12/02/2014

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	clients (#3 and #4), the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to monitor the client's programs in regards to revision/implementation/tracking of program objectives. The QIDP failed to ensure privacy during medications, failed to ensure clients attended community events, failed to ensure client's funds were monitored, failed to ensure sufficient staff were provided and trained, failed to ensure programs were implemented, and failed to ensure client's behavior programs contained all interventions. Findings include: A review of client #1's record was conducted on 10/22/14 at 2:15 P.M.. Review of client #1's Individual Support Plan (ISP) dated 6/12/14 indicated the following training objectives which could have been implemented: "Will learn to cut appropriate quarter size bites of food when eating...Will place her own plate on table prior to meals...Will place 2 quarters in my purse Will be able to get a drink of my choice from the breakfast table and take my meds...Will complete an exercise of my choice...Will be able to place my dirty laundry into the washer with hand over wrist assistance...Will be able to brush my teeth after dinner...Will		done by Adult Services Manager monthly. ¿Goals have been updated for consumers ¿Agency Nurse will review drug regimen of consumers at least quarterly, the Habilitation Coordinator will discuss drug regimen at the quarterly meetings. The agency nurse will review all consumers' psychotropic med reviews, pharmacy reviews and nutritional assessments at least quarterly and follow-up with any recommendations to the consumers. The Agency nurse will monitor medication passes and supervised disposal of medications monthly. A competency in regards to medication passing and disposal will be done annually to ensure staffs competency. Habilitation Coordinator will review quarterly. Monitoring to ensure they are completed will be by Adult Service Manager or Quality Assurance Specialist quarterly. ¿Consumer was reimbursed. Money is counted daily by direct care staff. Group home Supervisor will monitor weekly to ensure counts are correct. Group Home Supervisor will do audit on receipts and documentation monthly. Habilitation Coordinator will do a monthly check to ensure counts are being completed.	

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	learn how to communicate with sign language." Further review of client #1's record failed to indicate the QIDP monitored program data when client #1 made progress and/or completed program objectives for the months of 10/13, 11/13, 12/13, 1/14, 2/14, 3/14, 4/14, 5/14, 6/14 and 7/14. An interview with the QIDP was conducted on 10/29/14 at 2:00 P.M.. The QIDP indicated the client's program objectives are to be monitored by the QIDP monthly. The QIDP further indicated objectives should be changed when they are accomplished. The QIDP further indicated she was not sure if the prior QIDP monitored each client's objectives and made changes once the objectives were completed. Please refer to W130: The facility failed for 1 of 2 sampled clients and 1 additional client observed during medication administration (clients #1 and #3) to ensure privacy during medication administration. Please refer to W136: The facility failed to provide frequent opportunities for out of home social, religious and group activities for 2 of 2 sampled clients and 1 additional client (clients #1, #2 and 3).			

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	Please refer to W140: The facility failed to maintain an accurate accounting system for 1 of 2 sampled clients (client #2), for whom the facility managed their personal funds accounts. Please refer to W186: The facility failed for 2 of 2 sampled clients and 2 additional client (clients #1, #2, #3 and #4) residing at the group home, to provide sufficient numbers of direct care staff to supervise/manage as indicated in their Individual Support Plans (ISPs). Please refer to W189: The facility failed for 2 of 2 sampled clients and 2 additional clients (clients #1, #2, #3 and #4), to ensure staff were sufficiently trained to assure competence in 1. monitoring, detecting and preventing infestation/reinfestation of bed bugs and 2. of proper disposal and administration of medications as ordered. Please refer to W249: The facility failed to implement written objectives during times of opportunity for 2 of 2 sampled clients and 1 additional client (clients #1, #2 and #3). Please refer to W289: The facility failed for 1 of 2 sampled clients (client #1), to			

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	ensure systematic interventions (physical holds/restraints) were specifically written/described in the Behavior Support Plans (BSP). 9-3-3(a)			
W000186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation, record review and interview, the facility failed for 2 of 2 sampled clients and 2 additional client (clients #1, #2, #3 and #4) residing at the group home, to provide sufficient numbers of direct care staff to supervise/manage as indicated in their Individual Support Plans (ISPs).	W000186	As for Tag 186: Ø Consumer's Behavior Support Plan will be updated to include correct way to escort consumer. Staff will be trained on updated Behavior Plan and implementation on December 2, 2014. Monitoring to ensure Behavior Support Plan is being followed will be by Day Service Supervisor or Group Home	12/02/2014

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	Findings include: An evening observation was conducted at the group home on 10/20/14 from 4:45 P.M. until 7:00 P.M.. During the entire observation period, Direct Support Professional (DSP) #1 prepared clients #1, #2 and #3's meal, with client #3's assistance, client #2 sat with no activity or staff interaction and DSP #2 walked with client #1 blocking her with her physical body to keep her from physically aggressing on clients #2 and #3 and others at the group home as client #1 walked around the group home with no meaningful activity. A morning observation was conducted at the group home on 9/23/14 from 5:45 A.M. until 7:15 A.M.. During the entire observation period, DSP #3 walked with client #1 around the group home blocking her with her physical body to keep her from physically aggressing on clients #2 and #3 and others at the group home and DSP #4 administered medications as clients #1, #2 and #3 walked around the group home with no meaningful activity. At 6:30 A.M., client #3 was prompted to sit at the dining table. Client #3 sat at the dining table with no meaningful activity while DSP #3 assisted client #2 and DSP #4 administered medications until 6:43		Supervisor or Habilitation Coordinator or Adult Service Manager or Quality Assurance Specialist weekly. Ø Day Program will increase staff based on consumer program needs to ensure program implementation. Ø Staff retraining of training program by December 2, 2014 Ø Group Home has increased staffing to ensure sufficient staff. Ø Group home consumers daily schedules are revised to ensure active treatment. Monitoring of sufficient direct care staff will be by Day Service Supervisor or Group Home Supervisor or Habilitation Coordinator or Adult Service Manager or Quality Assurance Specialist on a weekly basis for 30 days then monthly thereafter.	

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	A.M. when client #3 was prompted to serve her cold cereal and milk into a bowl. Client #3 asked repeatedly if she could eat and stated "I'm hungry, I wanna eat." DSP #4 stated to client #3 "You know you have to wait until we get [client #1] situated so you can eat. We have to watch you eat so you don't choke." Client #3 sat with her prepared bowl of cold cereal in front of her until 7:05 A.M.. A facility owned day program observation was conducted on 10/24/14 from 11:30 A.M. until 12:45 P.M.. During the entire observation period, client #1 sat at a desk with her head lying on the desk. Day Program DSP #2 read a portion of a book out loud for 10 minutes as client #1 slept. Client #1 sat the entire observation period with no meaningful activity. A confidential interview was conducted. The interview indicated client #1 required 1 to 1 staffing at all times due to her physical aggression towards clients #2, #3, #4 and staff who work with her. The interview further indicated there are not enough scheduled staff to implement training objectives and proper supervision of client #1 at the group home and facility owned day program.			

