

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/19/2014
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
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W000000	<p>This visit was for the annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: December 16, 17, 18 and 19, 2014</p> <p>Facility Number: 008879 AIMS Number: 200076390 Provider Number: 15G672</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed January 5, 2015 by Dotty Walton, QIDP.</p>	W000000		
W000130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview for 1 of 3 clients in the sample (#1) and 1 additional client (#3), the facility failed to ensure the bathroom door was closed while clients #1 and #3 used the restroom and client #3 had a curtain for privacy on his bedroom window.</p> <p>Findings include:</p>	W000130	<p>In order to address this deficiency, the follow actions have been implemented: on 1/9/2015 staff purchased tint to apply to client #3's bottom portion of his bedroom window. Client #3 had no preference for window dressing. The other clients in the home expressed no preference for type of window</p>	01/21/2015

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

TITLE

(X6) DATE

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

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	<p>1) An observation was conducted at the group home on 12/16/14 from 3:00 PM to 5:07 PM. At 4:30 PM, client #3 asked the surveyor to go to his room. Client #3's bedroom window did not have a curtain. The window to his room looked out onto the driveway where staff, family and visitors parked their cars. When asked where his curtain was, client #3 pointed to his closet. There was a curtain on a shelf in his closet. Client #3's bedroom window did not have a curtain rod to hang the curtain. There was nothing in place to cover the window to ensure client #3 had privacy while in his bedroom.</p> <p>On 12/16/14 at 4:32 PM, staff #3 indicated client #3 would not leave his curtain up in his bedroom. Staff #3 indicated client #3 tore his curtain down on multiple occasions. Staff #3 indicated nothing else was tried to ensure client #3 had privacy while in his bedroom.</p> <p>On 12/17/14 at 10:21 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #3 had a curtain on his bedroom window when he started working at the home 2 months ago. The QIDP indicated client #3 needed a bedroom curtain or covering on his window for privacy.</p>		<p>covering. The clients in the home are limited in their ability to respond reliably to questions of this nature. The RPM will ensure that clients in all other group homes have either curtains or tinting in order to provide privacy. On 1/7/2015, staff for rolling hills met for an in-service training that addressed clients' right to privacy. Staff were instructed on how important it is to respect client's' right to privacy. Staff will encourage the clients to close the door whenever they are using the restroom or in their bedrooms changing clothes. Signs will be affixed to bathroom doors in order to remind staff to encourage the clients to close doors when they are using the restroom. QIDP will utilize monthly house meetings to reinforce to the staff the importance of client's rights, including privacy. The RPM will remind QIDPs during the monthly SGL meeting to remind staff of client's rights. An in-service for QIDPs was held on 1/21/2015 that further addressed clients' right to privacy.</p>				

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	<p>On 12/17/14 at 10:21 AM, the Regional Program Manager (RPM) indicated client #3 needed a curtain or something (window frosting or tint) on the window for privacy.</p> <p>2) An observation was conducted at the group home on 12/17/14 from 5:44 AM to 7:53 AM. On 12/17/14 at 5:44 AM, client #3 was sitting on the toilet in the hallway with the door open with his pants down. At 5:49 AM, client #3 was standing in the bathroom with staff #4. The bathroom door was open while client #3 was standing by the toilet with his pants down. Client #5 walked past the bathroom while the door was open. Staff #4 did not shut the door or provide assistance to client #3 to shut the door for privacy. At 6:05 AM, client #3 came out of his bedroom with no pants on. Staff #9 prompted client #3 to go to the bathroom and close the door. At 7:23 AM, client #1 went to the hallway bathroom to use the restroom. Client #1 left the door open while she used the restroom. At 7:47 AM, client #1 walked toward the hallway bathroom. Client #1 pulled down her pants prior to going into the bathroom. Client #1 used the bathroom with the door open.</p> <p>On 12/17/14 at 10:41 AM, the RPM stated the staff should provide training to</p>						

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W000137	<p>the clients to ensure their "right to privacy" when using the restroom.</p> <p>9-3-2(a)</p> <p>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 3 non-sampled clients (#3), the facility failed to ensure client #3 had the right to retain and use his personal possessions including his clothing.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/16/14 from 3:00 PM to 5:07 PM and 12/17/14 from 5:44 AM to 7:53 AM. During the observations, client #3 did not have his personal clothing in his bedroom. His bedroom closet was empty. His dresser drawers had one pair of soiled underwear and a pair of shorts. During the observations, client #3's personal clothing was stored in a spare bedroom located on the other side of the group home. At 6:58 AM, staff #3 indicated to client #3 she needed to get</p>	W000137	<p>QIDP and RPM held an in-service for staff to address client #3's right to retain his personal possessions. Staff were instructed to keep an adequate amount of clothes in his drawers and closet that he has access to. The QIDP will be present in the home on a daily basis to ensure compliance. The house lead will continue to monitor daily Client #3 and the rest of the clients in the home to ensure they are retaining the right to access their personal belongings. QIDP will utilize monthly house meetings to reinforce to the staff the importance of client's rights, including right to retain personal possessions. The RPM will remind QIDPs during the monthly SGL meeting to remind staff of client's rights.</p>	01/21/2015	

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	<p>his clothes in order for him to change his clothes.</p> <p>On 12/17/14 at 8:49 AM, a review of client #3's record indicated there was no plan or documentation indicating client #3's clothing was removed from his bedroom. Client #3's record contained no plan indicating the need for his personal clothing to be removed from his bedroom.</p> <p>On 12/17/14 at 6:50 AM, staff #3 indicated client #3's clothes were moved to the spare bedroom due to client #3 changing his clothes several times a night.</p> <p>On 12/17/14 at 10:41 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated he was unsure where client #3's clothes were. The QIDP indicated there was no plan in place to remove his clothes from his bedroom.</p> <p>On 12/17/14 at 10:41 AM, the Regional Program Manager (RPM) indicated he was not sure where client #3's clothes were. The RPM stated, when told staff #3 indicated the clothes were removed due to client #3 changing his clothes frequently, it sounded like a "staff convenience." The RPM indicated it was an unnecessary restriction.</p>			

