

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G558		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2013	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6341 FOREST AVE HAMMOND, IN 46324			
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: June 3, 4, and 5, 2013.</p> <p>Facility number: 001072 Provider number: 15G558 AIM number: 100235500</p> <p>Surveyors: Amber Bloss, QIDP-TC David Piotrowski, QIDP (June 3 and 4, 2013)</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed June, 12, 2013 by Dotty Walton, QIDP.</p>	W000000					

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

TITLE

(X6) DATE

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

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review the facility failed to immediately report 2 of 2 injuries of unknown source to the facility administrator that occurred during the time period of 3/14/12 through 6/3/13. This affected 2 of 3 clients in the sample, Clients #2 and #3. Findings include: 1. Incident review was conducted on 6/3/13 commencing at 12:15 PM of the facility investigations into allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown source for the time parameter 3/14/12 through 6/3/13, it was indicated the facility reported an injury of unknown source for Client #3 on 10/12/12. The incident report documented upon return from school, Client #3 was observed with a small amount of blood smeared on his face and hands. The incident was investigated and though a plausible cause was identified, the cause of the injury remained unknown.</p>	W000153	<p>All staff are trained on abuse/neglect and reporting policy upon hire and at least annually thereafter. Person responsible: Ruth Fields, Training Coordinator. All instances of unknown injuries are to be report immediately per policy. Responsible person: Sheila O'Dell, Group Home Director. QMRP, Manager and staff will be re-trained on policy #28 reporting and investigating incidents of abuse, which includes immediately reporting of unknown injuries. Responsible person: Sheila O'Dell, Group Home Director. To ensure future compliance, all internal incident reports are to be reviewed daily to ensure they were reported timely. Responsible person: Starr Frohock, Group Home Manager. To ensure future compliance, a reliability will be completed to ensure competency. Responsible person: Starr Frohock, Group Home Manager.</p>	07/05/2013			

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	<p>Examination of the notifications section of the facility's incident report indicated the section for notification to the Facility Administrator (FA) was blank. In an interview with the Qualified Intellectual Disabilities Professional (QIDP) on 6/3/13 at 12:55 PM, the QIDP was asked if there was any documentation evincing the FA was immediately notified of the incident on the date it occurred. The QIDP reviewed the report and explained that she typically completed that section, but had no evidence it was done for this particular incident. There was e-mail correspondence from the FA to the QIDP on 10/15/13 at 4:27 PM stating the need for additional information for BQIS (Bureau of Quality Improvement Services), but that correspondence also did not identify the date and time the FA was first notified of the incident.</p> <p>2. Incident review was conducted on 6/3/13 commencing at 12:15 PM of the facility investigations of unknown source for the time parameter of 3/14/12 through 6/3/13. The facility reported an injury of unknown source for Client #2 on 9/20/12 to BDDS (Bureau of Developmental Disabilities Services). The BDDS report</p>						

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	<p>indicated DSP #1 (Direct Support Professional) observed Client #2 with injuries of unknown origin while assisting him with removing his shirt preparing for bedtime. The report indicated Client #2 was observed with "3 marks on his chest: a 1" (inch) abrasion on the upper left chest just below the collarbone, a 4" abrasion on right upper chest, and a nickel sized bruise midway between the right collarbone and armpit." The incident was investigated and though a plausible cause was identified for the 2 abrasions, the source of the bruise remained unknown. Examinations of the notification section of the investigation of the injuries of unknown source for Client #2 indicated the section for notification of FA (Facility Administrator) was blank. In an interview with the QIDP (Qualified Intellectual Disabilities Professional) on 6/3/13 at 12:55 PM, the QIDP was asked if there was any documentation evincing the FA was immediately notified of the incident on the date it occurred. The QIDP reviewed the report and indicated though she typically completed that section, she had no documentation which indicated the FA was notified</p>				

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	immediately of Client #2's injury of origin reported on 9/20/12. 9-3-2(a)				