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	A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident Reports (IR) and/or investigations was conducted on 10/21/14 at 11:30 A.M.. The facility's reports indicated the following: -Investigation record dated 1/11/14 involving client #1 indicated: "Nature of the Event/Alleged Event: Staff noticed small bruises on the back of [client #1]'s right arm. Interview with [Staff #13]: Have you ever had to use 'force' to redirect [client #1]? 'You have to be forceful with [client #1] sometimes, I wouldn't consider it abuse, it's how we were trained.' Have you ever placed you (sic) fingers under her armpits to redirect her before? 'Yes. Just last week [Staff #14] and I had to 'scoop' (elbows under armpits) her up to get her out of the chair to go home after the day.' Have [client #1]'s behaviors been more frequent?			

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	'Yes, they are getting bad.' Interview with Staff #16: Have you ever seen anyone grab [client #1] in a 'reactive' way? 'Not here in day services. This past weekend I worked the Group Home. [Client #1] did grab [Staff #15]'s hair and I did see [Staff #15] pushing [client #1] onto the love seat for time out. I didn't see if her hands were open but she did have to keep pushing her down on the love seat....I wouldn't consider it abusive though. I didn't find it forceful. No more forceful then we have to be to get her corrected. [Client #1]'s behaviors are getting worse and she is very difficult to handle for some staff.' Interview with [Staff #17]: Have you ever noticed anyone grabbing [client #1] in a forceful way? Not really even forceful way, but in a 'reactive' way? 'No, staff in day service uses our bodies to block or place our hand in the small of her back to guide her.' Interview with Staff #18: Have you ever had a 'reaction' that may			

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	have caused bruises to [client #1]? 'I think any corrective measure we take to redirect [client #1] and even [client #1]'s corrective actions like 'hands to self' could cause a bruise on her. I'm going to be honest, the other day she had me on the floor with both of her hands pulling my hair. I just reacted. I was in survival mode. I couldn't tell you how I got her hands out of my hair. I just knew I had to get them out, but I couldn't tell you how I did. I'm pretty sure I didn't grab her arms, but there are times she is just to (sic) much to handle. I can see why staff doesn't stay long. [Client #1] is very manipulative. She knows if she throws fits she will usually get what she wants, and that's wrong. [Client #1] runs that house. Every consumer there is scared of her. It's not fair to the other consumers to be scared in their own home. After a night working with [client #1] I am sore the next few days because she just beats the (c--p) out of me.' Abuse and neglect is not substantiated in these incidents. The investigation concluded that the reported pattern of unknown origin bruises is suspicious nature. After reviewing the information, it appears as though [client #1] has exhibited an increase of aggressive behaviors during this time period. There			

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	is evidence to support that [client #1] required to (sic) escorting to time out and was physically aggressive with staff, which in any situation could cause bruising. There is no evidence to support that staff intentionally caused bruising: however, it does appear that staff may have reacted with a natural instinct of protecting themselves and [client #1] during aggressive behaviors which could have likely resulted in bruising." Investigation record dated 1/12/14 involving client #1 indicated: "Nature of the Event/Alleged Event: Staff noticed small bruises on the back of [client #1]'s right arm. Interview with Staff #13: Have you ever had to use 'force' to redirect [client #1]? 'You have to be forceful with [client #1] sometimes, I wouldn't consider it abuse, it's how we were trained.' Have you ever placed you (sic) fingers under her armpits to redirect her before? 'Yes. Just last week [Staff #14] and I had to 'scoop' (elbows under armpits) her up to get her out of the chair to go home after the day.'			

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	Have [client #1]'s behaviors been more frequent? 'Yes, they are getting bad.' Interview with Staff #16: Have you ever seen anyone grab [client #1] in a 'reactive' way? 'Not here in day services. This past weekend I worked the Group Home. [Client #1] did grab [Staff #15]'s hair and I did see [Staff #15] pushing [client #1] onto the love seat for time out. I didn't see if her hands were open but she did have to keep pushing her down on the love seat....I wouldn't consider it abusive though. I didn't find it forceful. No more forceful then we have to be to get her corrected. [Client #1]'s behaviors are getting worse and she is very difficult to handle for some staff.' Interview with [Staff #17]: Have you ever noticed anyone grabbing [client #1] in a forceful way? Not really even forceful way, but in a 'reactive' way? 'No, staff in day service uses our bodies to block or place our hand in the small of her back to guide her.'			

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	Interview with Staff #18: Have you ever had a 'reaction' that may have caused bruises to [client #1]? 'I think any corrective measure we take to redirect [client #1] and even [client #1]'s corrective actions like 'hands to self' could cause a bruise on her. I'm going to be honest, the other day she had me on the floor with both of her hands pulling my hair. I just reacted. I was in survival mode. I couldn't tell you how I got her hands out of my hair. I just knew I had to get them out, but I couldn't tell you how I did. I'm pretty sure I didn't grab her arms, but there are times she is just to (sic) much to handle. I can see why staff doesn't stay long. [Client #1] is very manipulative. She knows if she throws fits she will usually get what she wants, and that's wrong. [Client #1] runs that house. Every consumer there is scared of her. It's not fair to the other consumers to be scared in their own home. After a night working with [client #1] I am sore the next few days because she just beats the (c--p) out of me.' Abuse and neglect is not substantiated in these incidents. The investigation concluded that the reported pattern of unknown origin bruises is suspicious			

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	nature. After reviewing the information, it appears as though [client #1] has exhibited an increase of aggressive behaviors during this time period. There is evidence to support that [client #1] required to (sic) escorting to time out and was physically aggressive with staff, which in any situation could cause bruising. There is no evidence to support that staff intentionally caused bruising: however, it does appear that staff may have reacted with a natural instinct of protecting themselves and [client #1] during aggressive behaviors which could have likely resulted in bruising." A review of client #1's record was conducted on 10/22/14 at 2:15 P.M.. Review of client #1's BSP dated 7/8/14 indicated: "Behaviors to be Decreased/Target Behaviors: Physical aggression: pinching, bitting (sic), slapping, or other physical contact directed towards another person with the intent of causing harm....This behavior has been an ongoing concern since [client #1] has been with CDC. This behavior has been addressed through the BSP since October 2005.." Review of client #1's Individual Support Plan (ISP) dated 6/12/14 indicated: History of seizures. Needs verbal reminders at times to chew her food thoroughly. Will sometimes swallow her food without chewing			

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	properly. Is food aggressive this puts her at risk for choking." The "Risk Plan for Falls" dated 6/12/14 indicated: "Staff will be within arms (sic) length of [client #1], as much as possible, when she is walking." A review of staffing schedules at the group home and facility owned day program dated 1/14 to 10/14 was conducted on 10/24/14 at 2:20 P.M.. Review of the staff schedules failed to indicate 1 to 1 staffing for client #1. The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 10/29/14 at 2:00 P.M.. The QIDP indicated there should be enough staff present to supervise/manage and implement training objectives to clients at all times while awake. The QIDP further indicated client #1 requires 1 to 1 supervision at all times due to her physical aggression, non-compliance and risk for falling. 9-3-3(a)			