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W000149	<p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 6 incident/investigative reports reviewed affecting clients #3 and #5, the facility neglected to implement its policies and procedures to conduct thorough investigations of incidents of choking.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/16/14 at 12:16 PM and indicated the following:</p> <p>1) On 9/23/14 at 1:45 PM at the facility-operated day program, client #5 was sitting at the table eating her snack and started to cough. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 9/23/14, indicated, in part, "...Staff asked her to slow down and make sure she chewed her food. As she started to take another bit (sic) she started to cough hard again (sic) she was choking on phlegm from</p>	W000149	<p>As of 1/8/2015, the QIDP and the RPM conducted follow up investigations of IR# 638089 and IR# 650146. RPM instructed the QIDP on when to conduct an investigation and within what time frame. The investigations were forwarded to BDDS in a follow-up. The investigation findings were forwarded to APS and the guardians of the clients. The RPM will continue to monitor incidents as they occur to help determine if an investigation should be started. When house staffs observe an instance of ANE, they will notify the QIDP within an hour. The QIDP will then suspend any staff that allegedly violated ANE standards. The QIDP will then conduct a thorough investigation and complete the investigation within 5 days of the incident. The RPM will remind QIDPs during each monthly meeting to be aware of investigation criteria. The RPM will schedule investigation training with Steve Corya for the QIDPs. An in-service for QIDPs was held on 1/21/15 regarding proper</p>	01/21/2015

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	<p>where she had been sick and started to hit her face due to it being caught in her throat and couldn't get it out. Staff raised her arm and started to pat her on the back and got her to take a drink to get it dislodged from her throat. After taking a drink she was fine...". There was no documentation an investigation was conducted.</p> <p>2) On 11/12/14 at 11:00 AM at the facility-operated day program, client #3 was eating lunch (sloppy joes, beets and cantaloupe). The BDDS incident report, dated 11/13/14, indicated client #3 took a bite of the cantaloupe and started to cough. Client #3 coughed harder and staff ran over to him. Client #3 was having trouble getting the cantaloupe up or down. Client #3's face turned red. His eyes got big and were watering. Staff got him to stand up and tried to do the Heimlich maneuver on him but nothing came up except thick phlegm. Staff took him to the doctor. The Bureau of Developmental Disabilities Services incident report, dated 11/13/14, indicated, in part, "Will continue to follow dining and health risk plans on [client #3] choking. Per risk plan [client #3] has Dysphagia and his food is to be mechanical soft with finely chopped meats and vegetables." There was no documentation an investigation was</p>		<p>investigative techniques and timelines. The RPM will follow up on all investigations to ensure that they are completed within 5 days from the initial incident.</p>				

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	<p>conducted.</p> <p>The facility's incident report, dated 11/12/14 at 11:00 AM, indicated, "Client was eating lunch and ate cantaloupe that was sent in his lunch and started choking and wouldn't cough it up. [Team Lead] did Heimlic (sic) on client. Client started coughing and continued coughing thick phelm (sic) that at times was greenish in color. Staff continued to monitor client & (and) notified Q (Qualified Intellectual Disabilities Professional) at 11:12 AM. Q stated he would tried (sic) to get ahold of staff to take client to the doctor."</p> <p>An email, dated 11/12/14 at 6:21 PM, from the Registered Nurse to the Regional Program Manager indicated, in part, "I just go (sic) off the phone with [name of nurse], who recently spoke with [staff #3]. According to [staff #3], [name of hospital] claimed there was substance detected in the lung on the x-ray they did. Upon evaluation at [name of another hospital], [name of another hospital] is stating they are not seeing substance/objects in the lung on the same x-ray viewed. (no CT (Computed Tomography) scan had been done to my knowledge at this point). The plan is of course: client admitted to [name of hospital], to be started on antibiotics and monitored. To do a Barium Swallow</p>			

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	<p>(BS) tomorrow and then if that is within normal limits and they can rule out any obstruction with the BS, they will then proceed to do a swallow study. [Name of nurse] reports that [staff #3] stated [client #3] was given some pudding by the [hospital] staff to try to see if he tolerated it, and so far, no problem. [Client #3] had been on a Mechanical soft 2 diet, prior to this incident. Apparently the client is not in any distress at this time, in fact pretty much loving all the attention he is receiving there. Now it is just 'wait and see' what the tests reveal tomorrow."</p> <p>On 12/16/14 at 3:20 PM, the Regional Program Manager (RPM) provided a Special Case Conference document, dated 11/13/14, indicating, in part, "Team met to discuss this incident. [Client #3's] Dining plan was discussed. He is on the correct diet plan. Discussed that both the group home and workshop should know his dining plan. Doctors (sic) reports didn't show any blockage in his throat. [Client #3] spent the night in hospital and was released the next day. He was able to continue to normal activities. Team decided to continue his current dining plan."</p> <p>On 12/16/14 at 2:16 PM, the Team Lead at the day program indicated client #3 choked on hard, unripened cantaloupe.</p>						

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	<p>The Team Lead indicated the cantaloupe was not cut up or chopped as it should have been. The Team Lead indicated the group home staff sent the cantaloupe in that way.</p> <p>On 12/16/14 at 12:19 PM, the RPM indicated client #3 was given cut up melon, choked, was taken to the hospital and he did not aspirate. The RPM indicated client #3 was on a modified diet prior to the incident. The RPM indicated the Day Program Manager looked into the incident and found the staff followed client #3's plan. The RPM indicated he was unsure if an investigation was conducted.</p> <p>A review of the facility's policy on conducting investigations was conducted on 12/16/14 at 1:24 PM. The facility's Protocol for Completing Investigations, dated 1/3/06, indicated, "Any event involving the potential or actual risk of harm to a client served, will be documented, reported, investigated and corrective action taken to alleviate the potential for future risk." The investigation must be initiated within 24 hours and completed within 5 working days." The policy indicated, in part, "...will be investigated immediately and thoroughly." The policy indicated, "1. Instances of suspected violations of</p>				

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	<p>rights, abuse or neglect, or inadequate protection of the health and safety of individuals served will be investigated immediately and thoroughly. Examples of inadequate protection of health and safety include but are not limited to: injuries of unknown origin, behavior incidents resulting in client/staff injuries, accidents resulting in the need of medical treatment, incidents caused by possible staff neglect and suspected criminal activity by staff or clients. The investigation must be thorough and shall include the following: a. Review of the incident reports, b. Interview with the client and or guardian and/or advocate, c. Interview of all staff involved including whenever possible.</p> <p>i. Person suspected of violation (if abuse, neglect is suspected) ii. Person (s) who witnessed the incident or discovered the concern iii. Other staff who provide services to the individual d. Interview of others having knowledge of the incident or concern.</p> <p>The policy indicated, "The investigative report should include the following information as applicable: a. Description of the concern, b. Review and summary of any documentation, c. Listing and summary of personal interviews, d. Review of agency policies, e. A summary of findings/conclusions investigation has discovered, f. Resolution/outcome, and g.</p>			