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review, interview, and observation, the facility failed to thoroughly investigate an injury of unknown origin for 1 of 2 investigations reviewed for injury of unknown origin for 1 of 3 sampled clients (Client #2).</p> <p>Findings include: Incident review was conducted on 6/3/13 commencing at 12:15 PM of the facility investigations of unknown origin for the time parameter of 3/14/12 through 6/3/13. The facility reported an injury of unknown origin for Client #2 on 9/20/12 to BDDS (Bureau of Developmental Disabilities Services). The BDDS report indicated DSP #1 (Direct Support Professional) observed Client #2 with injuries of unknown origin while assisting him with removing his shirt preparing for bedtime. The report indicated Client #2 was observed with "3 marks on his chest: a 1" (inch) abrasion on the upper left chest just below the collarbone, a 4" abrasion on right upper chest, and a nickel sized bruise midway between the right collarbone and armpit."</p>	W000154	<p>All staff are trained on abuse/neglect and reporting policy upon hire and at least annually thereafter. Person responsible: Ruth Fields, Training Coordinator. All instances of unknown injuries are to be report immediately and investigated thoroughly per policy.</p> <p>Responsible person: Sheila O'Dell, Group Home Director. QMRP and Manager will be re-trained on policy #28 reporting and investigating incidents of abuse, which includes completing a thorough investigation of any unknown injuries. Responsible person: Sheila O'Dell, Group Home Director. To ensure future compliance, an investigation packet will be completed. The investigation packet will contain everything that is needed for a thorough investigation for unknown injuries. This includes an assessment of the injury, review of the incident report, communication with staff, review of behavioral data, a visual check of the environment, communication with the consumer, review of the house log and any other. It also includes if medical intervention was needed and that all of the team was contacted about the incident. There is a section that they are to</p>	07/05/2013

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	<p>The investigation packet included the BDDS follow up report which indicated the facility documented interviews with all staff who worked with Client #2 during the 24 hour period prior to the discovery of the injury of unknown origin plus the school bus staff. The BDDS follow up concluded Client #2 "was having a very bad day at school. He was displaying aggression, SIB (self-injurious behavior) and resistance to instruction. He was resistant when school staff was helping him put on his bus harness. The bruise lines up with where the school staff's thumb would come in contact with his chest when putting on the harness, so we believe that is what caused his bruise. There are no indications of abuse or mistreatment."</p> <p>The investigation packet included a written statement from Client #2's bus driver on 9/20/12. The written statement from Client #2's bus driver stated, "On putting consumer [Client #2] on bus for home, I [name of bus driver] noticed that he [Client #2] was jerking real hard while being secured in his seat w/ (with) harness."</p> <p>The investigation packet included a</p>		<p>check if it is substantiated or not, if the action taken appears to be sufficient or if further action is needed like: training, shift change, supervision levels reestablished, BSP retraining, etc. The last section of the investigation packet is that the Program Director/Administrator receives this packet within five days of the incident and a summery/assessment based off the the information is completed. It then gets passed off to the next scheduled safety committee meeting. Responsible person: Elaina Blystone, QDDP.</p>		

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	<p>written conclusion from QIDP (Qualified Intellectual Disabilities Professional) on 9/24/12 which stated, "After speaking with the bus aide and teacher, the group home manager and I feel that the bruise occurred (sic) when school staff were trying to put the bus harness on [Client #2]. He was aggressive and resistant to instruction all day. He resisted putting on the harness and the bruise most likely came from the school staff's thumb pressing on his chest area while trying to secure the harness."</p> <p>On 6/3/13 at 12:55 PM, the QIDP was interviewed and indicated Client #2 used the harness on the bus to protect others from injury and also, he was known to rock very hard and would sometimes hit his head on the seat in front of him. The QIDP indicated Client #2 usually put the harness on before boarding the bus. The QIDP indicated once boarded on the bus, Client #2 normally had his harness clipped to the school bus seat by bus staff. The QIDP indicated Client #2 was unable to release himself from the harness but maintained free use of arms and some motion of the torso while clipped into his harness. The QIDP indicated she did not</p>			

