

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G013	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2015
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 817 MENDLESON DR RICHMOND, IN 47374
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W 0000 Bldg. 00	<p>This visit was for an annual recertification and state licensure survey. This visit included the investigation of complaint #IN00173224.</p> <p>Complaint #IN00173224: Substantiated, Federal and state deficiencies related to the allegations are cited at W148 and W331.</p> <p>Dates of survey: July 13, 14, 15, 16, 17 and 24, 2015.</p> <p>Facility Number: 000588 Provider Number: 15G013 AIMS Number: 100233310</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0136 Bldg. 00	<p>483.420(a)(11) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities.</p> <p>Based on interview and record review for</p>	W 0136	Correctiveactionforresident(s)foun	08/21/2015

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>3 of 3 sampled clients (A, B and C) and 3 additional clients (D, E and F), the facility failed to ensure the clients were provided the opportunity to participate in various social and community activities on a regular and ongoing basis.</p> <p>Findings include:</p> <p>Review of client A's, B's and C's 2015 finances on 7/14/15 at 2:30 PM indicated no social and/or community outings for March, April, May, June or July, 2015.</p> <p>Review of the Petty Cash Tracking record for the clients living in the group home (clients A, B, C, D, E and F) on 7/17/15 at 9 AM indicated no expenditures for social or community outings for the clients in February, March, April, May, June and July, 2015.</p> <p>Review of client A's, B's, C's, D's, E's and F's daily staff notes for March, April, May, June and July, 2015 on 7/17/15 at 1 PM indicated:</p> <p>__ No social and/or community outings provided by the facility and/or for client A in March, April, May, June or July, 2015.</p> <p>__ No social and/or community outings provided by the facility for client B in March, April, May, June or July, 2015.</p> <p>__ Client C went out with his mother on</p>		<p>dtohavebeenaffected.</p> <p>All individuals served will have the opportunity to participate in social, religious, and community group activities. In this year clients participated at church, grocery shopping, Special Olympics, ball practice, picnics, and some went out with their family. Benchmark did not have a separate activity log or documentation when a client refused to attend an activity. Staff and Team Leaders will be retrained on the importance of helping encourage clients to participate in activities in the community. Every client will be given the opportunity to attend an out of the house activity at least weekly.</p> <p>How facility will identify other residents potentially affected and what measures taken</p> <p>All residents could be affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>A new Activity Log has been created that will outline all outside activities that were offered, what activities were chosen and if a client attended or refused. The staff and team leader will be retrained to offer clients the opportunity to engage in community activities.</p> <p>How corrective actions will be monitored</p>	

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	<p>4/27/15 and 5/4/15, to the grocery with staff on 5/2/15 and 6/6/15, a van ride on 6/7/15 and 6/21/15 and to ball practice on 6/12/15 and 6/22/15.</p> <p>__ Client D went to church with her father on 3/15/15, 4/26/15 and 6/7/15 and to the grocery with the staff on 3/14/15, 4/4/15, 4/25/15, 6/5/15 and 6/27/15.</p> <p>__ No social and/or community outings provided by the facility for client E in March, April, May, June or July, 2015.</p> <p>__ Client F went to Special Olympics practice once a week in March, 2015, twice in April, three times in May and twice in June, 2015 and to a church event with his mother in April, 2015.</p> <p>During interview with client D on 7/16/15 at 2:30 PM, client D:</p> <p>__ Indicated her sister and/or her father would come to visit and take her out to eat and to church.</p> <p>__ Stated, "I go to the grocery with the staff."</p> <p>__ Stated, "They (the staff) don't take us out to eat or anything. They just take us to get groceries."</p> <p>__ Indicated she would like to go to the movies, go bowling, play miniature golf and go to dances.</p> <p>__ Indicated she would like to go out to eat with her friend and pointed to a client near her work station.</p>		<p>redtoensurenorecurrence</p> <p>Activity logs will be reviewed by team leaders weekly. They will be turned in to the Q to be reviewed monthly and to document in the monthly summaries. Management will bring up the item of community participation at staff meetings to discuss ideas of community events to attend.</p>	

