STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	1010 KELLAM RD CENTERVILLE, IN 47330

(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
W000000	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: 2/18, 2/19, 2/20 and 2/24/14. Facility Number: 0012633 Provider Number: 15G805 AIMS Number: 201072030 Surveyor: Paula Chika, QIDP-TC These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed March 3, 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 interview and record review for 1 additional client (#3), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the client did not use his funds to pay for his daily reward in regard to the client's behavior.	W000104	**CORRECTION:** *The Governing body must exercise general policy, budget and operating direction over the facility.* Specifically, the governing body has directed the facility to pay for any soft drinks or other items used as reinforcers in Client #3's Behavior Support Plan. **ADDENDUM:** A review of support documents and client receipts	03/26/2014

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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	Findings include: Client #3's record was reviewed on 2/20/14 at 2:33 PM. Client #3's 11/5/13 Behavior Support Plan (BSP) indicated client #3 received a reward for dining. Client #3's BSP indicated "...[Client #3] will be rewarded with drinking a plastic bottle of pop (his preferred reinforcer), after lunch and dinner meal times, if he does not display target behaviors (physical aggression or property destruction) at the lunch or dinner meal...." The BSP indicated client #3 had a history of throwing food, drinks and dinnerware at the other clients. Client #3's financial records were reviewed on 2/19/14 at 10:10 AM. Client #3's financial records indicated the client had a savings account. Client #3's financial records indicated client #3 withdrew the following amounts (not all inclusive): -12/11/13 $7.00 -12/19/13 $10.00 -1/14/14 $10.00 -1/27/14 $7.00 -2/12/14 $7.00 Interview with the QIDP on 2/19/13 at 10:30 AM stated the above mentioned withdrawals were to pay for the client's		indicated that no other clients were affected by this deficient practice. **PREVENTION:** The QIDP has been retrained to assure that clients do not use personal funds to purchase items referenced in their support documents. Additionally, members of the Operations Team will conduct audits at the facility no less than twice monthly for the next 90 days and after two months, no less than monthly. The audits will include but not be limited to a review of client financial records to assure clients do not pay for items referenced in support documents. **RESPONSIBLE PARTIES:** QIDP, Direct Support Staff, Operations Team	

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	reward/reinforcer of "a big one" (pop) per the client's BSP. The QIDP indicated client #3 should not be using his personal funds to pay for the reinforcer. 9-3-1(a)			
W000125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2), and for 2 additional clients (#3 and #4), the facility failed to ensure the clients' rights as the facility was locking the food pantry without due process. The facility also failed to ensure the rights of clients in regard to the use of a door alarm as it was not part of the clients' program plans and failed to ensure the facility's Human Rights Committee/HRC had reviewed and/or approved its use. Findings include: 1. During the 2/18/14 observation period between 4:40 PM and 6:50 PM,	W000125	**CORRECTION:** *The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.* Specifically, the facility has assessed that the safety concerns that resulted in the installation of door alarms and locks on the food pantry no longer exist and therefore the alarms and locks will be removed. **ADENDEUM:** At the time of the initial survey, all four clients were affected by this deficient practice but as previously stated, the restrictions have been systematically discontinued.**PREVENTION:** The QIDP will be trained regarding the	03/26/2014

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	at the group home at 5:30 PM, staff #1 unlocked a food pantry door located in the kitchen. Staff #1 was in the pantry looking for a soft drink/pop for client #3. During the 2/19/14 observation period between 5:50 AM and 10:02 AM, at the group home, staff #4 unlocked the food pantry closet with a key and removed a plastic container which contained cereal for client #3. On 2/20/14 at 3:05 PM, the Qualified Intellectual Disabilities Professional (QIDP) obtained a key from staff and unlocked the food pantry cabinet. The food pantry cabinet contained cereal, canned goods, snacks, bread, chips and bananas. Client #1's record was reviewed on 2/20/14 at 11:58 AM. Client #1's 10/14/13 Behavior Support Plan (BSP) indicated "...He (client #1) has a history of binge eating on particular foods (or condiments) and consuming large quantities of liquids...." The 10/14/13 BSP indicated client #1 had a targeted behavior of "Non-compliance: health and safety issues (dietary, hygiene, medical): this includes refusing to cooperate with requests to follow the menu regarding in-between meal		need to incorporate changes in the level of rights restrictions for all clients as soon as the team consensually agrees on removal. Members of the Operations Team will incorporate reviews of rights restrictions into regularly scheduled quality assurance audits at the facility. Members of the Operations Team will incorporate audits of rights restrictions into twice monthly visits to the facility for the next 90 days and after three months, no less than monthly. **RESPONSIBLE PARTIES:** QIDP, Operations Team	

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	snacks/liquids;...." Client #1's BSP indicated the following in regard to non-compliance with following the menu: "If [client #1] approaches the kitchen in-between meals, staff will: -verbally remind him of the importance of a healthy diet and following the menu and redirect [client #1] to a preferred activity. -Provide verbal prompts to return the unopened/unused food item to the kitchen and place item in a location of his choosing until he is ready to consume it. -If he refuses, repeat prompts every 15 minutes until he returns the unopened/unconsumed food item to the kitchen area. -If he continues to refuse and becomes agitated, stop prompts, and document behavior(s)...." Client #1's 10/14/13 BSP and/or 12/23/13 ISP (Individual Support Plan (ISP) did not indicate the food pantry should be locked and/or indicate the client had given written informed consent for locking the pantry. Client #1's 12/23/13 Modification of Individual's Rights indicated client #1 would be restricted from going into the kitchen if the client did not bathe. Client #1's ISP, BSP and/or			

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	Modification of Individual Rights form did not indicate the food pantry should be locked. Client #1's 10/14/13 BSP did not indicate the facility's HRC reviewed and/or approved the client's right restriction, and did not indicate client #1 gave written informed consent to lock the food pantry. Client #2's record was reviewed on 2/20/14 at 1:51 PM. Client #2's 12/24/13 ISP and/or 10/18/13 BSP did not indicate the client had a need to have the food pantry locked. The ISP and/or BSP did not indicate client #2's guardian gave written informed consent in regard to locking the food pantry door. The facility's Human Rights Committee notes were reviewed on 2/20/14 at 11:45 AM. The facility's 9/24/13 notes/minutes indicated the facility's HRC approved locking the food pantry on 9/24/13. The HRC note indicated "... [Client #1's]: Locking of pantry door and Emergency food supply due to [client #1] eating Large (sic) amounts of food from the Emergency food supply...." Interview with staff #5 on 2/19/14 at 12:53 PM indicated client #1 would refuse to eat and go into the kitchen and get food out of the pantry and eat at			