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W000154	<p>Suggestive Corrective Action to prevent further issues from reoccurring."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 2 of 6 incident/investigative reports reviewed affecting clients #3 and #5, the facility failed to conduct thorough investigations of incidents of choking.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/16/14 at 12:16 PM and indicated the following:</p> <p>1) On 9/23/14 at 1:45 PM at the facility-operated day program, client #5 was sitting at the table eating her snack and started to cough. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 9/23/14, indicated, in part, "...Staff asked her to slow down and make sure she chewed her food. As she started to take another</p>	W000154	<p>As of 1/8/2015, the QIDP and the RPM conducted follow up investigations of IR# 638089 and IR# 650146. An in-service training was held on 1/7/2015 in order to instruct staff on what dysphagia triggers are, where to find them on the client's dining plan and when to call the house nurse to report them. Staff were also instructed to follow the clients' dining plans and all instructions or prompts. Staff will continue to track dysphagia on the dysphagia tracking sheet located in the house. Staff have attended dysphagia training and the staff who need to attend will sign up for this training on 1/21/15. The QIDP will ensure that all staff are current with their first aid/ cpr classes. RPM instructed the QIDP on when to conduct an investigation for choking and within what time frame. The investigations for choking incidents were</p>	01/21/2015

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	<p>bit (sic) she started to cough hard again (sic) she was choking on phlegm from where she had been sick and started to hit her face due to it being caught in her throat and couldn't get it out. Staff raised her arm and started to pat her on the back and got her to take a drink to get it dislodged from her throat. After taking a drink she was fine...". There was no documentation an investigation was conducted.</p> <p>2) On 11/12/14 at 11:00 AM at the facility-operated day program, client #3 was eating lunch (sloppy joes, beets and cantaloupe). The BDDS incident report, dated 11/13/14, indicated client #3 took a bite of the cantaloupe and started to cough. Client #3 coughed harder and staff ran over to him. Client #3 was having trouble getting the cantaloupe up or down. Client #3's face turned red. His eyes got big and were watering. Staff got him to stand up and tried to do the Heimlich maneuver on him but nothing came up except thick phlegm. Staff took him to the doctor. The Bureau of Developmental Disabilities Services incident report, dated 11/13/14, indicated, in part, "Will continue to follow dining and health risk plans on [client #3] choking. Per risk plan [client #3] has Dysphagia and his food is to be mechanical soft with finely chopped</p>		<p>forwarded to BDDS in a follow-up. The investigation findings were forwarded to APS and the guardians of the clients. The RPM will continue to monitor incidents as they occur to help determine if an investigation should be started. When house staff observe an instance of ANE, they will notify the QIDP within an hour. The QIDP will then suspend any staff that allegedly violated ANE standards. The QIDP will then conduct a thorough investigation and complete the investigation within 5 days of the incident The RPM will remind QIDPs during each monthly meeting to be aware of investigation criteria. The RPM will schedule investigation training with Steve Corya for the QIDPs. An in-service was held on 1/21/2015 for the QIDPs in regards to conducting a thorough investigation, such as interviewing all clients in the home, or facility where the incident takes place, as well as all the staff. We also addressed maintaining client confidentiality during the interviewing and reporting process.</p>	

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	<p>meats and vegetables." There was no documentation an investigation was conducted.</p> <p>The facility's incident report, dated 11/12/14 at 11:00 AM, indicated, "Client was eating lunch and ate cantaloupe that was sent in his lunch and started choking and wouldn't cough it up. [Team Lead] did Heimlic (sic) on client. Client started coughing and continued coughing thick phelm (sic) that at times was greenish in color. Staff continued to monitor client & (and) notified Q (Qualified Intellectual Disabilities Professional) at 11:12 AM. Q stated he would tried (sic) to get ahold of staff to take client to the doctor."</p> <p>An email, dated 11/12/14 at 6:21 PM, from the Registered Nurse to the Regional Program Manager indicated, in part, "I just go (sic) off the phone with [name of nurse], who recently spoke with [staff #3]. According to [staff #3], [name of hospital] claimed there was substance detected in the lung on the x-ray they did. Upon evaluation at [name of another hospital], [name of another hospital] is stating they are not seeing substance/objects in the lung on the same x-ray viewed. (no CT (Computed Tomography) scan had been done to my knowledge at this point). The plan is of course: client admitted to [name of</p>			

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	<p>hospital], to be started on antibiotics and monitored. To do a Barium Swallow (BS) tomorrow and then if that is within normal limits and they can rule out any obstruction with the BS, they will then proceed to do a swallow study. [Name of nurse] reports that [staff #3] stated [client #3] was given some pudding by the [hospital] staff to try to see if he tolerated it, and so far, no problem. [Client #3] had been on a Mechanical soft 2 diet, prior to this incident. Apparently the client is not in any distress at this time, in fact pretty much loving all the attention he is receiving there. Now it is just 'wait and see' what the tests reveal tomorrow."</p> <p>On 12/16/14 at 3:20 PM, the Regional Program Manager (RPM) provided a Special Case Conference document, dated 11/13/14, indicating, in part, "Team met to discuss this incident. [Client #3's] Dining plan was discussed. He is on the correct diet plan. Discussed that both the group home and workshop should know his dining plan. Doctors (sic) reports didn't show any blockage in his throat. [Client #3] spent the night in hospital and was released the next day. He was able to continue to normal activities. Team decided to continue his current dining plan."</p> <p>On 12/16/14 at 2:16 PM, the Team Lead</p>			

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	<p>at the day program indicated client #3 choked on hard, unripened cantaloupe. The Team Lead indicated the cantaloupe was not cut up or chopped as it should have been. The Team Lead indicated the group home staff sent the cantaloupe in that way.</p> <p>On 12/16/14 at 12:19 PM, the RPM indicated client #3 was given cut up melon, choked, was taken to the hospital and he did not aspirate. The RPM indicated client #3 was on a modified diet prior to the incident. The RPM indicated the Day Program Manager looked into the incident and found the staff followed client #3's plan. The RPM indicated he was unsure if an investigation was conducted.</p> <p>9-3-2(a)</p>						
W000227	<p>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 3 clients in the sample (#5), the facility failed to develop a cigarette reduction plan.</p>	W000227	HRC approval for client #5's smoking reduction plan implemented by her doctor has been approved by her guardian and HRC approval was obtained on 1/9/2015. Client #5	01/16/2015			