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	<p>investigate whether the bus staff should have fastened Client #2's harness to his seat while he was resistant and struggling. Though the use of the bus harness for Client #2 was reviewed by the Human Rights Committee and approved as a restrictive method for Client #2, the QIDP indicated the harness was applied by school staff and no further training was done with bus staff as a result of the investigation nor was the harness protocol revised for safe application because her investigation did not conclude mistreatment occurred.</p> <p>On 6/3/13 at 3:55 PM, Client #2's Behavior Specialist was interviewed. The Behavior Specialist indicated she remembered the 9/20/12 investigation involving Client #2. The Behavior Specialist indicated she was unsure whether the bus staff acted inappropriately by having clipped Client #2's harness onto the bus seat while he was struggling and resistant because she recalled the conclusion of the investigation was just "speculative." The Behavior Specialist was unsure whether Client #2 leaned into the halter causing the injuries of unknown injury.</p>						

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	<p>On 6/4/13 at 8:30 AM, Client #2 was observed to get on the school bus. The bus was observed to have the bus driver and a bus aide in attendance. Client #2's bus aide clipped his harness onto his bus seat without incident while the bus driver was able to observe while seated by looking into his rear view mirror.</p> <p>No documentation of an interview for the bus aide who worked with Client #2 during the 9/20/12 incident was available for review.</p> <p>9-3-2(a)</p>				

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W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on interview and record review the facility failed to report the results of one investigation of an injury of unknown source that occurred during the time period of 3/14/12 through 6/3/13 to the facility administrator or designee within five working days for 1 of 2 investigations of injury of unknown origin reviewed for 1 of 2 clients (Client #3).</p> <p>Findings include:</p> <p>Incident review was conducted on 6/3/13 commencing at 12:15 PM of the facility investigations into allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown source for the time parameter 3/14/12 through 6/3/13. The facility reported an injury of unknown source for Client #3 on 10/12/12. The incident report documented upon return from school Client #3 was observed with a small amount of blood smeared on his face and hands. The incident was investigated and though a plausible cause was identified, the cause of the injury remained unknown.</p>	W000156	<p>All staff are trained on abuse/neglect and reporting policy upon hire and at least annually thereafter. Person responsible: Ruth Fields, Training Coordinator. All instances of unknown injuries are to be report immediately, investigated thoroughly and to report results to designee within five days per policy. Responsible person: Sheila O'Dell, Group Home Director. QMRP and Manager will be re-trained on policy #28 reporting and investigating incidents of abuse, which includes reporting the results of the investigation to designee within five days. Responsible person: Sheila O'Dell, Group Home Director. To ensure future compliance, an investigation packet will be completed. The investigation packet will contains everything that is needed for a thorough investigation for unknown injuries. This includes an assessment of the injury, review of the incident report, communication with staff, review of behavioral data, a visual check of the environment, communication with the consumer, review of the house log and any other. It also includes</p>	07/05/2013			

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	<p>Examination of the facility's incident report indicated no evidence the results of the investigation were reported to the Facility Administrator (FA) or designee within five working days. In an interview with the Qualified Intellectual Disabilities Professional (QIDP) on 6/3/13 at 12:15 PM to ascertain where the evidence of such was located, the QIDP reviewed the investigative file and stated, "There's usually a packet with a summary page from the Administrator." The QIDP verified the packet was not there.</p> <p>9-3-2(a)</p>		<p>if medical intervention was needed and that all of the team was contacted about the incident. There is a section that they are to check if it is substantiated or not, if the action taken appears to be sufficient or if further action is needed like: training, shift change, supervision levels reestablished, BSP retraining, etc. The last section of the investigation packet is that the Program Director/Administrator receives this packet within five days of the incident and a summery/assessment based off the the information is completed. It then gets passed off to the next scheduled safety committee meeting. Responsible person: Elaina Blystone, QDDP. Responsible person: Elaina Blystone, QDDP.</p>		