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W000189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on record review and interview, the facility failed for 2 of 2 sampled clients and 2 additional clients (clients #1, #2, #3 and #4), to ensure staff were sufficiently trained to assure competence in 1. monitoring, detecting and preventing infestation/reinfestation of bed bugs and 2. of proper disposal and administration of medications as ordered. Findings include: 1. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident Reports (IR) and/or investigations was conducted on 10/21/14 at 11:30 A.M.. The facility's reports indicated the following: -BDDS report dated 7/7/14 indicated: "[Exterminator name] was called out to	W000189	As for Tag 189: ¿a Bug Infestation procedure has been developed and staff were trained by Group Home Supervisor on the procedure as of 11-4-2014. CDC Resources had Orkin personnel come out and train staff on10-30-2014 as for what to look for an infestation of bed bug. Training of this will be done on hire and annually from this point on. Monitoring of the training will be done by Group Home Supervisor. Monitoring to ensure procedure is being followed will be done by a team of Group Home Supervisor, Habilitative Coordinator and the Quality Assurance Specialist. Monitoring will begin with a weekly check of the home for 60 days by Group Home Supervisor, Habilitative Coordinator and Quality Assurance will start a monthly check of the homes for the first Quarter then continue monthly checks by the Quality	12/02/2014

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	Group Home to check for bed bugs. Bed bugs were found in the living room that were dead. It was suggested that [Exterminator name] come back to do a heating treatment on the home and removal of the furniture. Consumers (#1, #2, #3 and #4) were relocated that day (7/7/14) to the CDC [city] facility and will remain relocated until it is ok to return to the home. [Exterminator name] is coming to the home on Friday 7/11/14 to treat it for bedbugs. Furniture has been removed from the home and will be replaced once [Exterminator name] has treated the home." A review of staff training of all employees who worked at the group home and day program with clients #1, #2, #3 and #4 was completed on 10/22/14 at 1:00 P.M.. Review of the employee training records failed to indicate any staff training in regard to monitoring, detecting and preventing infestation/reinfestation of bed bugs. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/29/14 at 2:00 P.M.. The QIDP indicated staff had not been trained, after the detection of bed bugs at the group home, in regard to monitoring, detecting and preventing infestation/reinfestation of bed bugs.		Assurance Specialist. Group Home Supervisors will also do a monthly check after the 60 days. A Professional will check the home Bi-Annually ¿Agency Nurse will review drug regimen of consumers at least quarterly, the Habilitation Coordinator will discuss drug regimen at the quarterly meetings. The agency nurse will review all consumers' psychotropic med reviews, pharmacy reviews and nutritional assessments at least quarterly and follow-up with any recommendations to the consumers. Habilitation Coordinator will review quarterly. Monitoring to ensure they are completed will be by Adult Service Manager or Quality Assurance Specialist quarterly.	

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	2. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident Reports (IR) and/or investigations was conducted on 10/21/14 at 11:30 A.M.. The facility's reports indicated the following: -Investigation record dated 12/13/13 indicated: "Staff called Group Home Supervisor into the med room and handed her an envelope. The envelope was supposed to contain a Xanax (anti anxiety medication) that had fallen on the floor on 11/27/13 that had not been disposed of. The envelope was sealed and a corner of the envelope had been opened and the pill was gone. This incident is substantiated that the pill cannot be located. It is unknown as to what happen (sic) to the pill. The envelope was sealed initially however it appears that a paperclip could have opened it and the pill fallen (sic) out in the medication area. (The pill is a size that could easily be concealed). There was no indication from staff that they were aware of or have information on anyone taking the pill out of the envelope." -BDDS report dated 10/13/13 involving client #4 indicated: "[Client #4] was not			

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	administered her 7:00 A.M. medication of Prednisone Acetate 1% (anti-inflammatory) drop in each eye for 1 week. Staff will be re-trained on medication administration and will complete three supervised med passes." -BDDS report dated 12/3/13 involving client #4 indicated: "Staff [Staff name] did not administer correct medication to [client #4]. [Client #4] was administered 1 Calcium Carb +D 600 mg (milligram) -400 IU (International Units) tab (supplement) instead of 2 tabs....Staff observed the medication error on 12/4 when the medication was to be administered next. Staff will be unable to pass medications until they receive four supervised med passes before giving medications again." -BDDS report dated 1/8/14 involving client #4 indicated: "Staff did not administer to [client #4] her medication Citrucil (sic) 500 mg on (fiber) 1/8 at 7:00 A.M.. Staff did not observe the medication error until 1/9 at the next medication dose time. A second staff check of medications has been implemented." -BDDS report dated 1/22/14 involving client #4 indicated: "Residential manager went to classroom to check [client #4].			

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	[Client #4] complained of a sore throat. Day service staff was informed to provide [client #4] PRN (as needed) medication. Staff Administered (sic) to [client #4] Acetaminophin (sic) (pain) 650 mg tab....Staff failed to administer to [client #4] Mi-Acid 1 tsp (teaspoon) for reflux or sore throat and gave Acetaminophen instead.....Staff was retrained on reading MAR (Medication Administration Record) and physician orders. Staff received verbal counseling." -BDDS report dated 9/6/14 involving client #1 indicated: "[Client #1] is ordered 3/125 mg caps of Divalproex (bipolar/seizures) twice daily. On 9/6/14 at 8:00 P.M. she was given 1 cap instead of 3....Plan of correction for the staff making the medication error is a supervised medication pass and staff making the medication pass will request a second check by another staff working at the home. Both staff working at the time of the medication error will receive verbal counseling." -BDDS report dated 9/12/14 involving client #3 indicated: "Staff noticed [client #3] had only been given 15 mg of Zyprexa (schizophrenia) 1 tab at bedtime on 9/12/14 and 9/13/14. [Client #3] is prescribed 20 mg 1 tab at bedtime....The			

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	staff making the error will be counseled, placed on a probation period, and be required to complete three supervised medication passes before administering medications. The staff will be monitored at least weekly for thirty days." -BDDS report dated 10/8/14 involving client #3 indicated: "[Client #3] is prescribed Diazepam (panic disorder) 1 tablet every morning at 7 A.M.. [Client #3] received this dose on 10/8/14 at 7 A.M.. Staff administered a second dose at 8:00 P.M. on 10/8/14....Staff making the error is prohibited from giving medications for thirty days, the staff will be required to complete three supervised medication passes, and will be required to be passed for medication administration by the health and safety personnel." -BDDS report dated 10/8/14 involving client #1 indicated: "[Client #1] is prescribed Xanax 1 tablet for anxiety. [Client #1] was given her 7 A.M., and 6 P.M. dose on 10/8/14 as prescribed. Staff administered a third dose at 8:00 P.M. on 10/8/14. Staff making the error is prohibited from giving medications for thirty days, the staff will be required to complete three supervised medication passes, and will be required to be passed for medication administration by the			