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	night and during the day. Staff #5 stated "He would eat throughout the day." Staff #5 indicated clients #1, #2, #3 and #4 did not have access/a key to the food pantry. Interview with the QIDP on 2/20/14 at 3:05 PM stated the food pantry was being locked as "[Client #1] would run into the kitchen and garage to get food." The QIDP did not know if the facility's HRC had approved the locking of the food pantry. The QIDP did not know if client #1 gave written informed consent for locking the pantry. Interview with the QIDP on 12/20/14 at 3:50 PM indicated he had spoken with the behavior clinician and administrative staff #2, by phone, and they indicated the food pantry was not to be locked. The QIDP stated client #1 had an order to lock the food pantry but it was supposed to have been "discontinued." The QIDP stated, "Staff to monitor at night." The QIDP indicated he did not get client #1's order discontinued as recommended at client #1's 12/23/13 annual meeting. 2. During the 2/18/14 observation period between 4:40 PM and 6:50 PM and the 2/19/14 observation period between 5:50 AM and 10:02 AM, at the			

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	group home, indicated the group home had door alarms on the front door and the garage door of the group home. The alarms would sound each time clients #1, #2, #3,#4 and facility staff went through the doors. Client #1's record was reviewed on 2/20/14 at 11:58 AM. Client #1's 12/23/13 ISP and/or 10/14/13 BSP did not indicate client #1 had a need to have his mobility/movement restricted. Client #1's record and/or BSP did not indicate client #1 gave written informed consent for the use of the door alarms. Client #2's record was reviewed on 2/20/14 at 1:51 PM. Client #2's 10/18/13 BSP indicated client #2 demonstrated the targeted behavior of "Leaves Assigned Area." The BSP indicated client #2 would leave the group home without staff supervision and/or leave the group home through his bedroom window. Client #2's 8/18/13 Modification of Individual's Rights, 10/18/13 BSP and/or 12/24/13 ISP did not indicate the use of door alarms had been incorporated into the client's programs, and/or indicate what client #2 had to do to get his mobility/movement right back.			

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	Review of the facility's 2/13 to 2/14 HRC notes/minutes on 2/20/14 at 11:45 AM did not indicate the facility's HRC reviewed the systemic use of the door alarm for clients #1, #2, #3 and #4. Interview with staff #3 on 2/19/14 at 1:40 PM indicated the door alarms were on the doors due to clients #2 and #4 demonstrating elopement behavior. Staff #3 indicated the use of the door alarms was not part of the clients' behavior plans. Interview with the QIDP indicated the door alarms were on the doors due to clients #2 and #4. The QIDP indicated the clients would elope from the group home. The QIDP indicated he thought the use of the door alarms was part of the clients' BSPs and on the clients' Modification of Rights restriction forms. The QIDP indicated client #2 and #4's BSPs did not indicate what the clients would need to do to get the right's restrictions lifted. 9-3-2(a)			

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W000137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation, interview and record review for 1 of 2 sampled clients (#2), the facility failed to allow the client to have access to his own personal property (radio). Findings include: During the 2/18/14 observation period between 4:40 PM and 6:50 PM, at the group home, client #2 had a built in locked cabinet on a shelf in the client's bedroom. Interview with client #2 on 2/18/13 at 5:20 PM, indicated his radio was inside the locked cabinet in his bedroom. Client #2 indicated he did not have a key to the locked box. Client #2's record was reviewed on 2/20/14 at 1:51 PM. Client #2's 12/24/13 Individual Support Plan (ISP) and/or 10/18/13 Behavior Support Plan (BSP) indicated client #2 would throw objects/demonstrated property destruction. Client #2's BSP and ISP indicated client #2's mother was the client's guardian. The ISP/BSP did not indicate the client's guardian gave	W000137	**CORRECTION:** *The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.* Specifically, the need to secure Client #2's radio will be incorporated into the Behavior Support Plan and the team will obtain approval for the restriction from Client #2's legal guardian. **ADDENDUM:** A review of support documents and facility procedures indicated no other clients were affected by this deficient practice. **PREVENTION:** The QIDP will be trained on the need to obtain written informed consent prior to the implementation of rights restrictions. Members of the Human Rights committee will assure guardian approval is in place prior to approving rights restrictions. Members of the Operations Team will conduct periodic reviews to assure that all programs are incorporated into clients' plans and that due process occurs. These reviews will occur no less than quarterly. **RESPONSIBLE PARTIES:** QIDP, Direct Support Staff, Operations Team	03/26/2014

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	written informed consent in regard to the client's radio being locked up. The facility's Human Rights Committee/HRC minutes were reviewed on 2/20/14 at 11:45 AM. The facility's 12/17/13 HRC notes indicated the HRC committee reviewed and approved the locking of client #2's radio in the client's bedroom. Interview with staff #5 on 2/19/14 at 12:53 PM stated "He has gone through 8 radios. He throws and destroys them." Staff #5 indicated client #2's mother would buy client #2 another radio each time the client became upset and broke his radio. Staff #1 indicated the facility's maintenance department built the cabinet for client #2's radio so he would not continue to destroy it. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 2/20/14 at 3:05 PM indicated the locking of client #2's radio should be part of the client's behavior plan. The QIDP indicated the facility's HRC approved the rights restriction on 12/17/13. The QIDP indicated he still needed to obtain written informed consent from client #2's guardian. 9-3-2(a)			

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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 on interview and record review for 2 of 2 sampled clients (#1 and #2) and for 2 additional clients (#3 and #4), the facility failed to maintain a complete accounting of the clients' funds kept by the facility. Findings include: 1. Client #1's financial records were reviewed on 2/19/14 at 10:10 AM. Client #1's savings account ledger indicated client #1 withdrew $50.00 from his account on 9/11/13 and then withdrew $500.00 on 9/12/13. Client #1's financial records indicated the facility did not have any receipts for the 9/11/13 and 9/12/13 withdrawals. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 2/19/14 at 10:17 AM indicated he could not locate any receipts for the 9/11 and 9/12/13 withdrawals. The QIDP indicated client #1 had a savings account only. The QIDP indicated he was not at the group at that time (9/13). The QIDP indicated the group home did not have a	W000140	**CORRECTION:** *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.* Specifically, The QIDP responsible for failing to provide receipts for purchases cited in the MRMZ11 2567 has been replaced and the current QIDP has been trained on protocols for accounting for client funds. The facility will conduct a thorough audit of all client financial records and the governing body will replace any monies that cannot be accounted for with receipts. For Clients #1, #2, #3 and #4, the QIDP will maintain an up to date ledger to track purchases for all clients including a sign-out log for money to be spent at day service and workshops. All staff will assure that clients provide receipts for purchases as appropriate and the QIDP will maintain copies of receipts for purchases recorded on the ledgers. **PREVENTION:**	03/26/2014