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	<p>Findings include:</p> <p>An observation was conducted at the facility-operated day program on 12/16/14 from 1:20 PM to 2:40 PM. At 1:59 PM, client #5 went outside to smoke a cigarette.</p> <p>On 12/16/14 at 1:59 PM, the Day Program Manager (DPM) indicated client #5 was down to one cigarette a day. The DPM indicated as of January 1, 2015, client #5 will be a non-smoker. The DPM indicated client #5's use of cigarettes had been decreasing over the past few months until she will stop smoking in January 2015.</p> <p>On 12/17/14 at 7:33 AM, a review of the communication book between the group home and the day program contained one cigarette for client #5 to smoke while at the day program.</p> <p>On 12/17/14 at 10:03 AM, a review of client #5's record was conducted. On 9/18/14, client #5 had an appointment with her physician. The appointment form indicated, in part, "(Right) 3rd finger lesion (due to) cigarette burn persists... Taper cigarettes by 1 cig (cigarette)/day/month: Start limit 4 cigs (cigarette)/d (day) in 4 wks (weeks)</p>		<p>was down to one cigarette a day. The newplan will require client#5 to reduce to zero cigarettes a day. The day programthat Client #5 attends will receive a copy of the HRC approved reduction planin order to support client #5's effort to stop smoking. The QIDP will monitorclient #5 in order to determine her need for any further supports to help herbe successful in this endeavor. The RPM will discuss cigarette reduction plansat the next SGL meeting on 1/21/15 in order to ensure that all clients whoeither need a reduction plan or who are on a reduction plan have the propersupports and approvals to implement said reduction plan.</p>				

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W000240	<p>(decrease) 3 cigs (cigarette)/d etc." The facility failed to develop a plan to address the physician's recommendations for a cigarette reduction.</p> <p>On 12/17/14 at 10:19 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #5 should have a plan to reduce her use of cigarettes. The QIDP indicated she was to have one a day for the rest of the month and then she will be finished smoking. The QIDP indicated there was no plan in place.</p> <p>On 12/17/14 at 10:19 PM, the Regional Program Manager (RPM) indicated client #5 should have a plan to reduce her use of cigarettes. The RPM indicated there was no plan in place.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 1 of 3 clients in the sample (#5), the facility failed to describe the relevant interventions needed to address client #5's maladaptive behavior of attempting to take keys from staff and visitors to the group home.</p>	W000240	<p>An in-service was held on 1/7/2015 in order to address client # 5's maladaptive behavior of attempting to take keys from staff and visitors to the group home. On 1/12/15, day program staff will meet with the QIDP and the</p>	01/21/2015			

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	<p>Findings include:</p> <p>An observation was conducted at the group home on 12/16/14 from 3:00 PM to 5:07 PM. At 4:05 PM, client #5 attempted to take the surveyor's car keys from his coat pocket. Client #5 approached the surveyor and placed her hand into his coat pocket to grab his keys three times. At 4:26 PM when the Qualified Intellectual Disabilities Professional (QIDP) arrived, client #5 attempted to locate and take his keys.</p> <p>An observation was conducted at the group home on 12/17/14 from 5:44 AM to 7:53 AM. At 5:57 AM, client #5 attempted to get her hand into the surveyor's coat pocket to take his keys on two occasions. At 7:45 AM, client #5 attempted to get into the surveyor's coat pocket to get his keys.</p> <p>On 12/17/14 at 7:39 AM, staff #4 indicated client #5 attempted to take his keys and cell phone the first few times he worked at the group home. Staff #4 indicated client #5 attempted to take new staff and visitor's keys. Staff #4 stated, "It's a game with her."</p> <p>On 12/17/14 at 10:03 AM, client #5's Behavior Support Plan, dated 12/2/14,</p>		<p>Regional Program Manager of day program and the industry manager in order to address Client#5's maladaptive behavior at the day program. Staff at both the house and the day program will redirect the client when she attempts to steal keys from staff or visitors. Per her Behavior plan, staff should not laugh and joke about her stealing so that she is not encouraged to continue her jokes. The client should be encouraged to use her sign language and picture magazines in order to communicate her wants and needs. Stealing is addressed in her BSP and workshop staff will receive a copy of her BSP in order to support her. The house lead will work with staff on a daily basis in order to address these preventative strategies. The QIDP will utilize monthly observations in order to encourage staff to follow her BSP.</p>				

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	<p>indicated she had a targeted behavior of stealing (includes stealing keys, cell phones, credit cards, etc.). The BSP indicated, in part, "This client also has a habit of stealing keys, cell-phones, credit cards and anything left out that she knows will be missed. She often uses this behavior as a game to get attention from staff but at the same time will pick anything up that tempts her. When missing items are noticed she will often laugh and refuse to tell where she hid the item. Later she will sometimes reveal where she had hidden the item to get attention or to finish playing her game. [Client #5] understands that this is unacceptable behavior and thrives on the mischievousness of the incident." In the preventative strategies section, the plan indicated, in part, "Staff should not laugh and joke about her stealing so that she is not encouraged to continue her jokes." The Reactive Strategies section did not address stealing. The plan did not indicate what the staff should do when client #5 was attempting to steal. The plan did not indicate visitors should be notified to put their personal belongings in a safe location.</p> <p>On 12/17/14 at 10:19 AM, the Regional Program Manager indicated when client #5 attempted to steal, the staff should redirect her. The RPM indicated the plan</p>			

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W000248	<p>should indicate the reactive measures staff should take.</p> <p>9-3-4(a)</p> <p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on interview and record review for 3 of 3 clients (#1, #4 and #5) in the sample who attended the facility-operated day program, the facility failed to ensure the day program had the clients' current program plans.</p> <p>Findings include:</p> <p>On 12/16/14 at 1:30 PM, the Day Program Manager indicated the day program did not have the clients' current plans.</p> <p>On 12/16/14 at 2:16 PM, a review of client #1's program plans at the day program indicated the following: -Client #1's record did not contain her Individual Program Plan (IPP) and Behavior Support Plan (BSP). -Client #4's record did not include his BSP.</p>	W000248	<p>As of 12/19/2014, QIDP sent current program plans to the day program. All health risk plans, all dining plans, IPPs and BSPs have been sent and updated for all clients attending the day program at JRI. QIDP will coordinate with the day program manager in order to ensure that these documents are being properly implemented on a real time basis. The QIDPs will ensure on a monthly basis that plans at the day program are relevant and up to date. The RPM will ensure that all counties have current plans in place. The RPM will emphasis at monthly SGL meetings that all QIDPS need to not only ensure program plans are in place and current at the homes but at their respective day programs as well.</p>	01/21/2015