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	health and safety personnel." A review of the facility's "Physician Orders and Medication Administration" policy dated 5/24/13 was conducted on 10/23/14 at 12:30 P.M.. Review of the policy indicated: "Purpose: The purpose of this procedure is to ensure consumers are administered medication as prescribed by a physician....Drug Disposal: All unused drugs and medication will be disposed of by the following means: a. Complete the medication disposal form with at least one witness. b. Dispose of the medication, by returning them to the pharmacy, or by other appropriate route (controls to be taken to the Police Department for disposal). c. When possible return unused medications to the pharmacy for disposal. d. Submit the original form for filing in the master file; attach a copy. e. File a copy of the disposal form in the home book for residential services, to be filed and retained according to department guidelines. Procedures for administering medication: Preparing and administering medication			

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	requires staff to be diligent at all times. Proper handling and dispensing of medication ensures that the consumer is receiving the correct medication. Specific guidelines must be followed in the event that a medication is not given at the correct time or needs to be destroyed. All staff must be aware of the guidelines for controlled substances, storing medications, and maintaining medical asepsis. All staff is responsible for following directions given in Core A and Core B Curriculum (where applicable) and/or Medication Administration Curriculum. 2. When administering medication: c. Read the label 3 times. Confirm the '6 Rights' of medication administration. Remain with the consumer while he/she takes medication. Staff must remain until medication is taken....e. After giving the medication, initial the MAR to document all medications have been administered. This must be done immediately after the medication is given. Never chart before a medication is given-only immediately after....g. Medications may be given 1/2 hour before of 1/2 hour after the assigned time. That is administered outside the 1/2 hour before/after guideline but is still within label directions should be documented on the Med Error form to ensure that consistency is preserved, but such occurrences will not be considered			

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	significant medication errors." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/29/14 at 2:00 P.M.. The QIDP indicated staff are trained on the facility's medication administration upon hire and then annually. The QIDP indicated staff should pass medications as ordered by the physician and further indicated staff should follow the policy at all times. 9-3-3(a)			
W000249	483.440(d)(1) PROGRAM IMPLEMENTATION 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. Based on observation, record review and interview, the facility failed to implement written objectives during times of opportunity for 2 of 2 sampled clients	W000249	As for Tag 249: ¿Day Program will increase staff based on consumer program needs to ensure program implementation. ¿Staff retraining of training	12/04/2014

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	and 1 additional client (clients #1, #2 and #3). Findings include: An evening observation was conducted at the group home on 10/20/14 from 4:45 P.M. until 7:00 P.M.. During the entire observation period, Direct Support Professional (DSP) #1 prepared clients #1, #2 and #3's meal, with client #3's assistance and DSP #2 walked with client #1 blocking her with her physical body to keep her from physically aggressing on clients #2 and #3 and others at the group home as client #1 walked around the group home with no meaningful activity. Clients #1 and #2 were non verbal in they did not speak or communicate in their home. There was no communication training during this observation period. A morning observation was conducted at the group home on 9/23/14 from 5:45 A.M. until 7:15 A.M.. During the entire observation period, DSP #3 walked with client #1 around the group home blocking her with her physical body to keep her from physically aggressing on clients #2 and #3 and others at the group home. DSP #4 administered medications as clients #1, #2 and #3 walked around the group home with no meaningful activity. At 6:30 A.M., DSP #4 administered		program by December 2, 2014 ¿Group home consumers daily schedules are revised to ensure active treatment. Monitoring of sufficient direct care staff will be by Day Service Supervisor or Group Home Supervisor or Habilitation Coordinator or Adult Service Manager or Quality Assurance Specialist on a weekly basis for 30 days then monthly thereafter. Addendum to Tag 249 Monitoring of sufficient staffing has been increased to a daily check by Group Home Supervisor and Day service Supervisor for thirty days then weekly thereafter. Monitoring of ensure active treatment is being given has been increased to twice weekly by Group Home Supervisor or Day Service Supervisor or Habilitation Coordinator or Adult Service Manager or Quality Assurance Specialist then weekly for 30 days then monthly thereafter.	

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	client #3's medications. Client #3 did not learn to identify her Depakote. Clients #1 and #2 were non verbal in they did not speak or communicate in their home. There was no communication training during this observation period. A facility owned day program observation was conducted on 10/24/14 from 11:30 A.M. until 12:45 P.M.. During the entire observation period, client #1 sat at a desk with her head lying on the desk. Day Program DSP #2 read a portion of a book out loud for 10 minutes as client #1 slept. Client #1 sat the entire observation period with no meaningful activity. A review of client #1's record was conducted on 10/22/14 at 2:15 P.M.. Review of client #1's Individual Support Plan (ISP) dated 6/12/14 indicated the following training objectives which could have been implemented: "Will learn to cut appropriate quarter size bites of food when eating...Will place her own plate on table prior to meals...Will learn how to communicate with sign language, Speaking Difficulties: non-verbal, gestures, pointing, signing." A review of client #2's record was conducted on 10/22/14 at 2:50 P.M.. Review of the ISP dated 8/20/14			

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	indicated the following training objectives which could have been implemented: "Will exercise...Will increase in individual and group activities to increase her leisure, socialization, academic, household management skills." A review of client #3's record was conducted on 10/22/14 at 3:20 P.M.. Review of the ISP dated 2/18/14 indicated the following training objectives which could have been implemented: "Will learn to identify her Depakote...Will wash her hands before her evening meal...Will exercise...Will socialize appropriately by saying thank you to peers and staff...Will work on skills to increase her community safety skills." The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 10/29/14 at 2:00 P.M.. The QIDP indicated client objectives should be implemented at all times. The QIDP further indicated clients #1, #2 and #3 should have been provided with meaningful active treatment activities during the observation periods. 9-3-4(a)			

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W000289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on observation, record review and interview, for 1 of 2 sampled clients (client #1), the facility failed to ensure systematic interventions (physical holds/restraints) were specifically written/described in the Behavior Support Plans (BSP). Findings include: An evening observation was conducted at the group home on 10/20/14 from 4:45 P.M. until 7:00 P.M.. During the entire observation period, Direct Support Professional (DSP) #2 held onto client #1's arm as she attempted to dart towards	W000289	As for Tag 289 Consumer's Behavior Support Plan will be updated to include correct way to escort consumer. Staff will be trained on updated Behavior Plan and implementation on December 2, 2014. Monitoring to ensure Behavior Support Plan is being followed will be by Day Service Supervisor or Group Home Supervisor or Habilitation Coordinator or Adult Service Manager or Quality Assurance Specialist weekly for 30 days then bi-monthly thereafter.	12/02/2014

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	clients #2 and #3 and this surveyor. Clients #2 and #3 hold their arms and legs up in a blocking motion as client #1 would attempt to lunge towards them. At 6:00 P.M., client #1 grabbed this surveyors arm and held it firmly. DSP #2 attempted to block client #1 with her body and prompted client #1 to let go. Client #1 then pushed DSP #2. DSP #2 blocked client #1 with her physical body to keep her away from others at the group home during the entire observation period. A morning observation was conducted at the group home on 10/21/14 from 6:15 A.M. until 8:30 A.M.. During the entire observation period, DSP #3 and #4 held onto client #1's arm as she attempted to dart towards clients #2 and #3 and this surveyor. At 6:40 A.M., client #1 began swinging and hitting DSP #4 when DSP #4 attempted to block client #1 with her physical body. DSP #3 and #4 blocked client #1 with their physical bodies to keep her away from others at the group home during the entire observation period. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident Reports (IR) and/or investigations was conducted on 10/21/14 at 11:30 A.M..			