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	<p>During interview with client C's guardian on 7/15/15 at 11 AM, the guardian: ___ Indicated she traveled with her occupation and could not spend as much time as she would like with client C. ___ Indicated client C was involved with Special Olympics and attended some of their activities. ___ Stated other than the Special Olympics, "He (client C) doesn't get out in the community like I wish he could."</p> <p>During telephone interview with client F's guardian on 7/15/15 at 10 AM, the guardian: ___ Stated client F participated in Special Olympics and "I usually am the one to take him." ___ Stated, "I would like to see them (the facility staff) take him (client F) out more often and do different things with him other than just Special Olympics." ___ Indicated she was elderly and stated, "I'm concerned when I'm gone that he won't be getting out much at all."</p> <p>During interview with the Residential Manager (RM) on 7/17/15 at 3 PM, the RM: ___ Indicated some of the clients went with the staff to go grocery shopping. ___ Indicated an allotted amount of money is given to the group home from Benchmark to replenish the monthly</p>			

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W 0148 Bldg. 00	<p>petty cash (money provided to the group home to take the clients out to eat and/or out into the community on outings as a group).</p> <p>__ Indicated the request to replenish the petty cash was misplaced and no money was issued to the home for community events/activities from February 2015 through July 2015.</p> <p>__ Indicated the facility had not taken the clients out to eat and/or on community outings since January of 2015 due to the misplacement of the petty cash receipts.</p> <p>__ Indicated the receipts and requests were found in a book at the facility reception desk and have been sent to Benchmark for review and replacement of the group home petty cash.</p> <p>9-3-2(a)</p> <p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview for 3 of 3 sampled clients (A, B and C) and 3 additional clients (D, E and F), the facility failed to notify the clients'</p>	W 0148	<p>Corrective action for resident(s) found to have been affected Benchmark has ongoing and open communication with all guardians and parents.</p>	08/21/2015

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	<p>families and/or legal representatives within 24 hours of the discovery of bed bugs in the group home and to ensure client A's guardian was notified in a timely manner of all significant behavioral incidents displayed by client A.</p> <p>Findings include:</p> <p>1. The facility's records were reviewed on 7/13/15 at 2 PM. The records indicated the following:</p> <p>An invoice dated 2/24/15 from a local professional pest extermination company. The record indicated the home of clients A, B, C, D, E and F was inspected by a professional exterminator. The record indicated "Found 1 live bedbug on bedspring. Signs and a couple exoskeleton on bed. Recommend treatment."</p> <p>An email from the Residential Manager (RM) to client A's guardian dated 3/3/15 at 10:04 AM indicated "I am informing guardians that we will be having [company name of exterminator] come in on Friday, March 6 at 9a to spray the house for pest. Some items will need to be removed from bedrooms to do this process."</p>		<p>Benchmark's Bed Bug policy was followed. As soon as an infestation of bed bugs was discovered and verified by a licensed pest control company, guardians were contacted. Guardians were not contacted when one bug was found because the pest control company said it could have been a hitchhiker. When they came back to check, two bugs were found and guardians were contacted.</p> <p>Benchmark will document all communication with guardians. This can be by email or the completion of a telephone conference call form.</p> <p>How facility will identify other residents potentially affected and what measures taken All residents are affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence QIDPs and LPN will be retrained on the importance of communication with guardians and clients. QIDPs and LPN will ask families and guardians how they prefer to be communicated with.</p> <p>How corrective actions will be monitored to ensure no recurrence Regional Director will retrain the QIDPs and the LPN and will ensure the staff receive training on reporting any incidents immediately. QIDPs and LPN will document all guardian communication either by an</p>		