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, interview, and record review, the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to ensure the bus harness protocol was being monitored and revised as indicated for less restrictive measures for 2 of 3 sampled clients (#2 and #3), the facility's QIDP failed to revise one behavioral objective when criterion was achieved for 1 of 3 clients in the sample (Client #1), the facility's QIDP failed to revise the individual program plan when lack of progress was noted in one of nine skill training objectives established for 1 of 3 sampled clients (Client #3), the facility's QIDP failed to ensure written consent for a behavior support plan with restrictive interventions was obtained from both legal guardians for 1 of 3 sampled clients (Client #3).</p> <p>Findings include:</p> <p>1. On 6/4/13 at 8:30 AM, Client #3 left the residence to board a bus to embark for school. Client #3 wore a bus harness as a safety measure while in transport to and from school. Record review for Client #3 on 6/3/13 commencing at 10:40 AM</p>	W000159	<p>QDDP will be re-trained on active treatment programming and the coordination/monitoring for each client. Responsible person: Sheila O'Dell, Group Home Director. School is currently out and they do not use the harness on the van. A monitoring system will be set up and ready to go for the start of the school year and make revision accordingly per protocol. Responsible person: Elaina Blystone, QDDP. Quarterly the team will review behavioral goals and restrictive protocols. Responsible person: Karen Warner, Behaviorist and Elaina Blystone, QDDP.</p>	07/05/2013	

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	<p>indicated consent for use of the bus harness was obtained from Client #3's father as part of Client #3's behavior management plan (BMP) and the BMP had been reviewed and sanctioned by the facility's Human Rights Committee (HRC).</p> <p>Criterion for reduction of dependency on the use of a bus harness was identified in the record which included a phase down plan contingent upon Client #3 going at least two weeks without behavioral episodes on the bus. On 6/4/13 at 10:40 AM review of the "Bus harness data collection" sheet for May 2013 indicated the following instruction, "If there was no behavior, document an N." Handwritten entries for every day Client #3 was in attendance at school in May were coded N. Client #3 went four weeks without any behavioral incidents on the bus.</p> <p>Interview with Client #3's Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/4/13 commencing at 2:05 PM. The QIDP was asked if she had facilitated and monitored the plan to reduce the use of the bus harness. The QIDP indicated it was a school procedure, but also indicated based on the review of May data with criterion being met, she had no knowledge if the plan was being followed.</p>				

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	<p>1 a. During an observation on 6/5/13 at 7:25 AM, Client #2 was observed to put his bus harness on before the bus arrived. When Client #2 boarded the bus to travel to his day program, Client #2 was observed to have his bus harness clipped to the seat by bus staff. During record review on 6/4/13 commencing at 10:40 AM, the Behavior Program Consent Form dated 7/1/12 indicated Client #2 had a bus protocol for use of the halter and indicated a "step program will be used to fade the use of the harness."</p> <p>Criterion for reduction of dependency on the use of a bus harness was identified in the record which included a phase down plan contingent upon Client #2 going at least two weeks without behavioral episodes on the bus. On 6/4/13 at 10:40 AM review of the "Bus harness data collection" sheet for May 2013 indicated handwritten entries for every day Client #2 was in attendance at school in May, no behaviors were noted. Client #2 went four weeks without any behavioral incidents on the bus. During an interview on 6/4/13 at 2:05 PM, the QIDP indicated she had no knowledge if the step down plan for less restrictive measures with Client #2's bus harness was being applied.</p> <p>2. The QIDP failed to revise the</p>				

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	<p>individual program plan when an objective was met for 1 of 3 clients (Client #1). Please see W255.</p> <p>3. The QIDP failed to revise the individual program plan when lack of progress occurred for 1 of 3 clients (Client #3). Please see W257.</p> <p>4. The QIDP failed to document efforts to obtain guardian consent for 1 of 3 clients (Client #3). Please see W263.</p> <p>9-3-3(a)</p>			

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W000255	<p>483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review the facility failed to revise one behavioral objective when criterion was achieved for one of three clients in the sample, Client #1.</p> <p>Findings include:</p> <p>On 6/3/13 commencing at 3:15 PM, Client #1 was observed sitting at the dining room table. Client #3 chose a communication device from a credenza and searched for a button. When Client #1 pressed the button a programmed song, "Twinkle, Twinkle Little Star" was heard. After the song was over, Client #1 pressed another button and the word "Goodbye" was pronounced. Interview with a nearby direct support professional (DSP #2) indicated Client #1 always plays the jingle first followed by the word goodbye when he's finished listening to the song. DSP #2 stated, "It had to be in that order."</p> <p>On 6/4/13 at 2:35 PM, record review for</p>	W000255	<p>QDDP will be re-trained on active treatment programming and the coordination/monitoring for each client. Responsible person: Sheila O'Dell, Group Home Director. A revision will be made to Client #1's objective to decrease self-injurious behaviors. Responsible person: Karen Warner, Behaviorist and Elaina Blystone, QDDP. Quarterly the team will review behavioral goals and restrictive protocols to ensure objective will be revised when criterion is achieved. Responsible person: Karen Warner, Behaviorist and Elaina Blystone, QDDP.</p>	07/05/2013			