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	system in place to account for the client's expenses and deposits. The QIDP indicated he was in the process of training staff how to do the clients' finances and documentation. 2. Client #2's financial records were reviewed on 2/19/14 at 10:10 AM. Client #2's financial records indicated the client had a savings account. Client #2's savings account ledger indicated client #2 withdrew $50.00 on 9/6/13 from his account. The client's financial records indicated the facility could not account for $43.67 of the $50.00 as the facility only had a receipt for $6.33. Client #2's savings account ledger indicated client #2 withdrew $30.00 on 9/20/13. Client #2's financial records indicated the client had a receipt for $1.09 and a receipt for $3.07. The facility could not account for $25.84 of the withdrawal made on 9/20/13. Interview with the QIDP on 2/19/14 at 10:25 AM indicated he could not locate any additional receipts for the above mentioned purchases. The QIDP indicated client #2 had a savings account only. The QIDP indicated he was not at the group at that time (9/13). The QIDP indicated the group home did not have a system in place to account for the client's expenses and deposits. The		The QIDP will maintain responsibility for maintaining client financial records and will update these records no less than weekly. All staff will be retrained regarding the need to assist clients with budgeting and collecting receipts. The QIDP will turn in client financial records to the Business Manager no less than monthly for review and filing. Additionally, members of the Operations Team will include audits of client finances as part of an ongoing facility audit process. **RESPONSIBLE PARTIES:** QIDP, Direct Support Staff, Operations Team	

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	QIDP indicated he was in the process of training staff how to do the clients' finances and documentation. 3. Client #3's financial records were reviewed on 2/19/14 at 10:10 AM. Client #3's financial records indicated the client had a savings account. Client #3's financial records indicated client #3 withdrew $420.00 on 2/20/13. Review of client #3's 2/2013 receipt folder indicated the client did not have any receipts for that month located in the folder. Interview with the QIDP on 2/19/14 at 10:30 AM indicated he was not sure why there were no receipts in the client's 2/13 financial folder. The QIDP indicated he was not at the group at that time (2/13). The QIDP indicated the group home did not have a system in place to account for the client's expenses and deposits. The QIDP indicated he was in the process of training staff how to do the clients' finances and documentation. 4. Client #4's financial records were reviewed on 2/19/14 at 10:10 AM. Client #4's financial records indicated the client had a checking and a savings account. Client #4's financial records indicated client #4 did not have a ledger			

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	for his checking account which indicated the amount of funds the client had in the account. Client #4's savings account indicated the client withdrew $240.00 on 11/27/13. Client #4's financial records indicated client #4 had no receipts for the $240.00 withdrawal. Client #4's financial records indicated client #4 withdrew $112.00 on 12/18/13. Client #4's financial records indicated client #4 had a receipt for $17.04. The facility could not account for $94.96 of the $112.00 withdrawn on 12/18/13. Interview with the QIDP on 12/19/14 at 10:35 AM indicated he just learned on 12/18/13 that client #4 had a checking account. The QIDP indicated he was in the process of conducting an investigation in regard to client #4's finances and checking account. The QIDP stated a facility staff assisted client #4 to set up the checking account so the client could "order stuff online." The QIDP indicated he went to the bank to get a print out of the amount of money in the account. The QIDP indicated the staff who helped the client set up the account no longer worked at the facility. The QIDP indicated he had learned client #4 had another checking account prior to this one, but it was closed when he did not have enough money in it to order something. The			

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	QIDP indicated the checking account was opened on 12/31/13 with a balance of $74.72. The QIDP indicated client #4 had $58.72 in the account as of 2/17/14. The QIDP indicated the group home did not have a system in place to account for the client's expenses and deposits. The QIDP indicated he was in the process of training staff how to do the clients' finances and documentation. 9-3-2(a)			
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 interview and record review for 1 of 11 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to report an allegation of staff to client abuse immediately to the administrator and/or to state officials (Bureau of Developmental Disabilities Services and/or Adult Protective Services). Findings include:	W000153	**CORRECTION:** *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.* Specifically, The QIDP who failed to report the allegations of abuse on 3/6/14 no longer works for the company. Additionally, the facility has retrained all staff on the need to report allegations immediately.	03/26/2014

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	The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 2/19/14 at 11:47 AM. The facility's 4/25/13 reportable incident report indicated "On 04/25/2013 while investigating a performance issue. ResCare Program Manager [administrative staff #2], received a report from a staff that kellam (sic) staff [staff #2] had drug the staff and [client #3] (individual supported by Rescare) onto the group home couch and also yelled at [client #3] during a two person hold. Staff [staff #2] has been suspended pending an investigation of abuse and neglect." The facility's 5/3/13 investigation indicated an initial allegation of abuse was reported to Qualified Intellectual Disabilities Professional (QIDP) #2 on 3/6/13 at 3:00 PM. The facility's investigation indicated QIDP #2 did not immediately report the allegation of abuse to the administrator and/or to other state officials on 3/6/13. The facility's investigation indicated QIDP #3 initiated an investigation and did not substantiate the allegation. The facility's investigation indicated "...Conclusion:...6. The evidence substantiates that [QIDP #2] failed to follow established reporting protocols for allegations of abuse and neglect at		Since the inservice no further late reporting has occurred. **PREVENTION:** Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor responsible for Quality Assurance, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation, the governing body will administer written corrective action up to and including termination of employment. **RESPONSIBLE PARTIES:** QIDP, Direct Support Staff, Operations Team	

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	15209 (sic) Kellam...." The facility's investigation indicated QIDP #2 did not report the allegation of abuse immediately to the administrator and/or to the Bureau of Developmental Disabilities Services within 24 hours as required. Interview with the QIDP on 2/20/14 at 3:05 PM indicated he took QIDP #2's place in 12/13. The QIDP did not know why QIDP #2 did not report the allegation of abuse immediately to the administrator and/or to other state officials on 3/6/13. 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 interview and record review for 2 of 11 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct a thorough investigation in regard to client to client abuse/aggression and failed to investigate an injuries of unknown source involving clients #2 and #3. Findings include: The facility's reportable incident reports,	W000154	**CORRECTION:** *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically, QIDP has been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed and all relevant documents reviewed and that investigations need to be completed within five business days of discovery of the allegations.	03/26/2014