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W000249	<p>-Client #5's record did not include her IPP and BSP.</p> <p>On 12/17/14 at 8:58 AM, a review of client #1's group home record indicated she had an IPP dated 1/20/14 to 1/20/15 and a BSP dated 1/20/14.</p> <p>On 12/17/14 at 9:41 AM, a review of client #4's group home record indicated he had a BSP dated 4/19/14.</p> <p>On 12/17/14 at 10:03 AM, a review of client #5's group home record indicated she had an IPP dated 12/2/14 to 12/2/15 and a BSP dated 12/2/14.</p> <p>On 12/17/14 at 10:19 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated he was contacted on 12/16/14 by the day program. The day program staff indicated they did not have the clients' current plans. The QIDP indicated he sent client #3's current plans on 12/16/14 and client #1's plans on 12/17/14. The QIDP indicated the day program should have copies of the clients' current plans.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has</p>						

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	<p>formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 2 of 3 clients in the sample #1 and #5 and two additional clients (#2 and #3), the facility failed to ensure the clients' program plans were implemented as written.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 12/17/14 from 5:44 AM to 7:53 AM. At 7:06 AM while eating breakfast, client #3 was coughing. At 7:12 AM, client #3 coughed again, several times. Staff #9 went to the dining room table to check on client #3 due to his coughing. Staff #4 and #9 were not seated at the table while client #3 was eating. Staff #4 and #9 did not prompt client #3 to take a drink between bites. During the observation, staff #4 and #9 were not observed to notify the nurse of client #3's coughing during breakfast.</p> <p>On 12/17/14 at 8:49 AM, client #3's record was reviewed. There was no documentation the staff notified the nurse of client #3's coughing during breakfast.</p>	W000249	<p>In order to ensure that program plans are being implemented by the house staff, an in-service training was held on 1/7/2015. This in-service covered the following issues: staff are to follow the clients dysphagia trigger protocol as defined on the clients' dining plans. Staff were instructed to call the house nurse when they observe dysphagia triggers. Staff were instructed to encourage Client#3 to take drinks between bites. Staff were instructed to sit at the table with the clients at eye level while they are eating. Staff are to encourage clients to identify their medications per their TAs according to each clients' functioning level. Staff are to encourage clients to properly wash their hands before meals, after meals, before med pass according to each clients' hand washing TA. This same in-service covered the need to redirect client #5 when she begins to SIB. Staff are to redirect the client or block her hits per her BSP. Staff are to assess why the client is upset and follow the proper interventions. The house lead will monitor on a daily basis in order to ensure compliance</p>	01/21/2015

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	<p>Client #3's 1/13/13 Dining Plan indicated, in part, "Needs verbal prompts to take a drink between bites and to not talk with mouth full... Staff should be seated at eye-level and monitor client during all food intakes. Staff should verbally prompt client to slow down while eating and take smaller bites... TRIGGERS To Notify Nursing Staff: coughing with signs of struggle (watery eyes, drooling, facial redness)..."</p> <p>On 12/17/14 at 10:19 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated he spoke to the nurse earlier in the day and she was not notified of client #3's coughing during breakfast. The QIDP indicated client #3's coughing should be communicated to the nurse per the plan. The QIDP indicated client #3's plan should be implemented as written.</p> <p>2) An observation was conducted at the group home on 12/17/14 from 5:44 AM to 7:53 AM. At 7:18 AM, client #2 was eating her breakfast unsupervised by staff #4 and #9. At 7:26 AM, client #2 continued to eat her breakfast without staff supervision.</p> <p>On 12/17/14 at 8:44 AM, client #2's 4/15/14 Dining Plan indicated, in part, "Staff should be seated at eye-level and monitor client during all food intakes."</p>		<p>and competency is demonstrated.</p> <p>When the house lead cannot be there, the QIDP will monitor for compliance and offer training as needed until staff are demonstrating proper techniques.</p> <p>The QIDP will reinforce this training during monthly house meetings.</p> <p>The RPM will ensure that the QIDPs are having staff follow their client's respective BSPs or ISPs in order to serve our clients better.</p>	

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	<p>On 12/17/14 at 10:19 AM, the QIDP indicated client #2's Dining Plan should be implemented as written.</p> <p>On 12/17/14 at 10:19 AM, the Regional Program Manager (RPM) indicated client #2's Dining Plan should be implemented as written.</p> <p>3) An observation was conducted at the group home on 12/17/14 from 5:44 AM to 7:53 AM. During the observation, client #1, #2 and #3's medication administration training objectives were not implemented.</p> <p>a) On 12/17/14 at 6:09 AM, client #1 received her medications from staff #4. Staff #4 did not prompt or inform client #1 to identify and say the name of her medications, identify the correct time the medication was taken, and inform staff when the next dose of medication was due.</p> <p>On 12/17/14 at 8:58 AM, client #1's Individual Program Plan (IPP), dated 1/20/14 to 1/20/15, indicated she had a medication training objective to identify and say the name of her medications, identify the correct time the medication was taken, and inform staff when the next dose of medication was due.</p>			

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	<p>b) On 12/17/14 at 6:31 AM, client #3 received his medications from staff #4. Staff #4 prompted client #3 to wash his hands or use hand sanitizer. Client #3 used hand sanitizer prior to the medication pass. Client #3 was not prompted by staff #4 to identify the sink, turn on the water, put soap on his hands, rub the soap on his hands, scrub his hands under the water, dry his hands, shut off the water and get a glass of water.</p> <p>On 12/17/14 at 8:49 AM, client #3's December 2014 medication training objective was reviewed. The training objective indicated client #3 would identify the sink, turn on the water, put soap on his hands, rub the soap on his hands, scrub his hands under the water, dry his hands, shut off the water and get a glass of water.</p> <p>c) On 12/17/14 at 6:53 AM, client #2 received her medications from staff #4. Staff #4 did not prompt or inform client #1 to identify and say the name of her medications, identify the correct time the medication was taken, inform staff when the next dose of medication was due and trace the alphabet A-Z using the provided yellow sheet for her practice.</p> <p>On 12/17/14 at 8:50 AM, client #2's</p>						