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	The facility's reports indicated the following: -Investigation record dated 1/11/14 involving client #1 indicated: "Nature of the Event/Alleged Event: Staff noticed small bruises on the back of [client #1]'s right arm. Interview with [Staff #13]: Have you ever had to use 'force' to redirect [client #1]? 'You have to be forceful with [client #1] sometimes, I wouldn't consider it abuse, it's how we were trained.' Have you ever placed you (sic) fingers under her armpits to redirect her before? 'Yes. Just last week [Staff #14] and I had to 'scoop' (elbows under armpits) her up to get her out of the chair to go home after the day.' Have [client #1]'s behaviors been more frequent? 'Yes, they are getting bad.' Interview with Staff #16: Have you ever seen anyone grab [client			

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	#1] in a 'reactive' way? 'Not here in day services. This past weekend I worked the Group Home. [Client #1] did grab [Staff #15]'s hair and I did see [Staff #15] pushing [client #1] onto the love seat for time out. I didn't see if her hands were open but she did have to keep pushing her down on the love seat....I wouldn't consider it abusive though. I didn't find it forceful. No more forceful then we have to be to get her corrected. [Client #1]'s behaviors are getting worse and she is very difficult to handle for some staff.' Interview with [Staff #17]: Have you ever noticed anyone grabbing [client #1] in a forceful way? Not really even forceful way, but in a 'reactive' way? 'No, staff in day service uses our bodies to block or place our hand in the small of her back to guide her.' Interview with Staff #18: Have you ever had a 'reaction' that may have caused bruises to [client #1]? 'I think any corrective measure we take to redirect [client #1] and even [client #1]'s corrective actions like 'hands to self'			

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	could cause a bruise on her. I'm going to be honest, the other day she had me on the floor with both of her hands pulling my hair. I just reacted. I was in survival mode. I couldn't tell you how I got her hands out of my hair. I just knew I had to get them out, but I couldn't tell you how I did. I'm pretty sure I didn't grab her arms, but there are times she is just to (sic) much to handle. I can see why staff doesn't stay long. [Client #1] is very manipulative. She knows if she throws fits she will usually get what she wants, and that's wrong. [Client #1] runs that house. Every consumer there is scared of her. It's not fair to the other consumers to be scared in their own home. After a night working with [client #1] I am sore the next few days because she just beats the (c--p) out of me.' Abuse and neglect is not substantiated in these incidents. The investigation concluded that the reported pattern of unknown origin bruises is (sic) suspicious nature. After reviewing the information, it appears as though [client #1] has exhibited an increase of aggressive behaviors during this time period. There is evidence to support that [client #1] required to (sic)escorting to time out and was physically aggressive with staff, which in any situation could cause bruising. There is no evidence to			

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	support that staff intentionally caused bruising: however it does appear that staff may have reacted with a natural instinct of protecting themselves and [client #1] during aggressive behaviors which could have likely resulted in bruising." Investigation record dated 1/12/14 involving client #1 indicated: "Nature of the Event/Alleged Event: Staff noticed small bruises on the back of [client #1]'s right arm. Interview with Staff #13: Have you ever had to use 'force' to redirect [client #1]? 'You have to be forceful with [client #1] sometimes, I wouldn't consider it abuse, it's how we were trained.' Have you ever placed you (sic) fingers under her armpits to redirect her before? 'Yes. Just last week [Staff #14] and I had to 'scoop' (elbows under armpits) her up to get her out of the chair to go home after the day.' Have [client #1]'s behaviors been more frequent?			

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	'Yes, they are getting bad.' Interview with Staff #16: Have you ever seen anyone grab [client #1] in a 'reactive' way? 'Not here in day services. This past weekend I worked the Group Home. [Client #1] did grab [Staff #15]'s hair and I did see [Staff #15] pushing [client #1] onto the love seat for time out. I didn't see if her hands were open but she did have to keep pushing her down on the love seat....I wouldn't consider it abusive though. I didn't find it forceful. No more forceful then we have to be to get her corrected. [Client #1]'s behaviors are getting worse and she is very difficult to handle for some staff.' Interview with [Staff #17]: Have you ever noticed anyone grabbing [client #1] in a forceful way? Not really even forceful way, but in a 'reactive' way? 'No, staff in day service uses our bodies to block or place our hand in the small of her back to guide her.' Interview with Staff #18: Have you ever had a 'reaction' that may			

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	have caused bruises to [client #1]? 'I think any corrective measure we take to redirect [client #1] and even [client #1]'s corrective actions like 'hands to self' could cause a bruise on her. I'm going to be honest, the other day she had me on the floor with both of her hands pulling my hair. I just reacted. I was in survival mode. I couldn't tell you how I got her hands out of my hair. I just knew I had to get them out, but I couldn't tell you how I did. I'm pretty sure I didn't grab her arms, but there are times she is just to (sic) much to handle. I can see why staff doesn't stay long. [Client #1] is very manipulative. She knows if she throws fits she will usually get what she wants, and that's wrong. [Client #1] runs that house. Every consumer there is scared of her. It's not fair to the other consumers to be scared in their own home. After a night working with [client #1] I am sore the next few days because she just beats the (c--p) out of me.' Abuse and neglect is not substantiated in these incidents. The investigation concluded that the reported pattern of unknown origin bruises is (sic) suspicious nature. After reviewing the information, it appears as though [client #1] has exhibited an increase of aggressive behaviors during this time			

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	period. There is evidence to support that [client #1] required to (sic) escorting to time out and was physically aggressive with staff, which in any situation could cause bruising. There is no evidence to support that staff intentionally caused bruising: however it does appear that staff may have reacted with a natural instinct of protecting themselves and [client #1] during aggressive behaviors which could have likely resulted in bruising." A review of client #1's record was conducted on 10/22/14 at 2:15 P.M.. Review of client #1's BSP dated 7/8/14 indicated: "Behaviors to be Decreased/Target Behaviors: Physical aggression: pinching, bitting (sic), slapping, or other physical contact directed towards another person with the intent of causing harm....This behavior has been an ongoing concern since [client #1] has been with CDC. This behavior has been addressed through the BSP since October 2005.." Further review of the BSP did not indicate or describe what the least restrictive but most effective hold should be implemented when client #1 is a risk to herself or to others. Client #1's BSP did not indicate the use of physical blocking with one's body as a means for staff to utilize during aggressive behavior.			