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	<p>A Bureau of Developmental Disabilities Services (BDDS) report dated 3/6/15 indicated "On Friday February 27th an exterminator was called in to inspect for bed bugs. The exterminator found 1 bug at that time. Preventative measures and laundering was (sic) done on that day. The exterminator came back on Monday 3/2/15 and found two additional bugs." _The BDDS report indicated client A's, B's, C's, D's, E's and F's families were notified of bedbugs in the group home on 3/6/15.</p> <p>The facility records failed to indicate client A's, B's, C's, D's, E's and F's families and/or legal representatives were notified of bedbugs in the home within 24 hours of knowledge of the home having bedbugs.</p> <p>During interview with the Residential Manager (RM) on 7/17/15 at 4 PM, the RM indicated all of the clients' (clients A, B, C, D, E and F) families and/or legal representatives were emailed and/or called informing them there were "pests" in the home and an exterminator would be coming to exterminate.</p> <p>During telephone interview with client A's legal representative/mother on 7/16/15 at 8:40 AM, client A's mother: _Indicated she was notified on 3/3/15 in</p>		email or on a telephone conference callform.	

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	<p>an email from the RM there were pests in the home.</p> <p>__ Stated, "We (client A's family) had no idea what they were referring too."</p> <p>__ Indicated she found out there were bed bugs in the home after going to the home and was told by the staff.</p> <p>During telephone interview with client D's legal representative/father on 7/20/15 at 1 PM, client D's father stated, "They never have called to tell us the home has been cleared of bed bugs. I just assumed they'd (the facility) let us know. Maybe I should call them."</p> <p>2. The facility's records were reviewed on 7/13/15 at 2 PM. The records indicated the following:</p> <p>An email dated 3/9/15 at 12:55 AM from client A's mother to the facility's RN and LPN, the Qualified Intellectual Disabilities Professional (QIDP) and the RM. The email indicated "During our February meeting in regards to [client A], I (client A's mother) requested information for review. Last week I asked [name of the facility's LPN] for assistance in obtaining some of this information. Following is a minimum list of information requested. If there are any other documents that will be useful, please add them to the list as I am not</p>			

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	<p>familiar with all of your documentation.... [Name of QIDP], thank you for Behavior Data Sheets you have started sending. I have received 12 sheets for January.... Please continue to send the rest of the Behavior Data Sheets that are listed on the Summary Report."</p> <p>Client A's record was reviewed on 7/14/15 at 2 PM. Client A's Behavior Data Sheets (BDS) indicated the following:</p> <p>1/2/15 at 6:05 AM - Client A was slamming and tipping chairs over, hitting the doors and walls and slamming her bedroom door repeatedly. The BDS indicated no duration of the behavior.</p> <p>1/6/15 at 7:30 AM - Client A was at the breakfast table and for no apparent reason became angry and started yelling at clients G and B. The staff asked client A not to yell and not to be speaking to other clients in a harsh manner when client A started throwing four of the chairs. The staff asked client A again to calm down. Client A walked to her room punching the walls and screaming. Approximately 30 minutes went by and client A is still screaming. Client B went to her room to get her coat and client A came out of her room and started aggressively screaming in client B's face. The staff went back and</p>			

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	<p>told client A to stop and not to come out of her room being mean at client B as she had done nothing to client A. Client B was escorted to the living room and client A continued to scream and throw things and punch walls. The BDS indicated client A's behaviors lasted one hour and thirty minutes.</p> <p>1/7/15 at 5:30 PM - Client A "complained" client B was bothering her. Client B had done nothing or said anything to client A. Client A got angry and "threw down a chair" and ran down the hall yelling that client B was bothering her. The BDS indicated client A's behaviors lasted one hour.</p> <p>1/8/15 at 7:30 AM - Client A got into a dispute with other clients saying other clients were bothering her. Client A was "crying and upset." The BDS indicated client A's behaviors lasted thirty minutes.</p> <p>1/9/15 at 7:30 AM - "She (client A) was angry and frustrated at another client. She threw furniture. She stormed off to her bedroom. She said this client was bothering her. This client said [client A] threatened her by hitting her with a chair and breaking her glasses. I only heard a portion of this, was busy giving another client meds. I saw a small bit of what happened." The BDS indicated client A's</p>			