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	internal incident reports and/or investigations were reviewed on 2/19/14 at 11:47 AM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following (not all inclusive): -11/17/13 "Another client (client #3) was having a behavior and slapped [client #2] with his hands, scratching him on his right cheek." The reportable incident report indicated "...His housemate's aggression was not aimed directly at [client #2]. He just happened to be in the area...." The 11/17/13 reportable incident report did not indicate any documentation a thorough investigation was conducted. -11/2/13 "While dressing client (#3) for bed staff discovered 4-5 small red marks looking like bug bites on client's left foot and lower left leg." The 11/2/13 incident report did not indicate any additional information and/or investigation was conducted. -11/3/13 "Upon doing nightly body assessment 4 small pea sized circular areas on top of upper (L) (left) thigh/leg were discovered (client #3)." The 11/3/13 incident report did not indicate any additional information and/or investigation was conducted.		**PREVENTION:** The QIDP will turn in copies of completed investigations to the Clinical Supervisor responsible for Quality Assurance to allow for appropriate oversight and follow-up. The Clinical Supervisor will follow-up with the QIDP as needed but no less than weekly to review incident documentation and completed investigations to assure they have been completed thoroughly. Additionally, the governing body will submit a request to the Indiana State Department of Health for an inservice presentation to all agency professional staff regarding the components of a through investigation. **RESPONSIBLE PARTIES:** QIDP, Direct Support Staff, Operations Team	

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	Interview with administrative staff #1 on 2/20/14 at 12:30 PM, by phone, indicated the Qualified Intellectual Disabilities Professional (QIDP) would have the investigations for any client to client aggression/abuse and injuries of unknown source incidents. Interview with the QIDP on 2/20/14 at 3:05 PM indicated he was not the QIDP at the time of the above incidents. The QIDP indicated he could not locate any additional information and/or investigation in regard to the above mentioned incidents for clients #2 and #3. 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 2 of 11 allegations of abuse and/or neglect reviewed for client #3, the facility failed to put in place corrective measures to ensure the protection of the client in regards to an alleged incident involving a parent, and failed to ensure facility staff were retrained in regard to reporting allegations of abuse as recommended. Findings include:	W000157	**CORRECTION:** *If the alleged violation is verified, appropriate corrective action must be taken.* Specifically, Client #3' Behavior Support Plan will be revised to incorporate strategies to keep Client #3 and others safe when visitors are present in the house. All staff will be trained toward proper implementation of the plan. **PREVENTION:** The QIDP will bring all relevant elements of the interdisciplinary	03/26/2014

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	The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 2/19/14 at 11:47 AM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following: -12/21/13 "On 12/21/13, at 1:30 PM, [Staff #8] called the Qualified Intellectual Disabilities Professional) (QIDP) and reported that he had observed [name of parent] (Step father of [client #3]/alleged perpetrator) grab [client #3] (Individual supported by ResCare/alleged victim) by the throat after [client #3] had pulled on [name of parent's] shirt...." The facility's 12/24/13 investigation indicated "Conclusion: 1. The evidence substantiates that [name of step father] (Step father of [client #3]/alleged perpetrator) grabbed [client #3] (individual supported by ResCare/alleged victim) by the throat on the afternoon of 12/21/13. By his own admission, [name of step father] intervened in [client #3's] behavior by grabbing his throat and holding his mouth.		team together after serious incidents including but not limited to elopement to review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes and plan revisions to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action. **RESPONSIBLE PARTIES:** QIDP, Direct Support Staff, Behavior Therapist, Operations Team	

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	2. The evidence does not substantiate that the actions of [name of step father] (Step father of [client #3]/alleged perpetrator resulted in [client #3] (individual supported by ResCare/alleged victim) experiencing injury on the afternoon of 12/21/13. Specifically, a physical assessment performed after the incident did not reveal any physical injury. 3. The evidence substantiates that the actions of [name of step father] (Step father of [client #3]/alleged perpetrator resulted in [client #3] (individual supported by ResCare/alleged victim) experiencing mental anguish on the afternoon of 12/21/13. Specifically. (sic) [client #3] remained agitated for over 24 hours after the incident and required the use of manual restraint four times." The 12/24/13 investigation did not indicate any corrective actions/measures were put in place to ensure the protection/safety of client #3. -4/25/13 "On 04/25/2013 while investigating a performance issue. ResCare Program Manager [administrative staff #2], received a report from a staff that kellam (sic) staff [staff #2] had drug the staff and [client #3] (individual supported by Rescare) onto the group home couch and also			

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	yelled at [client #3] during a two person hold. Staff [staff #2] has been suspended pending an investigation of abuse and neglect." The facility's 5/3/13 investigation indicated an initial allegation of abuse was reported to Qualified Intellectual Disabilities Professional (QIDP) #2 on 3/6/13 at 3:00 PM. The facility's investigation indicated "...Conclusion:...1. The evidence does not substantiate that [staff #2]...dragged [client #3] (individual supported by ResCare/alleged victim) through his living room on the afternoon of 3/2/13. 2. The evidence dies (sic) not substantiate that [staff #2]...spoke to [client #3] (individual supported by ResCare/alleged victim) in a loud and disrespectful manner on the afternoon of 3/2/13. 3. The evidence substantiates that [staff #9]...engaged in a pattern of verbally aggressive behavior with [client #3] (individual supported by ResCare/alleged victim). 4. The evidence does not substantiate that [staff #9]...engaged in a pattern pf physically aggressive behavior with [client #3] (individual supported by ResCare/alleged victim). 5. The evidence does not substantiate that [QIDP #2] failed to address allegations of abuse at 15109 (sic) Kellam. 6. The			

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	evidence substantiates that [QIDP #2] failed to follow established reporting protocols for allegations of abuse and neglect at 15209 (sic) Kellam...." The facility's investigation indicated QIDP #2 did not report the allegation of abuse immediately to the administrator and/or to the Bureau of Developmental Disabilities Services within 24 hours as required. The facility's 5/3/13 Investigation of Peer Review indicated a recommendation to "...Retrain all staff on specific reporting responsibilities." Interview with the QIDP on 2/20/14 at 3:05 PM indicated he did not know if facility staff had been retrained on reporting, as recommended, as he did not start working at the group home until 12/13. 9-3-2(a)			
W000227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 of 2 sampled clients	W000227	**CORRECTION:** *The individual program plan states the specific objectives necessary to meet the*	03/26/2014