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CDC INC	2906 N 400 E MONTICELLO, IN 47960

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	An interview with the Qualified Intellectual Disability Professional (QIDP) was conducted on 10/29/14 at 2:00 P.M.. The QIDP indicated client #1's BSPs did not indicate how the holds/techniques would be implemented when needed. The QIDP further indicated they did not have the description of the holds to be used in the BSP for staff guidance to ensure proper implementation. The QIDP further indicated the blocking by staff with their bodies, was not included in client #1's BSP. 9-3-5(a)			
W000331	483.460(c)			

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	NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 2 sampled clients and 2 additional clients (clients #1, #3 and #4), the facility's nursing staff failed to ensure facility staff were adequately trained and showed competency in regard to administering medications and proper disposal of medications. Findings include: A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident Reports (IR) and/or investigations was conducted on 10/21/14 at 11:30 A.M.. The facility's reports indicated the following: -Investigation record dated 12/13/13 indicated: "Staff called Group Home Supervisor into the med room and handed her an envelope. The envelope was supposed to contain a Xanax (anti anxiety) that had fallen on the floor on 11/27/13 that had not been disposed of. The envelope was sealed and a corner of the envelope had been opened and the pill was gone. This incident is substantiated that the pill cannot be located. It is unknown as to what happen	W000331	As for Tag 331 CDC Resources hired Agency Nurse on November 1, 2014. The agency nurse will complete supervised med pass upon hire of staff. Group Home Supervisor will complete a supervised med pass twice a month for 30 days then one a month for 60 days. The Agency nurse will monitor medication passes and supervised disposal of medications monthly. A competency in regards to medication passing and disposal will be done annually to ensure staffs competency. Habilitation Coordinator and Day Service Supervisor will monitor bi-monthly. Quality Assurance Specialist will monitor medication errors monthly for trends.	12/02/2014

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	to the pill. The envelope was sealed initially however it appears that paperclip could have opened it and the pill fallen out in the medication area. (The pill is a size that could easily be concealed). There was no indication from staff that they were of or have information on anyone taking the pill out of the envelope." -BDDS report dated 10/13/13 involving client #4 indicated: "[Client #4] was not administered her 7:00 A.M. medication of Prednisone Acetate 1% (anti-inflammatory) drop in each eye for 1 week. Staff will be re-trained on medication administration and will complete three supervised med passes." -BDDS report dated 12/3/13 involving client #4 indicated: "Staff [Staff name] did not administer correct medication to [client #4]. [Client #4] was administered 1 Calcium Carb +D 600 mg (milligram) -400 IU (International Unit) tab (supplement) instead of 2 tabs....Staff observed the medication error on 12/4 when the medication was to be administered next. Staff will be unable to pass medications until they receive four supervised med passes before giving medications again." -BDDS report dated 1/8/14 involving			

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	client #4 indicated: "Staff did not administer to [client #4] her medication Citrucil (sic) 500 mg on (fiber) 1/8 at 7:00 A.M.. Staff did not observe the medication error until 1/9 at the next medication dose time. A second staff check of medications has been implemented." -BDDS report dated 1/22/14 involving client #4 indicated: "Residential manager went to classroom to check [client #4]. [Client #4] complained of a sore throat. Day service staff was informed to provide [client #4] PRN (as needed) medication. Staff Administered (sic) to [client #4] Acetaminophin (sic) (pain) 650 mg tab....Staff failed to administer to [client #4] Mi-Acid 1 tsp (teaspoon) for reflux or sore throat and gave Acetaminophen instead.....Staff was retrained on reading MAR (Medication Administration Record) and physician orders. Staff received verbal counseling." -BDDS report dated 9/6/14 involving client #1 indicated: "[Client #1] is ordered 3/125 mg caps of Divalproex (bipolar/seizures) twice daily. On 9/6/14 at 8:00 P.M. she was given 1 cap instead of 3....Plan of correction for the staff making the medication error is a supervised medication pass and staff			

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	making the medication pass will request a second check by another staff working at the home. Both staff working at the time of the medication error will receive verbal counseling." -BDDS report dated 9/12/14 involving client #3 indicated: "Staff noticed [client #3] had only been given 15 mg of Zyprexa (schizophrenia) 1 tab at bedtime on 9/12/14 and 9/13/14. [Client #3] is prescribed 20 mg 1 tab at bedtime....The staff making the error will be counseled, placed on a probation period, and be required to complete three supervised medication passes before administering medications. The staff will be monitored at least weekly for thirty days." -BDDS report dated 10/8/14 involving client #3 indicated: "[Client #3] is prescribed Diazepam (panic disorder) 1 tablet every morning at 7 A.M.. [Client #3] received this dose on 10/8/14 at 7 A.M.. Staff administered a second dose at 8:00 P.M. on 10/8/14....Staff making the error is prohibited from giving medications for thirty days, the staff will be required to complete three supervised medication passes, and will be required to be passed for medication administration by the health and safety personnel."			

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	-BDDS report dated 10/8/14 involving client #1 indicated: "[Client #1] is prescribed Xanax 1 tablet for anxiety. [Client #1] was given her 7 A.M., and 6 P.M. dose on 10/8/14 as prescribed. Staff administered a third dose at 8:00 P.M. on 10/8/14. Staff making the error is prohibited from giving medications for thirty days, the staff will be required to complete three supervised medication passes, and will be required to be passed for medication administration by the health and safety personnel." A review of the facility's "Physician Orders and Medication Administration" policy dated 5/24/13 was conducted on 10/23/14 at 12:30 P.M.. Review of the policy indicated: "Purpose: The purpose of this procedure is to ensure consumers are administered medication as prescribed by a physician....Drug Disposal: All unused drugs and medication will be disposed of by the following means: a. Complete the medication disposal form with at least one witness. b. Dispose of the medication, by returning them to the pharmacy, or by other appropriate route (controls to be taken to the Police Department for disposal).			

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	c. When possible return unused medications to the pharmacy for disposal. d. Submit the original form for filing in the master file; attach a copy. e. File a copy of the disposal form in the home book for residential services, to be filed and retained according to department guidelines. Procedures for administering medication: Preparing and administering medication requires staff to be diligent at all times. Proper handling and dispensing of medication ensures that the consumer is receiving the correct medication. Specific guidelines must be followed in the event that a medication is not given at the correct time or needs to be destroyed. All staff must be aware of the guidelines for controlled substances, storing medications, and maintaining medical asepsis. All staff is responsible for following directions given in Core A and Core B Curriculum (where applicable) and/or Medication Administration Curriculum. 2. When administering medication: c. Read the label 3 times. Confirm the '6 Rights' of medication administration. Remain with the consumer while he/she takes medication. Staff must remain until medication is taken....e. After giving the medication, initial the MAR to document all			

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	medications have been administered. This must be done immediately after the medication is given. Never chart before a medication is given-only immediately after....g. Medications may be given 1/2 hour before of 1/2 hour after the assigned time. That is administered outside the 1/2 hour before/after guideline but is still within label directions should be documented on the Med Error form to ensure that consistency is preserved, but such occurrences will not be considered significant medication errors." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/29/14 at 2:00 P.M.. The QIDP indicated staff are trained on the facility's medication administration upon hire and then annually. The QIDP indicated staff should pass medications as ordered by the physician and further indicated staff should follow the policy at all times. 9-3-6(a)			
W000362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.			