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	<p>December 2014 medication training objective was reviewed. The training objective indicated client #2 would identify and say the name of her medications, identify the correct time the medication was taken, inform staff when the next dose of medication was due and trace the alphabet A-Z using the provided yellow sheet for her practice.</p> <p>On 12/17/14 at 10:19 AM, the QIDP indicated the clients' medication training objectives should be implemented at every medication pass.</p> <p>On 12/17/14 at 10:19 AM, the RPM indicated the clients' medication training objectives should be implemented at every medication pass.</p> <p>4) An observation was conducted at the group home on 12/17/14 from 5:44 AM to 7:53 AM. On 12/17/14 at 5:57 AM, client #5 hit herself several times with her fist on her chin. Staff #4 stated to client #5, "Don't be hitting yourself." Client #5 continued to hit her chin. At 5:59 AM, client #5 hit herself on the chin with her fist. Client #5 hit herself in the mouth numerous times. There was no staff redirection provided to client #5. At 6:39 AM, client #5 hit herself on the chin several times with no staff redirection. Staff did not prompt client #5 to change</p>			

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W000250	<p>activities or give her choices between two activities. Staff did not ask her what was wrong and try to determine why she was upset. Staff did not encourage client #5 to use sign language or pictures to communicate her wants and needs.</p> <p>Client #5's Behavior Support Plan, dated 12/2/14, indicated she had a targeted behavior of self injurious behavior. The plan indicated, in part, "When she begins to... Hit herself in the chin with her fist or beat her head against the wall... Staff should encourage client to do another activity or give her choices between two activities. If she continues... Staff should ask her what is wrong and try to determine why she is upset." In the preventative Strategies section, the plan indicated, "The client should be encouraged to use her sign language and pictures (magazines) to better communicate her wants and needs to staff."</p> <p>On 12/17/14 at 10:19 AM, the RPM indicated the plan should be implemented as written.</p> <p>9-3-4(a)</p> <p>483.440(d)(2)</p>						

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	<p>PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>Based on observation, interview and record review for 3 of 3 clients in the sample (#1, #4 and #5), the facility failed to develop an active treatment schedule outlining the current active treatment programs for clients #1, #4 and #5 while they were at the day program. The day program staff did not have active treatment schedules readily available for review by relevant staff.</p> <p>Findings include:</p> <p>An observation was conducted at the facility-operated day program on 12/16/14 from 1:20 PM to 2:40 PM. During the observation, client #1 sat on a couch with the exception of 2 minutes when she ate yogurt at a table. Client #1 was not engaged in activities. During the observation, client #4 sat in a rocking chair. At 2:02 PM, client #4 was thrown a ball. During the observation, client #5 wandered around the room, went out to smoke at 1:59 PM and then returned to no activity in the room.</p> <p>On 12/16/14 at 2:10 PM, the Day Program Manager (DPM) indicated there was no set schedule and no</p>	W000250	On 1/12/15, day program staff will meet with the QIDP and the Regional Program Manager of day program and the industry manager in order to address the lack of program implementation. The QIDP will provide up to date client plans to the day program. The QIDP will utilize monthly observations of the day program to ensure staff are indeed following the clients' plans. The RPM will address the need of proper program implementation at monthly SGL meetings. The RPM will coordinate with the day program RPM in order to ensure staff at all day programs are following the clients' plans.	01/16/2015			

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W000259	<p>documentation of activities for the day. The DPM indicated client #4 did not like to be around others and did not like to draw or participate in table top activities. At 2:32 PM, the DPM indicated the clients did not have an active treatment schedule.</p> <p>On 12/16/14 at 2:32 PM, the Day Program Team Lead indicated the clients did not have an active treatment schedule.</p> <p>On 12/17/14 at 10:19 AM, the Regional Program Manager (RPM) indicated the clients should have an active treatment schedule for their time at the day program.</p> <p>On 12/17/14 at 10:19 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the clients did not have an active treatment schedule for their time at the day program.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for</p>	W000259	The QIDP will ensure that as of 1/16/2015, all client CFAs will be	01/16/2015			

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W000262	<p>2 of 3 clients in the sample (#1 and #4), the facility failed to review the clients' comprehensive functional assessments (CFA) for relevancy and updated as needed at least annually.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 12/17/14 at 8:58 AM. Client #1's most recent CFA was dated 2013 (no month or day indicated). There was no documentation in client #1's record indicating her CFA was reviewed and updated as needed at least annually.</p> <p>Client #4's record was reviewed on 12/17/14 at 9:41 AM. Client #4's most recent CFA was dated 2013 (no month or day indicated). There was no documentation in client #4's record indicating his CFA was reviewed and updated as needed at least annually.</p> <p>On 12/17/14 at 10:41 AM, the Regional Program Manager indicated the clients' CFAs should be reviewed and updated at least annually.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and</p>		<p>updated. The RPM will work with the QIDP in order to set up an annual schedule of CFAs so that we can avoid this lapse in the future. The RPM will use monthly SGL meetings to ensure all QIDPs have current CFAs in place. The QIDP will ensure that these current CFAs are in the house client files.</p>		

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	<p>monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#1), the facility's specially constituted committee (HRC - Human Rights Committee) failed to review, approve and monitor client #1's restrictive Behavior Support Plan (BSP).</p> <p>Findings include:</p> <p>On 12/17/14 at 8:58 AM, a review of client #1's record was conducted. Client #1's 12/2/14 BSP included the use of psychotropic medications (Abilify for anxiety and Trazodone for insomnia). There was no documentation in client #1's record indicating the HRC reviewed, approved and monitored client #1's restrictive BSP.</p> <p>On 12/17/14 at 10:19 AM, the Qualified Intellectual Disabilities Professional indicated the HRC should review, approve and monitor the clients' BSP at least annually.</p> <p>On 12/17/14 at 10:19 AM, the Regional Program Manager indicated the HRC should review, approve and monitor the clients' BSP at least annually.</p>	W000262	The QIDP is getting HRC approval for client #5 on 1/13/15. The QIDP will then make sure all client plans are approved by the HRC. The QIDP will ensure that HRC will review, approve and monitor the clients' BSP at least annually. The RPM will ensure that all QIDPs keep their HRC approvals up to date during the monthly SGL meeting.	01/16/2015