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	(#2), the client's Individual Support Plan (ISP) failed to address the client's identified vocational/alternate programming needs. Findings include: During the 2/19/14 observation period between 5:50 AM and 10:02 AM, at the group home, client #2 did not attend a day program. Client #2 walked around the group home, interacted with staff and obsessed over money and going to buy snacks. Client #2 was not encouraged and/or prompted to go to the day program. Client #2's record was reviewed on 2/20/14 at 1:51 PM. Client #2's 12/23/13 active treatment schedule indicated client #2 attended a local day program between 9:00 AM and 12:30 PM. Client #2's 10/20/13 workshop Case Conference indicated client #2's interdisciplinary team (IDT) met to discuss client #2's returning to the workshop Monday through Friday from 2:30 PM to 3:30 PM with staffing. The IDT case note indicated "...[client #2] is doing better with behaviors but will still have difficulties with focusing on task...Begin Nov (November) 11th. IDT		*client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.* Specifically, the team will revise Client #2's Active Treatment Schedule to include meaningful training activities during the day when Client #2 does not attend outside day services. All staff will be trained toward proper implementation of the revised active treatment strategies. **ADDENDUM:** A review of support documents revealed deficiencies in Client #1, #3 and #4's Active Treatment schedules. The QIDP has revised all clients' Active Treatment Schedules to reflect current support needs. **PREVENTION:** The agency will retrain QIDP and regarding the need to develop necessary supports and measureable objectives to support clients toward independence. **ADDENDUM:** Members of the Operations Team will incorporate audits of support documents into weekly visits to the facility for the next 30 days, no less than twice monthly visits for an additional 60 days and after three months, no less than monthly to assure appropriate supports are included in each client's support plan. **RESPONSIBLE PARTIES:** QIDP, Direct Support Staff, Behavior Therapist, Operations Team	

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	to discuss progress on 11-27-13 2 PM." Client #2's record, IDT note and 12/24/13 ISP did not indicate the client's IDT met to address the client's vocational training needs and/or put in place alternate programming/training for client #2. Interview with staff #5 on 2/19/14 at 1:53 PM indicated client #2 did not attend a day program. Staff #5 indicated client #5 would refuse to get out of the van. Staff #5 stated client #2 would start to "bang on the windows" and have a behavior when he got to the workshop. Interview with the Qualified Intellectual Disabilities Professional (QIDP) indicated client #2 would refuse to go to the workshop. The QIDP indicated client #2 would have a behavior when they took him to the workshop. The QIDP indicated client #2 was only attending work for an hour a day. The QIDP indicated client #2 could return to the workshop if he wanted to. The QIDP indicated client #2's active treatment schedule still indicated client #2 was to attend the workshop. The QIDP indicated he would need to revise client #2's active treatment schedule. When asked if client #2 had alternate programming/training in place for the			

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	client's vocational needs, QIDP stated "No." 9-3-4(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, interview and record review for 1 of 2 sampled clients (#1), the facility failed to implement the client's Individual Support Plan (ISP) objectives and/or behavior plan as written when formal and/or informal training opportunities existed. Findings include: During the 2/18/14 observation period between 4:40 PM and 6:50 PM, client #1 sat in the living room without an activity/training, sat with a flashlight on a string around his neck, and/or watched TV without redirection to participate in a more meaningful activity except to carry his plate to the table and to get his medication.	W000249	**CORRECTION:** *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.* Specifically, all direct support staff will be retrained regarding the need to provide consistent and continuous active treatment for Client #1, including at intervals in which Client #1 is unwilling to participate. Additionally the team will modify Client #1's active treatment schedule to include additional activities in which Client #1 may be willing to participate.	03/26/2014

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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
	During the 2/19/14 observation period between 5:50 AM and 10:02 AM, client #1 lay in a lounge chair in his bedroom, sat in the living room drinking water and/or tea, sat without an activity or training except to play with some play dough, to name his medications and to put on a clean shirt. Client #1 did not participate in any type of day program and/or training during this time. Client #1's bedroom had clothes and items on the bed and/or floor. Client #1's bedroom also had an odor. During the above 2/18/14 and 2/19/14 observation periods, client #1 did not have an aquarium/fish in his bedroom. Client #1's record was reviewed on 2/20/14 at 11:58 AM. Client #1's 12/23/13 ISP indicated client #1 had objectives to plan an activity in the community, to make his bed and pick things up off the floor of his bedroom every morning after getting out of bed with staff assistance, to assist with cooking one meal a day and to clean up after at least one meal a day. The objectives were not implemented when formal and/or informal opportunities of training existed. Client #1's undated Active Treatment Schedule indicated activities between		**PREVENTION:** The QIDP will be expected to observe no less than two morning and two evening active treatment sessions per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff provide continuous active treatment at both formal and informal opportunities. Additionally, members of the Operations Team will conduct active treatment observations no less than twice monthly for the next 90 days and after two months, no less than monthly to assure staff provide continuous active treatment at both formal and informal opportunities per the individual support plan. **RESPONSIBLE PARTIES:** QIDP, Direct Support Staff, Health Services Team, Behavior Therapist, Operations Team	

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	the following times that were not implemented: -To participate in painting on Tuesday between 4:30 PM and 5:00 PM. -To prep for dinner meal and eat meal on Tuesdays between 5:00 PM and 6:00 PM. -To clean his bedroom between 7:00 AM and 8:00 AM. -To participate in feeding fish and cleaning aquarium on Wednesdays between 9:00 AM and 10:00 AM. Client #1's 10/14/13 Behavior Support Plan (BSP) indicated facility staff were to "...Encourage [client #1] to play a role in the scheduling of his day as well as to make as many choices through his day as possible...Encourage [client #1] to participate in group activities...." Interview with the Qualified Intellectual Disabilities Professional (QIDP) indicated client #1 did not attend day program. The QIDP indicated client #1 would refuse to participate in most training and/or activities. The QIDP indicated client #1's active treatment schedule would need to be revised. Interview with nurse #1 on 2/20/14 at 3:58 PM, by phone, stated "He refuses everything; prompting."			