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	<p>Client #1 on 6/4/13 commencing at 2:35 PM indicated an Individual Support Plan (ISP) dated 9/21/12. The behavioral objective, "[Client #1] will decrease incidents of compulsive behavior to an average of two per month for six months" had been established. Data was handwritten on the back sheet of the objective and the following frequencies were reported: Oct 2012 - 0; Nov 2012 - 0; Dec 2012 - 0; Jan 2013 - 0; Feb 2013 - 0; Mar 2013 - 1; Apr 2013 - 0. Based on the data recorded, Client #1 met the objective. There was no documentation evident in the record the objective had been revised after successful achievement.</p> <p>A Behavior Support Plan (BSP) dated 11/20/12 was also in the record. It identified compulsive behavior as any "non-functional act that is repetitive, cyclical and results in property damage or significant interference with activities of daily living." Under "History of Restrictive Methods" was a statement about "Medication" identifying "[Client #1] has been prescribed medication to decrease self- injurious behavior and compulsive behavior."</p> <p>An interview was conducted with the Facility Administrator (FA) on 6/4/13 commencing at 4:00 PM to ascertain what</p>			

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	<p>the expectations were with respect to the revision of behavioral objectives particularly when the criterion for a reduction in the use of Risperdal was partially linked to obsessive compulsive behavior. The FA suggested a review of the "Medication Review Team" (MRT) report completed by the Behavior Specialist, stating that data might be more reliable. On 6/4/13 at 4:00 PM, review of the most recent MRT report in the record indicated Client #1 still met the objective within a six month period and no revision to the objective had been made.</p> <p>9-3-4(a)</p>			

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W000257	<p>483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. Based on observation, interview and record review, the facility failed to revise the individual program plan when lack of progress was noted in one of nine skill training objectives established for 1 of 3 clients in the sample, Client #3. Findings include: On 6/4/13 at 7:30 AM, Client #3 was observed coming out of his bedroom wearing one piece pajamas with a zipper in the back. Client #3 was escorted to the kitchen where he received medications and subsequently had breakfast. Client #3 was then escorted back to his room by his direct support staff (DSP #1) and at 7:50 AM came out of his room dressed in pants and a shirt. In an interview with DSP #1 at 8:00 AM, DSP #1 explained one piece pajamas were used as an intervention to help prevent smearing of feces and Client #3 also wore disposable briefs. DSP #1 also explained timed toileting was tried, but Client #3 still had occasional accidents at night. DSP #1 was observed spraying Client #3's mattress with a cleaning</p>	W000257	<p>QDDP will be re-trained on active treatment programming and the coordination/monitoring for each client. Responsible person: Sheila O'Dell, Group Home Director. Quarterly the team will review the goals and analyze the data when there has been a lack of progress on the training objective. Responsible person: Elaina Blystone, QDDP. QDDP will revise client #3 training objective for toileting. Responsible person: Elaina Blystone, QDDP. The QDDP will make the need revision to ensure progress is being made on training objectives. Responsible person: Elaina Blystone, QDDP.</p>	07/05/2013

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	<p>solution prior to her attempt to engage Client #3 in placing a new sheet on his bed.</p> <p>Record review for Client #3 on 6/4/13 commencing at 10:50 AM indicated an Individual Support Plan (ISP) dated 10/4/12. The skill training objective, "[Client #3] will eliminate in the toilet 5% of the time for three months" had been established. Data handwritten on the back of the objective indicated the following percentage computations: Oct 2012 - 0%; Nov 2012 - 0%; Dec 2012 - 0%; Jan 2013 - 1%; Feb 2013 - 3%; Mar 2013 - 1%; April 2013 - 0%. The comment "continue" was noted in the quarterly review of 4/9/13.</p> <p>In an interview with the Qualified Intellectual Disabilities Professional (QIDP) on 6/4/13 at 2:05 PM, she was asked if any changes had been made to this training objective as Client #3 had not made progress towards the objective for seven months. The QIDP stated for Client #3 it "might take years" to achieve the objective. The QIDP also acknowledged no revisions had been made to the plan for this particular objective.</p> <p>9-3-4(a)</p>						