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	Based on record review and interview, the facility failed for 4 of 4 clients living at the group home, (clients #1, #2, #3 and #4) to ensure the pharmacist reviewed clients' medications on a quarterly basis. Findings include: The pharmacist's medication review record was reviewed at the group home on 10/21/14 at 4:40 P.M.. Review of the pharmacist's medication review record indicated no medication reviews for the fourth quarter of 2013 and no medication review for the second and third quarters of 2014 for clients #1, #2, #3 and #4. A review of client #1's record was conducted on 10/22/14 at 2:15 P.M.. The record indicated client #1 was prescribed medications. A review of client #2's record was conducted on 10/22/14 at 2:50 P.M.. The record indicated client #2 was prescribed medications. A review of client #3's record was conducted on 10/22/14 at 3:20 P.M.. The record indicated client #3 was prescribed medications. A review of client #4's record was conducted on 10/22/14 at 3:45 P.M.. The	W000362	As for Tag 362 Agency Nurse will review drug regimen of consumers at least quarterly, the Habilitation Coordinator will discuss drug regimen at the quarterly meetings. The agency nurse will review all consumers' psychotropic med reviews, pharmacy reviews and nutritional assessments at least quarterly and follow-up with any recommendations to the consumers. Habilitation Coordinator will review quarterly. Monitoring to ensure they are completed will be by Adult Service Manager or Quality Assurance Specialist quarterly.	12/02/2014

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	record indicated client #4 was prescribed medications An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/29/14 at 2:00 P.M.. When asked how often medications are to be reviewed by the pharmacist, the QIDP stated "They should be reviewed quarterly." No further documentation was available for review to indicate medications were reviewed by the pharmacist quarterly. 9-3-6(a)			
W000368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review, and interview, the facility failed to assure medications administered to 1 of 2 sampled clients and 2 additional clients (clients #1, #3 and #4) were administered in compliance with the physician's orders. Findings include:	W000368	As for Tag 368: ¿CDC Resources hired Agency Nurse on November 1, 2014. The agency nurse will complete supervised med pass upon hire of staff. Group Home Supervisor will complete a supervised med pass twice a month for 30 days then one a month for 60 days. The Agency nurse will monitor medication	12/17/2014

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	A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident Reports (IR) and/or investigations was conducted on 10/21/14 at 11:30 A.M.. The facility's reports indicated the following: -BDDS report dated 10/13/13 involving client #4 indicated: "[Client #4] was not administered her 7:00 A.M. medication of Prednisone Acetate 1% (anti-inflammatory) drop in each eye for 1 week. Staff will be re-trained on medication administration and will complete three supervised med passes." -BDDS report dated 12/3/13 involving client #4 indicated: "Staff [Staff name] did not administer correct medication to [client #4]. [Client #4] was administered 1 Calcium Carb +D 600 mg (milligram) -400 IU (International Units) tab (supplement) instead of 2 tabs....Staff observed the medication error on 12/4 when the medication was to be administered next. Staff will be unable to pass medications until they receive four supervised med passes before giving medications again." -BDDS report dated 1/8/14 involving client #4 indicated: "Staff did not		passes monthly. Habilitation Coordinator and Day Service Supervisor will monitor bi-monthly. Quality Assurance Specialist will monitor medication errors monthly for trends. ¿Agency Nurse will review drug regimen of consumers at least quarterly, the Habilitation Coordinator will discuss drug regimen at the quarterly meetings. The agency nurse will review all consumers' psychotropic med reviews, pharmacy reviews and nutritional assessments at least quarterly and follow-up with any recommendations to the consumers. Habilitation Coordinator will review quarterly. Monitoring to ensure they are completed will be by Adult Service Manager or Quality Assurance Specialist quarterly. Addendum to Tag 368: Supervised med passes will be completed weekly for 30 days then bi-monthly for 30 days then monthly by Group Home Supervisor or Agency Nurse or Habilitation Coordinator or Quality Assurance Specialist. Agency Nurse will monitor along with Quality Assurance Specialist for trends of any medication errors weekly. A monitoring to ensure review of all consumers' psychotropic med reviews, pharmacy reviews and nutritional assessments at least quarterly and follow-up with any recommendations to the	

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	administer to [client #4] her medication Citrucil (sic) 500 mg on (fiber) 1/8 at 7:00 A.M.. Staff did not observe the medication error until 1/9 at the next medication dose time. A second staff check of medications has been implemented." -BDDS report dated 1/22/14 involving client #4 indicated: "Residential manager went to classroom to check [client #4]. [Client #4] complained of a sore throat. Day service staff was informed to provide [client #4] PRN (as needed) medication. Staff Administered (sic) to [client #4] Acetaminophin (sic) (pain) 650 mg tab....Staff failed to administer to [client #4] Mi-Acid 1 tsp (teaspoon) for reflux or sore throat and gave Acetaminophen instead.....Staff was retrained on reading MAR (Medication Administration Record) and physician orders. Staff received verbal counseling." -BDDS report dated 9/6/14 involving client #1 indicated: "[Client #1] is ordered 3/125 mg caps of Divalproex (bipolar/seizures) twice daily. On 9/6/14 at 8:00 P.M. she was given 1 cap instead of 3....Plan of correction for the staff making the medication error is a supervised medication pass and staff making the medication pass will request a		consumers have been reviewed will be done monthly by Quality Assurance Specialist or Adult Service Manager . Monitoring will then go to quarterly after a six month period to ensure all recommendations are being followed; Quality Assurance Specialist will monitor for compliance. Second Addendum for Tag 368 Staff making the Medication error will be prohibited from Medication Administration after making any error until they have been counselled, and have completed at least 2 Supervised Medication passes by Group Home Supervisor. Staff will be required to complete an On-Site Medication Assessment completed by trained professional. Staff making error will have on going monitoring by Group Home Supervisor or designee for the next 30 days by completing at least 2 Supervised Medication passes; then bi-monthly monitoring for the next 60 days.	

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	second check by another staff working at the home. Both staff working at the time of the medication error will receive verbal counseling." -BDDS report dated 9/12/14 involving client #3 indicated: "Staff noticed [client #3] had only been given 15 mg of Zyprexa (schizophrenia) 1 tab at bedtime on 9/12/14 and 9/13/14. [Client #3] is prescribed 20 mg 1 tab at bedtime....The staff making the error will be counseled, placed on a probation period, and be required to complete three supervised medication passes before administering medications. The staff will be monitored at least weekly for thirty days." -BDDS report dated 10/8/14 involving client #3 indicated: "[Client #3] is prescribed Diazepam (panic disorder) 1 tablet every morning at 7 A.M.. [Client #3] received this dose on 10/8/14 at 7 A.M.. Staff administered a second dose at 8:00 P.M. on 10/8/14....Staff making the error is prohibited from giving medications for thirty days, the staff will be required to complete three supervised medication passes, and will be required to be passed for medication administration by the health and safety personnel." -BDDS report dated 10/8/14 involving			

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	client #1 indicated: "[Client #1] is prescribed Xanax 1 tablet for anxiety. [Client #1] was given her 7 A.M., and 6 P.M. dose on 10/8/14 as prescribed. Staff administered a third dose at 8:00 P.M. on 10/8/14. Staff making the error is prohibited from giving medications for thirty days, the staff will be required to complete three supervised medication passes, and will be required to be passed for medication administration by the health and safety personnel." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/29/14 at 2:00 P.M.. The QIDP indicated staff are trained on medication administration upon hire, as needed and annually. The QIDP indicated staff should pass medications as ordered by the physician. 9-3-6(a)			
W000433	483.470(f)(3)			