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	9-3-4(a)			
W000257	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 for 1 of 2 sampled clients (#1), the Qualified Intellectual Disabilities Professional (QIDP) failed to revise the client's behavior plan/Individual Support Plan (ISP) objective in regard to the client's refusal to bathe as the client had not made progress over time. Findings include: During the 2/19/14 observation period between 5:50 AM and 10:02 AM, at the group home at 6:20 AM, client #1 came to the office area to get his morning medications. Client #1's hair was greasy in appearance, his beard was unkempt and client #1 had a body odor. Client #1 had the same clothes on he wore on 2/18/14. Client #1 was barefoot. Client #1's toenails were long and soiled. After client #1 got his medication, staff #5 asked client #1 if he would change his	W000257	**CORRECTION:** 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. Specifically, the interdisciplinary team will modify Client #1's program with regard to additional strategies to encourage bathing/showering. **PREVENTION:** Facility professional staff will be expected to observe no less than two morning and two evening active treatment sessions per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff actively encourage clients to attend to their personal hygiene in a manner consistent with Clients individual support plan strategies. Additionally, members of the Operations Team will conduct active treatment	03/26/2014

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	shirt as it looked wet. Staff #5 asked client #1 if he would take a bath and client #1 shook his head (indicating no). Staff #1 asked if the client would use a wet wipe to wash his body. Client #1 wiped his face and his arms only. Client #1 refused to wash his legs with the wet wipe. Client #1 went into his bedroom, changed his shirt and sat in the living room. Each time client #1 would move and/or get up, client #1 left an odor. During the above mentioned observation period, client #1's bedroom also had an odor in it. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 2/19/14 at 11:47 AM. The facility's reportable incident reports, internal incident reports and/or investigations indicated on 8/26/13 client #1 refused to go get his labs (laboratory tests for Clozaril -antipsychotic medication) done at a local hospital. The incident report indicated client #1 refused for 3 hours and became verbally aggressive with staff. The incident report indicated the staff called the police per the client's behavior plan. The incident report indicated a deputy sheriff came and reminded the client he would need to get his labs done. The report indicated "... [Client #1] cursed and called names and		observations on a twice monthly basis for the next 60 days and after two months, no less than monthly to assure that clients receive appropriate training toward maintaining personal hygiene. **RESPONSIBLE PARTIES:** QIDP, Direct Support Staff, Behavior Therapist, Operations Team	

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	got up and the sheriff asked [client #1] to shower and after 5 minutes of arguing, [client #1] showered and put on all clean clothes...." Client #1's record was reviewed on 2/20/14 at 11:58 AM. Client #1's Daily Progress Notes from 1/14 to the present indicated client #1 refused to bathe or shower. Client #1's 1/31/14 Record Of Visit (ROV) form indicated client #1 had an area on his abdomen. The ROV indicated client #1 was diagnosed with "Seborrhea Dermatitis" (inflammatory skin disorder). The ROV indicated a cream was ordered to be applied to the area. Client #1's 2/17/14 Nurse's note indicated "Observed area on and. (abdomen). Area healed. No redness or rash noted. Appears to have some skin flaking around belt area on and. Client's last shower approx. Oct. (October) 13...." Client #1's 12/1013 physician's order indicated "Client to bathe at east once a week due to poor hygiene and health concerns." Client #1's 12/23/13 Individual Support			

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	Plan (ISP) indicated "[Client #1] continues to have times where he will go days without showers, shaving, and other hygiene routines. When staff tries to prompt him to take a shower, he will either say that he will do it later or he will refuse. He will also wear the same clothes without changing them, but he will change when staff prompts him part of the time...When asked about not taking showers, [client #1] has said that 'He has put several explosive devices inside his body and if they get wet, then he will blow up.' [Client #1] has a history of going several days and even months without combing his hair, taking showers, changing his clothes, and other hygiene routines. [Client #1] has had several times in the past where he has gone long periods of time without completing any daily hygiene tasks even after being prompted by his staff. This has been an issue in the past, and continues to be an issue currently." Client #1's 12/23/13 ISP indicated client #1 had an objective to "...wash his head, face, arms, and legs everyday with a wash cloth provided by staff...by 11/1/13." Client #1's 2/14 data indicated client #1 refused to use a wash cloth 17 out of 19 days. Client #1's 11/13/13 Interdisciplinary Team (IDT) Meeting note indicated			

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	"The team discussed his many refusals to conduct daily hygiene. The team feels that the Doctor's ordered (sic) should be followed and staff should encourage [client #1] to bathe daily...The [name of town police] police is also willing to make welfare checks to encourage him to have good hygiene." Client #1's 10/14/13 Behavior Support Plan (BSP) indicated client #1 had a targeted behavior of "Non-compliance: health and safety issues (...hygiene, medical): this included ...refusing to take a bath/shower weekly (per doctor's order) or do other daily hygiene daily (bath wipes, brush teeth, change clothes/underwear etc.)...." The BSP indicated "[Client #1] will exhibit no more than 8 episodes of non-compliance: health and safety issues per month across 12 consecutive months by 11/27//2013 (sic)...." Client #1's 11/13/13 IDT note, 12/23/13 ISP and/or 10/14/13 BSP indicated the QIDP failed to revise the client's program in regard to bathing/showering as client #1 had not had a bath/shower since at least 10/13. Interview with staff #3 on 2/19/14 at 1:40 PM stated "I have been here since March only. He has bathed one time. He will wear same clothes for days and weeks." Staff #3 indicated they had wet			

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	wipes for client #1 to use but he would often refuse to use them. Staff #3 indicated client #1 had an odor. Interview with staff #5 on 2/19/14 at 1:53 PM indicated client #1 last had a bath on 8/26/13 when the client went to get a lab done for Clozaril and the police had to come to the house. Staff #5 indicated the officer asked client #1 to shower before going to get the lab. Staff #5 indicated client #1 would not wash his private area and/or change his pants but she could get client #1 to change his shirt, wash his face, hands and arms with the wet ones/cloths. Interview with QIDP #1 on 2/20/14 at 3:05 PM indicated client #1 would refuse to bathe and/or take a shower. When asked if client #1's BSP and/or ISP had been revised, QIDP #1 indicated client #1's BSP and/or ISP objective needed to be revised. Interview with nurse #1 on 2/20/14 at 3:58 PM, by phone, indicated client #1 would refuse to bathe. Nurse staff #1 indicated client #1 had a history of not bathing/showering for long periods of time. When asked if client #1's recent skin condition was from lack of bathing, nurse #1 indicated client #1's doctor could not state if the area was or was not			