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W000263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on interview and record review the facility's specially constituted committee failed to ensure written consent for a behavior support plan with restrictive interventions was obtained from both legal guardians for one client in the sample, Client #3.</p> <p>Findings include: Record review for Client #3 was conducted on 6/4/13 commencing at 10:50 AM. Client #3 was seventeen years old with a birth date of 10/12/95 and was admitted to the facility on 9/14/08. A copy of Client #3's parent's divorce decree dated 2/25/08 was present in the record. It indicated, "The parties shall have joint legal custody of the minor children of the parties and that respondent husband shall have physical custody of such children." A notice of acknowledgement of "Consumer Rights" was in the record signed by Client #3's father on 10/4/12. Additional record review indicated Client #3's father signed for the restrictions of time-out, medication, one-piece pajamas, physical restraint, restriction of water and use of a bus harness as part of a Behavior Support Plan (BSP) on 2/18/13 with a</p>	W000263	<p>Client #3's father/natural guardian has always signed all of the consents and all consents are sent out at least two weeks prior to HRC. Responsible person: Sandra Kimbrough, Administrative assistant. The QDDP is the last to sign and date all HRC consents to ensure that written consent is present by all parties prior to implementaion of any restrictive programs. Responsible person: Elaina Blystone, QDDP. The mother has never been in contact with us, the father or with client #3. We have no contact information on the mother. The mother has no known address. A goggle search was completed with no results. Responsible person: Elaina Blystone, QDDP. Quarterly, a search will be completed on client #3's mother or any other efforts and they will be documented. Responsible person: Elaina Blystone, QDDP.</p>	07/05/2013	

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	<p>prior review by the facility's Human Rights Committee (HRC) occurring on 2/11/13. On 5/16/13, Client #3's father gave consent for the use of child-proof doorknobs, cabinet locks and an audible alarm with a review by the HRC on 5/20/13.</p> <p>In an interview with the Qualified Intellectual Disabilities Professional (QIDP) on 6/4/13 commencing at 2:05 PM, the QIDP was asked what efforts had been made to obtain consent from Client #3's mother for the BSP with all its restrictive interventions and the recent blanket restrictions imposed by the facility. The QIDP indicated there had been no contact with Client #3's mother since 2008. When the QIDP was asked if there was any documentation evincing her efforts, or the HRC's efforts attempting to obtain consent from Client #3's mother, the QIDP indicated there was no documentation to that effect.</p> <p>With respect to the issue of the HRC review of Client #3's BSP prior to obtaining updated written consent from Client #3's father, the QIDP stated it was "sometimes hard to get parental consent" in a timely manner.</p> <p>9-3-4(a)</p>				

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W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview the facility failed to ensure its third shift evacuation drills were conducted on a quarterly basis for 3 of 3 sampled clients (Clients #1, #2, and #3) and 2 additional clients (Clienst #4 and #5). Findings include: The facility's evacuation drills were reviewed on 6/3/13 commencing at 4:15 PM. Documentation was present verifying drills were conducted on the night shift during the time period June 1st, 2012 through May 31st, 2013. These occurred on: 7/23/12 at 5:30 AM, 12/4/12 at 12:00 AM, 1/1/13 at 2:00 AM, and 3/27/13 at 3:30 AM. In a concurrent interview with the facility's Residential Manager (RM), she was asked why there was a five month time gap between the July and December night time drills. The RM reviewed the log and each drill verifying no other night shift drill had been conducted between those months. 9-3-7(a)</p>	W000440	<p>The Manager and staff will be re-trained how often and what shifts the evacuation drills need to be completed. Responsible person: Elaina Blystone, QDDP. To ensure compliance, drill summery sheet will be used. Responsible person: Starr Frohock. To ensure future compliance, monthly a program status review will be completed to check that all drills including the 3rd shift drill are completed on a quarterly basis. Responsible person: Elaina Blystone, QDDP and Sheila O'Dell, Group Home Director.</p>	07/05/2013	

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