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	FLOORS The facility must have exposed floor surfaces and floor coverings that promote mobility in areas used by clients. Based on record review and interview for 2 of 2 sampled clients (clients #1 and #2), who were at risk for falls, the facility failed to have level flooring that promoted mobility in areas used by clients. Findings include: A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS), Internal Incident Reports (IR) and/or investigations was conducted on 10/21/14 at 11:30 A.M.. The facility's reports indicated the following: -BDDS report dated 1/28/14 involving client #2 indicated: "[Client #2] and staff were returning from grocery store and entered through garage toward back door of home. Staff stated that [client #2] fell on garage floor hitting her knee cap. Staff asked if [client #2] was in pain and she stated no, staff assisted [client #2] to her feet. Staff observed redness to her left knee." -Investigation record dated 10/1/14 involving client #1 indicated: "[Client #1] was walking into the garage from the	W000433	As for Tag 433 Work order was submitted on 10-30-2014 to put gravel or cement to fill in the threshold area to prevent further mobility issues. Quality Assurance Specialist will monitor weekly for the next 60 days then monthly thereafter to ensure area is accessible without mobility issues. Monthly Quality Inspections of fall risk will be done by Quality assurance Specialist or Maintenance personnel.	12/02/2014

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	van. [Client #1] tripped over the cement lip leading into the garage and fell to her knees. [Client #1] lifted herself up with staff assistance. Staff checked her for injury, no injuries at this time. [Client #1] has a high risk of falls." A review of client #1's record was conducted at the facility's administrative office on 10/22/14 at 2:00 P.M.. A review of client #1's record indicated a "Risk Plan for Falls" dated 6/12/14 and indicated: "[Client #1] does not visually observe obstacles in her way. [Client #1] does not notice uneven surfaces. [Client #1] will increase her speed of walking when excited to get to an area and or person, which increases her chances of falls." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/29/14 at 2:00 P.M.. The QIDP indicated and surfaces should be level at the group home to ensure mobility for clients #1 and #2. 9-3-7(a)			

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CDC INC	2906 N 400 E MONTICELLO, IN 47960

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W000455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, record review and interview, the facility failed to maintain proper hygiene practices and prevent cross contamination, for 1 of 2 clients and 1 additional client observed during mealtimes (clients #1 and #3). Findings include: An evening observation was conducted at the group home on 10/20/14 from 4:45 P.M. until 7:00 P.M.. During the observation period client #1 walked around the group home grabbing items, touching the floor, put her finger in her mouth, grabbed staff and picked her nose. At 6:00 P.M., Direct Support Professional (DSP) #2 prompted client #1 to sit at the table. DSP #1 then placed a plate in front of client #1 and sprayed whipping cream on the plate. Client #1 then began eating the whip cream off the plate with her bare hands. Client #1 did not and was not prompted to wash her hands.	W000455	As for Tag 445 Staff will be retrained on infection control by December 2, 2014. Staff will be retrained on consumer hygiene by December 1, 2014. Consumers' daily schedule updated for hygiene. Monitoring consumer hygiene will be by Group Home Supervisor or Habilitation Coordinator or Adult Service Manger or Quality Assurance Specialist weekly for 30 days then monthly thereafter.	12/02/2014

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	A morning observation was conducted at the group home on 10/21/14 from 6:15 A.M. until 8:30 A.M.. At 6:43 A.M., client #3 sat at the dining table, grabbed a plastic container containing oat cereal, stuck her hand in the container, grabbed the measuring scoop, filled it with cereal and poured the cereal into her bowl. Client #2 then stuck her hand in the plastic container and served her cereal. Client #3 did not and was not prompted to wash her hands prior to sitting at the table. A review of client #3's record was conducted on 10/22/14 at 3:20 P.M.. Review of the ISP dated 2/18/14 indicated the following training objectives which could have been implemented: "Will wash her hands before her evening meal." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 10/29/14 at 2:00 P.M.. The QIDP indicated staff should have prompted clients #1 and #3 to wash their hands before sitting at the dining table during both mealtime observations. 9-3-7(a)			

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W009999	State Findings: The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met: 460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division. This state rule is not met as evidenced by: Based on record review and interview, the facility failed for 2 of 2 sampled clients and 2 additional client (clients #1, #2, #3 and #4), to report relocation of clients due to bed bugs and injuries of unknown origin to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.	W009999	As for Tag 9999 : ¿CDC will follow BDDS guidelines for reporting incidents to the BDDS office. ¿QIDP will be retrained on guidelines by December 1, 2014. ¿Abuse and Neglect training will be increased to bi-annually of staff. All abuse and neglect incidents will be reviewed by CDC's HRC team quarterly. All abuse and neglect incidents will be monitored to ensure investigation completed and for trends by Quality Assurance Specialist monthly. Staff will be retrained on reporting all allegations of abuse and neglect on December 1, 2014. Monitoring to ensure all allegations reported once a week by Group Home Supervisor and Habilitation Coordinator	12/02/2014

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	Findings include: A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident Reports (IR) and/or investigations was conducted on 10/21/14 at 11:30 A.M.. The facility's reports indicated the following: -BDDS report dated 1/11/14...Date of Knowledge: 1/11/14...Submitted Date: 1/14/14 indicated: "Staff was assisting [client #1] with a shower and staff observed a bruise on [client #1]'s outer/back right arm documented as 1 cm (centimeter) in size and red/purple in color." -BDDS report dated 1/12/14...Date of Knowledge: 1/12/14...Submitted Date: 1/14/14 indicated: Staff and supervisor were making observation of bruises (previously reported) and noticed a 2 cm (centimeter) bruise on [client #1]'s right inner arm documented as circular and black/purple in color." -BDDS report dated 7/7/14...Date of Knowledge: 7/7/14...Submitted Date: 7/9/14 indicated: "[Exterminator name] was called out to Group Home to check for bed bugs. Bud bugs were found in			

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	the living room that were dead. It was suggested that [Exterminator name] come back to do a heating treatment on the home and removal of the furniture. Consumers (#1, #2, #3 and #4) were relocated that day (7/7/14) to the CDC [city] facility and will remain relocated until it is ok to return to the home. [Exterminator name] is coming to the home on Friday 7/11/14 tot treat it for bedbugs. Furniture has been removed from the home and will be replaced once [Exterminator name] has treated the home." Further review of the record indicated an "Incident Follow-Up Report" was submitted on 7/18/14. This incident was not reported to BDDS within 24 hours and a follow up report was not submitted within 7 days. A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 10/22/14 at 5:50 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS....Incidents to be reported to BDDS...Any injury to an individual when the cause in unknown and the injury			

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	could be indicative of abuse, neglect or exploitation....A service delivery site with a structural or environmental problem that jeopardizes or compromises the health or welfare of an individual." An interview with administrative staff #1 was conducted on 10/29/14 at 2:00 P.M.. Administrative staff #1 indicated the incidents should have been reported within 24 hours to BDDS and follow up reports should have been submitted every 7 days. 9-3-1(b)			