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	due to the client's not bathing/showering. Nurse #1 indicated client #1 would take a bath for the local policemen. 9-3-4(a)			
W000263	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. Based on interview and record review for 1 of 2 sampled clients (#2), with restrictive programs, the facility failed to ensure the client's legally appointed guardian gave written consent for the client's medication changes/restrictive program. Findings include: Client #2's record was reviewed on 2/20/14 at 1:51 PM. Client #2's 10/18/13 Behavior Support Plan (BSP) indicated the facility could utilize You're Safe, I'm Safe (physical intervention techniques) and call 911 when client #2 demonstrated behaviors of threatening to harm others, would leave assigned areas and/or demonstrate physical aggression.	W000263	**CORRECTION:** *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.* Specifically, the interdisciplinary team will obtain guardian approval for all of Client #2's behavior controlling medications and other restrictive programs. **ADDENDUM:** A review of Client #1, #3 and #4's restrictive programs indicated prior written informed consent was obtained as required.**PREVENTION:** The QIDP will be retrained regarding the need to confirm that members of the Human Rights committee have assured guardian approval is in place prior to approving rights restrictions. Members of the Operations Team will conduct periodic reviews to assure that all programs are incorporated into	03/26/2014

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	Client #2's BSP indicated client #2 received the following medications: -Haldol for Paranoid Schizophrenia -Seroquel XR (extended release) for Paranoid Schizophrenia -Topamax for Paranoid Schizophrenia -Ativan Paranoid Schizophrenia -Lithium Carbonate for Paranoid Schizophrenia -Lexapro for Depression Client #2's HRC (Human Rights Committee) Conference Calling form (dated as below)indicated the following medication changes: -12/20/13 Seroquel was increased to 800 milligrams (mg) two times a day. -10/18/13 Seroquel increased from 1000 mg to 1200 mg a day and Ativan was increased from 2 mg daily to 3 mg daily. -7/18/13 Topamax and Lexapro were started and Haldol was increased from 10 mg to 14 mg. -6/11/13 Haldol was increased from 3 mg to 10 mg. The form indicated client #2's guardian gave verbal approval for the increase. -4/15/13 Seroquel increased from 800 mg to 1000 mg a day. Client #2's Topamax was increased from 200 mg to 300 mg daily. Client #2's record and/or BSP did not indicate client #2's		clients' plans and that due process occurs. These reviews will occur no less than quarterly. **RESPONSIBLE PARTIES:** QIDP, Human Rights Commitee, Operations Team	

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	guardian/mother gave written informed consent for the client's restrictive programs and/or medication changes. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 2/20/14 at 3:05 PM indicated he still needed to send out the consent form to client #2's guardian for the guardian to sign. The QIDP indicated client #2's guardian gave verbal consent, but not written informed consent. 9-6-4(a)			
W000268	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, interview and record review for 1 of 2 sampled clients (#2) and for 1 additional client (#3), the facility to ensure the clients dignity in regards to wearing clothing protectors/adult bibs. Findings include: During the 2/18/14 observation period between 4:40 PM and 6:50 PM, at the	W000268	**CORRECTION:** These policies and procedures must promote the growth, development and independence of the client. Specifically, the facility will no longer insist that Client #2 and Client #3 wear adult bibs/protective clothing during meals. Staff have been retrained on the need to participate in family style dining, supervising clients closely, teaching appropriate social amenities and assuring that recommended	03/26/2014

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	group home, staff #1 placed a long clothing protector/bib around client #2 and #3's neck after the clients sat down at 2 different dining room tables. Staff #1 then placed the bottom of the client's clothing protectors up on the table and sat the clients' plates on top of the clothing protectors. Clients #2 and #3 ate their dinner meal without redirection and/or training in regard to food spillage. Once the clients' were done, the staff removed the clothing protectors from the table and from around the clients. The QIDP (Qualified Intellectual Disabilities Professional) and staff #1, #2 did not encourage the adult male clients (#2 and #3) to eat in a more dignified manner. During the 2/19/14 observation period between 5:50 AM and 10:02 AM, at the group home, client #2 wore the long adult clothing protector when he ate his breakfast meal. Client #2's clothing protector was placed on top of the table with the client's bowl of cereal sitting on top of the clothing protector. Client #2 did not have an spillage on the clothing protector. Client #2's record was reviewed on 2/20/14 at 1:51 PM. Client #2's 12/24/13 Individual Support Plan (ISP) did not indicate client #2 was in need of		adaptive dining equipment is available and in use. **PREVENTION:** Facility professional staff will be expected to observe no less than two morning and two evening active treatment sessions per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff encourage clients to wear clothing that supports personal dignity. Additionally, members of the Operations Team will conduct active treatment observations on a twice monthly basis for the next 60 days and after two months, no less than monthly to assure that clients receive appropriate mealtime training in a dignified manner. **RESPONSIBLE PARTIES:** QIDP, Direct Support Staff, Operations Team	

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	and/or required the use of a clothing protector. Client #2's ISP did not indicate client #2 was provided training in regard to food spillage. Client #3's record was reviewed on 2/20/14 at 2:33 PM. Client #3's 11/15/13 ISP did not indicate client #3 required the use of/need for a clothing protector/bib. Client #3's ISP did not indicate client #3 was provided training in regard to food spillage. Interview with staff #3 on 2/19/14 at 1:40 PM indicated clients #2 and #3 wore clothing protectors. Staff #3 stated "They drop 25% of meal onto clothing. They wear to prevent stains. When asked why the client's clothing protectors were placed on top of the table and then the clients' dishes on top of the clothing protectors, staff #3 indicated to prevent spillage of food onto the clients' laps. Interview with the QIDP on 2/20/14 at 3:05 PM indicated the QIDP had questioned staff in regard to whi clients #2 and #3 wore the long clothing protectors. QIDP stated he was told the clients wore the clothing porotectors due to the "messes they make." The QIDP indicated clients #2 and #3 did not look like adult men eating their meals.			

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W000289	9-3-5(a) 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, interview and record review for 1 additional client (#3), the facility failed to ensure the facility incorporated a behavior management technique of removing objects from the client, into his behavior plan. Findings include: During the 2/19/14 observation period between 5:50 AM and 10:02 AM, at the group home client #3 carried around a jumping rope with plastic handles at the ends of the rope. At 9:05 AM, client #3 became upset with staff #4. Client #3 swung the jumping rope and hit staff #4 in the back of her legs with it. Client #3 started spitting at staff #4 and kicking at the staff. After which, client #1 hit staff #4 with the jumping rope again. Staff #4 reached out to hold client #4's hand and stated to client #3: "We can't use as a weapon. I will have to put in office if you keep on."	W000289	**CORRECTION:** *The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan.* Through ongoing assessment, the interdisciplinary team consensually agrees that although the criteria for removal of potentially harmful objects in Client #3's Behavior Support Plan is functional and appropriate as written, staff have not been following the protocols in the plan. Specifically, the team agrees that justification for securing Client #3's jump rope or other objects does not currently exist. Therefore staff have been retrained toward proper implementation of Client #3's plan with emphasis on moving potentially harmful objects out of Client #3's reach during episodes of aggressive behavior. **PREVENTION:** The QIDP will be expected to observe no less than two morning and two evening active treatment sessions per week to assess	03/26/2014