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W000263	<p>9-3-4(a)</p> <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. Based on record review and interview for 2 of 3 clients in the sample (#4 and #5), the facility's specially constituted committee (HRC - Human Rights Committee) failed to ensure written informed consent was obtained prior to the implementation of the clients' restrictive Behavior Support Plans (BSP).</p> <p>Findings include:</p> <p>On 12/17/14 at 9:41 AM, client #4's record indicated there was no documentation the facility obtained written informed consent from client #4 prior to implementing his restrictive BSP. The BSP, dated 4/19/14, included the use of Clonazepam, Depakote and Zyprexa.</p> <p>On 12/17/14 at 10:03 AM, client #5's record indicated there was no documentation the facility obtained written informed consent from client #5's guardian prior to implementing her</p>	W000263	Client # 4 does have informed consent for his restrictive medications. The HRC paperwork that included the signature page was at the regional office and had not been filed in the house as of the survey. The QIDP will ensure that the updated copy is placed in Client # 4's house files. Client#5 will have HRC approval as of 1/13/15 for her restrictive medications. The QIDP will plan ahead of time in order to coordinate the HRC meetings with the IPP annual renewal dates. The QIDP will emphasis the need to review annual plan dates and QIDPs will obtain informed consent in a timely manner.	01/16/2015

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W000312	<p>restrictive BSP. The BSP, dated 12/2/14, included the use of Abilify and Trazodone.</p> <p>On 12/17/14 at 10:19 AM, the Qualified Intellectual Disabilities Professional indicated the facility should have obtained written informed consent.</p> <p>On 12/17/14 at 10:19 AM, the Regional Program Manager indicated the facility should have obtained written informed consent.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 3 of 3 clients in the sample prescribed psychotropic medications (#1, #4 and #5), the facility failed to develop a plan of reduction the clients could achieve to reduce and eventually eliminate the behaviors for which the clients received psychotropic medications.</p> <p>Findings include:</p>	W000312	<p>Clients who are administered psychotropic drugs, clients # 1, 4 & 5 will have their BSPs updated to include specific drug reduction plans. The plans will include criteria that show behavioral goals or instances of targeted behavior within a timeframe that each client must meet or be under in order for the prescribing physician to reduce their medications. The criteria will</p>	01/21/2015			

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	<p>1) On 12/17/14 at 8:58 AM, a review of client #1's record was conducted. Client #1's Behavior Support Plan (BSP), dated 1/20/14, indicated she was prescribed Clonazepam (psychosis/aggression), Depakote (intermittent explosive disorder/aggression), Risperidone (intermittent explosive disorder/aggression), and Zyprexa (psychosis). The BSP indicated, "Medication reduction will be sought in conjunction with psychiatric, guardian review and consultation per below criteria: Medication reduction will be sought when instances are at or below: Physical aggression, 3 times weekly, 12 months. Seeking food, 25 times per month, 12 months." No medication had been identified as the first to be withdrawn. There was no documentation indicating the amount, in milligrams, the medication would be reduced.</p> <p>2) On 12/17/14 at 9:41 AM, a review of client #4's record was conducted. Client #4's BSP, dated 4/19/14, indicated he was prescribed Clonazepam (no diagnosis identified), Depakote (no diagnosis identified) and Zyprexa (no diagnosis identified). The BSP indicated, "Medication reduction will be sought in conjunction with psychiatric, guardian review and consultation per below criteria: Medication reduction will be</p>		<p>be individualized and obtainable for each client. The RPM will ensure at the monthly SGL meetings that client BSPs have specific and tailored psychotropic drug reduction plans in place.</p>				

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	<p>sought when instances are at or below: Public masturbation, 0 instances, 12 months. PICA (ingestion of non-nutritive items), 10 instances, 12 months. Public defecation, 0 instances, 12 months." No medication had been identified as the first to be withdrawn. There was no documentation indicating the amount, in milligrams, the medication would be reduced.</p> <p>3) On 12/17/14 at 10:03 AM, a review of client #5's record was conducted. Client #5's BSP, dated 12/2/14, indicated she was prescribed Abilify (anxiety) and Trazodone (insomnia). The BSP indicated, "Medication reduction will be sought in conjunction with psychiatric, guardian review and consultation per below criteria: Medication reduction will be sought when instances are at or below: Temper tantrums, 3 instances, 12 months. Self Injurious (behavior), 4 instances, 12 months." No medication had been identified as the first to be withdrawn. There was no documentation indicating the amount, in milligrams, the medication would be reduced.</p> <p>On 12/17/14 at 10:19 AM, the Regional Program Manager indicated the clients' BSPs should include clear criteria to reduce the clients' psychotropic medications.</p>			

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W000369	<p>9-3-5(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 2 of 9 medications/treatments for client #2, the facility failed to ensure staff administered the clients' medications as ordered.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 12/17/14 from 5:44 AM to 7:53 AM.</p> <p>1) On 12/17/14 at 6:53 AM, client #2 received her medications from staff #4. Staff #4 administered client #2 one tab of Vitamin C instead of two tabs. On 12/17/14 at 7:03 AM, staff #4 indicated when the error was brought to his attention, "Glad you caught that." Staff #4 administered client #2's second tab of vitamin C.</p> <p>On 12/17/14 at 8:26 AM, a review of client #2's Physician's Orders, dated 8/5/14, indicated, in part, "Vitamin C 500</p>	W000369	<p>An in-service was held for house staff on 1/7/2015. The staff who failed to administer the medication on 12/17/14 has since left the company. During the in-service, staff were instructed to follow the proper med pass procedure. Buddy checks are now in place to ensure that daily med passes are accurate.. The RPM will ensure that all QIDPs are implementing the buddy check med pass procedure in order to reduce and eliminate med pass errors. If a house has more than two med errors within a month, the house nurse will visit the house in order to help retrain staff upon proper med pass procedure. The facility will continue to monitor the amount of med errors and provide the staff with the proper disciplinary action and retraining; according to DSI's med error policy. The policy is as follows: 1st Medication Error- Counseling Memorandum with emphasis on client specific/medication orientation protocol. 2nd Medication Error- Counseling</p>	01/21/2015

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	<p>mg (milligrams) tablet chew. Give 2 tablets (1000 mg) orally once a day - chew."</p> <p>On 12/17/14 at 10:57 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated staff #4 failing to administer client #2's Vitamin C as ordered was a medication error.</p> <p>On 12/17/14 at 10:57 AM, the Regional Program Manager (RPM) indicated staff #4 failing to administer client #2's Vitamin C as ordered was a medication error. The RPM indicated the staff should administer the medication following the Physician's Orders.</p> <p>2) On 12/17/14 at 6:53 AM, client #2 received her medications from staff #4. Staff #4 did not offer client #2 a glass of cranberry juice during the medication pass. On 12/17/14 at 7:18 AM, client #2 ate her breakfast. Client #2 did not drink and was not offered a glass of cranberry juice. Client #2 did not have a drink during her breakfast. During the morning observation, client #2 did not drink and was not offered cranberry juice.</p> <p>On 12/17/14 at 8:26 AM, a review of client #2's Physician's Orders, dated 8/5/14, indicated, in part, "Offer 1 glass of cranberry juice every breakfast & (and</p>		<p>Memorandum and Completion of Core A retraining within 30 days. 3rd Medication Error- Disciplinary Action Category A Performance Criteria; Completion of Core A retraining within 30 days. 4th Medication Error- Disciplinary Action Category A Performance Criteria (Suspension) Completion of Core A retraining within 30 days. 5th Medication Error- Disciplinary Action Category A (Termination). The director of quality assurance ensures that these actions are carried out and the RPM will ensure that QIDPs will provide the proper disciplinary actions. An inservice for QIDPs regarding this procedure was held on 1/21/2015.</p>				

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W000440	<p>dinner."</p> <p>On 12/17/14 at 10:19 AM, the RPM indicated client #2's Physician's Orders should be implemented as written.</p> <p>9-3-6(a)</p> <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 for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to conduct quarterly evacuation drills for each shift.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 12/16/14 at 3:04 PM. There was no documentation the facility conducted evacuation drills quarterly during the day shift (7:00 AM to 3:00 PM) from 2/3/14 to 7/26/14. There was no documentation the facility conducted evacuation drills quarterly during the evening shift (3:00 PM to 11:00 PM) from 3/25/14 to 8/20/14. There was no documentation the facility conducted evacuation drills quarterly during the night shift (11:00 PM to 7:00 AM) from 4/19/14 to 9/14/14.</p>	W000440	<p>During the staff in-service on 1/7/14, the need to hold quarterly drills was emphasized. The QASSM will hold monthly audits and ensure that the needed drills are either in place or scheduled to take place. The RPM will ensure that the QIDPs know what drills need to take place quarterly during monthly SGL meetings.</p>	01/16/2015

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W000488	<p>On 12/16/14 at 3:08 PM staff #3 indicated the drills were completed however the originals were sent to the office. Staff #3 indicated there was no documentation to review indicating the drills were completed. Staff #3 indicated the facility was scheduled to conduct evacuation drills monthly.</p> <p>On 12/17/14 at 10:41 AM, the Qualified Intellectual Disabilities Professional indicated the facility should conduct monthly evacuation drills.</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 5 of 5 clients living at the group home (#1, #2, #3, #4 and #5), the facility failed to ensure the clients served themselves, assisted with meal preparation, packed their own lunches and cleaned out their lunch boxes.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 12/16/14 from 3:00 PM</p>	W000488	<p>An in-service was held on 1/7/15. The staff were instructed about how not to be custodial. The staff were instructed to have the clients assist with housekeeping, meal prep and any other activity that would enable them to be more self-sufficient. The QIDP will use their daily presence in the homes in order to reinforce these standards. The QIDP will train the house leads to help mentor staff on how to be less custodial with the clients. The</p>	01/21/2015

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	<p>to 5:07 PM. At 3:38 PM, staff #5 cleaned out the clients' lunch boxes and loaded the dishwasher with their dirty dishes and utensils. Clients #1, #2, #3, #4 and #5 were not involved and were not prompted to participate. At 4:19 PM, staff #5 used the blender to blend the pudding. Clients #1, #2, #3, #4 and #5 were not involved and were not prompted to participate. At 4:38 PM, staff #5 poured client #2's juice into her cup. Staff #5 cut up client #2's soft taco without asking client #2 to assist her. At 4:45 PM, staff #2 pureed client #3's food while client #3 stood in the kitchen and watched. Client #3 did not assist in the process. At 5:00 PM, staff #3 went into the kitchen to make Kool aid for the clients. Clients #1, #2, #3, #4 and #5 were not involved and were not prompted to participate. At 5:03 PM, staff #5 served client #4 pudding.</p> <p>An observation was conducted at the group home on 12/17/14 from 5:44 AM to 7:53 AM. At 5:54 AM, client #1, #2, #3, #4 and #5's lunch boxes were sitting on the kitchen counter and packed to take to the day program. Clients #1, #2 and #3 were in bed at the time. Clients #4 and #5 did not assist with packing their lunch boxes.</p> <p>On 12/17/14 at 9:32 AM, staff #4</p>		<p>QIDP will also utilize monthly observations as a tool for ensuring that staff are letting clients help with meals and cleaning. The RPM will emphasize the need for staff to involve the clients with all day to day house activities during the monthly QIDP SGL meeting.</p>				

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W009999	<p>indicated he packed the clients' lunch boxes.</p> <p>On 12/17/14 at 10:19 AM, the Regional Program Manager (RPM) indicated the clients should serve themselves food, with assistance as needed. The RPM indicated the clients should pack their own lunches.</p> <p>On 12/17/14 at 10:19 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the clients should be assisted to cut up their own food. The QIDP indicated client #3 should be involved with pureeing his food. The QIDP indicated the clients should pack their own lunches.</p> <p>9-3-8(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:</p> <p>460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job</p>	W009999	The QIDP will ensure that all staff will continue to be current on their TB testing. DSI utilizes a matrix that tracks training and other needed annual events. The QIDP will regularly check the staff's training records in order to comply.	01/16/2015

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	<p>duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 3 employee files reviewed (staff #6 and #8), the facility failed to ensure an annual Mantoux (5TU, PPD) tuberculosis (TB) screening was conducted.</p> <p>Findings include:</p> <p>A review of the facility's employee files was conducted on 12/16/14 at 12:23 PM and indicated the following: Direct Care Staff #6 had a negative TB test on 12/4/12. There was no documentation in staff #6's personnel file staff #6 had a</p>						

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	<p>annual screening or TB test conducted since 12/4/12. Direct Care Staff #8 had a negative TB test on 8/16/13. There was no documentation in staff #8's personnel file staff #8 had a annual screening or TB test conducted since 8/16/13.</p> <p>On 12/16/14 at 12:40 PM, the Regional Program Manager (RPM) indicated the staff should have an annual TB test. The RPM stated, "They are past due." The RPM stated "We failed to identify them as needing their TBs."</p> <p>9-3-3(e)</p>				