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	The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 2/19/14 at 11:47 AM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following: -2/6/14 "[Client #3] was sitting at kitchen table drinking a pop, got up and turned kitchen table over and chairs. Redirected to living room in his chair. [Client #3] got there for a minute, got up and tried hitting staff with his jumprope (sic). Jumprope (sic) removed and kept in med-room...." -1/10/14 "[Client #3] went into the kitchen while staff was making him a glass of juice-he asked for a soda. Staff told him 'No'- he took his juice cup & (and) threw it -then hit staff on the leg with his jump rope- staff took jump rope from [client #3] & told him he would get it back later-...." -10/31/13 "[Client #3] has a diagnosis of dementia in which he becomes confused or disoriented. [Client #3] became disoriented while he was eating his supper and he threw his plate. When asked to leave the dining room until he could act appropriately, he charged at		direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff implement behavior supports as written. Additionally, members of the Operations Team will conduct active treatment observations no less than twice monthly for the next 90 days and after two months, no less than monthly to assure staff follow behavior support plans as written and do not support unapproved and unnecessary rights restrictions. **RESPONSIBLE PARTIES:** QIDP, Direct Support Staff, Behavior Therapist, Operations Team	

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	staff attempting to hit staff with his jumprope (sic). Staff temporarily confiscated his jumprope (sic) because he was using his jumprope (sic) as a weapon...." -2/13/13 Staff reported client #3 started to have a behavior in tearing down a curtain rod and knocking over furniture. The 2/13/13 investigative report indicated "...[Staff #6] said that she observed [staff #7]...forcefully push [client #3] onto his bed and speak to him in a taunting and disrespectful manner." The investigation indicated "...[Staff #6] said that [client #3] began throwing shoes and hangers out into the living room. She said [staff #7] said 'Ha, ha. Now I've got your shoes. Now I've got your jump rope etc' throughout [client #3's] behavioral episode...." Client #3's record was reviewed on 2/20/14 at 2:33 PM. Client #3's 11/5/13 Behavior Support Plan (BSP) indicated client #3 would demonstrate physical aggression which included hitting others with objects and/or a jumping rope which has "...the potential to cause injury." Client #3's preventative procedures indicated "...Staff should be alert and remove all non-essential objects from [client #3's] reach. Staff should also be prepared to block [client			

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	#3's] actions and move out of his way while insuring the area is safe for [client #3] and others in the environment...." Client #3's 11/5/13 BSP reactive procedures did not indicate facility staff should remove objects/personal objects from client #3 when he used the object as a weapon. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 2/20/14 at 3:05 PM indicated facility staff were to remove client #3's jumping rope when he used the item as a weapon to hit others. When asked if removing the items/jumping rope was a part of the client's behavior plan, the QIDP stated "I thought it was." 9-3-5(a)			
W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 1 of 2 sampled clients (#1), the facility's nursing services failed to develop a risk plan for the client's pneumonia. Findings include: During the 2/18/14 observation period between 4:40 PM and 6:50 PM and the	W000331	**CORRECTION:** *The facility must provide clients with nursing services in accordance with their needs.* Specifically for Client #1, the nurse has developed a Comprehensive High Risk Plan for Pneumonia/respiratory infections and all staff have been trained toward proper implementation of the plan.	03/26/2014

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	2/19/14 observation period between 5:50 AM and 10:02 AM, at the group home, client #1 had a dry (deep) non-productive cough. During the 2/19/14 morning medication pass, client #1 was asked if he wanted to take his cough syrup and client #1 shook his head (indicating no). Client #1's record was reviewed on 2/20/14 at 11:58 AM. Client #1's 2/11/14 Record Of Visit form indicated client #1 went to see his doctor for "Cough." The 2/11/14 form indicated "Crackles (R) (right) lung Base Expiratory Wheeze." The 2/11/14 form indicated "Diagnosis: Pneumonia...Levaquin (antibiotic) 500mg (milligrams) daily #10 (number of pills for 10 days) and Cheritussin (cough syrup) AC 1 tsp (teaspoon) Q (every) 6 hr (hour) prn (as needed) 6 oz (ounces)." Client #1's Nurses Notes indicated the following (not all inclusive): -2/6/14 "...Observed rasp wet cough. appt (appointment) (with) [name of doctor] made. Client refused to take coat (sic) for nurse to listen to lungs." -2/11/14 "[Name of doctor] seen for cough and congestion. Dx (diagnosis)		**PREVENTION:** The facility nurse will be retrained regarding the need to include specific care procedures as appropriate when developing comprehensive high risk and care plans as well as the need to establish parameters for nurse notification during periods of serious illness. The Nurse Manager will review all revisions to facility nursing care plans for the next ninety days and thereafter will perform spot checks of facility nursing care plans as needed but no less than quarterly. Additionally, Operations Team members will review medical documentation while auditing active treatment sessions, no less than monthly, and make recommendations to the Health Services Team as appropriate. **RESPONSIBLE PARTIES:** QIDP, Direct Support Staff, Health Services Team, Operations Team	

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	Pneumonia. New atb (antibiotic) Levaquin 500 mg x (times) days once daily...." -2/17/14 "...Noted continued non productive wet cough. Refused to remove coat for nurse to listen to lungs. Will F/U (follow up) (with) [name of doctor] for X-ray after ATB tx (treatment) done." Client #1's 1/2/14 Pneumonia Prevention Score card indicated client #1 had a score of 19. The assessment indicated 0 to 30 points range and client #1 was a low risk for Pneumonia. Client #1's 9/25/13 risk plans and/or 12/23/13 Individual Support Plan (ISP) indicated client #1 did not have a risk plan for the client's Pneumonia. Client #1's record did not indicate what staff were to look for/monitor, when to call the nurse, how often his temperature should be monitored, and etc. until client #1 recovered from the Pneumonia. Interview with nurse #1 on 2/20/14 at 3:58 PM indicated client #1 was being treated for Pneumonia. Nurse #1 indicated client #1 still had a non productive cough. Nurse #1 indicated client #1 refused to let the nurse listen to his lung sounds. Nurse #1 indicated she			

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	had requested client #1 get a chest X-ray once his antibiotic was done. Nurse #1 stated client #1 had Pneumonia last year but it was "minimum." Nurse #1 indicated she had not yet developed a risk plan for client #1's pneumonia. Nurse staff #1 stated "Still working on that." 9-3-6(a)			