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	<p>behaviors lasted thirty minutes.</p> <p>1/11/15 at 9:15 AM - Client A was "angry and mad. She was crying a whole lot and said how [client B] was bothering her. I heard a crashing and banging sound and saw that client A threw a chair at [client B]. She banged the table and threw silverware. She ran off to the garage to play basketball to cool down." The BDS indicated client A's behaviors lasted thirty minutes.</p> <p>2/20/15 at 6:10 AM - Client A got into a fight with another client. Client A was yelling, screaming and crying. Client A said the other client was bothering her and told her to shut up. "[Client A] threw a chair at said client." The BDS indicated client A's behaviors lasted thirty minutes.</p> <p>1/22/15 at 6 AM - Client A indicated several other clients were bothering her and "starting stuff with her." The BDS indicated no one was bothering client A. Client A began hitting the table and throwing furniture, "placing herself and others at risk. She did this because she was mad and upset." The BDS indicated client A's behaviors lasted two hours.</p> <p>2/27/15 at 6:25 AM - Client A got into a confrontation with one of her housemates and they began arguing. When staff</p>				

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	<p>intervened and tried to stop the verbal altercation client A got up from the kitchen table and started tipping the dining room chairs over and "trying to destroy things." The BDS indicated client A's behaviors lasted ten minutes.</p> <p>3/15/15 at 12:30 PM - Everyone but client A had finished eating their lunch and was watching television when client A said something to client B. Client A then picked up a chair and headed toward client B. Client A dropped the chair when the staff intervened. The BDS indicated client A's behaviors lasted five minutes.</p> <p>3/17/15 at 7:30 AM - While everyone in the group home was eating their breakfast, client A began screaming and hollering at her housemates. Client A threw cereal containers and the group home telephone across the floor and slid a chair across the floor. Client A sat down to finish her breakfast "running her mouth saying everyone was bothering her." Client A pushed and hit the staff. The BDS indicated client A's behaviors lasted thirty minutes.</p> <p>4/18/15 at 5:35 PM - Client A became angry after being denied seconds of breadsticks. Client A threw down the chair next to her and began crying. Client A refused to pick up the chair and prior</p>			

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	<p>to the staff getting the chair picked up, client A tripped and fell over the chair. The BDS indicated client A's behaviors lasted two minutes.</p> <p>6/4/15 at 5:30 PM - Client A was having dinner with her house mates when she started yelling at a female house mate to leave her alone. The other house mate wasn't bothering client A. Client A then threw a chair and the cup she was drinking from. The BDS indicated client A's behaviors lasted five minutes.</p> <p>6/6/15 at 5:30 PM - Client A was told she couldn't have a second piece of pizza. The staff gave her a choice to have more salad or fruit. Client A got upset and threw a bottle of salad dressing. Client A then got up and threw a chair, slamming it into the floor and breaking it and threatening harm to the staff. The BDS indicated client A's behaviors lasted thirty minutes.</p> <p>Client A's Interdisciplinary Team (IDT) meeting note of 4/13/15 indicated "Confusion or reason for Tylenol 3 (a narcotic for pain) - [client A] needs to confirm that she is in pain and in need of meds. Mother feels she is in pain and we are not recognizing.... Mother states people are not communicating with her. She is frustrated.... Says more</p>			

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	<p>communication is needed.... Any Behavior write ups to [name of client A's mother] at least once a month. Weekly email to [client A's mother] to report how things are going." The IDT note indicated client A's guardian was present for the meeting but refused to sign the meeting form.</p> <p>During interview with the QIDP on 7/13/15 at 3 PM, the QIDP: ___ Indicated she began sending client A's mother client A's behavior data on 1/1/15. ___ Indicated there was an issue with communication with client A's mother. ___ Indicated client A's mother would frequently not return phone calls and/or acknowledge emails. ___ Indicated all documented communication from client A's mother from the facility had been provided for review. ___ Indicated client A's legal representative/mother was notified of all reportable incidents to BDDS and APS (Adult Protective Services) within 24 hours of the incident.</p> <p>During telephone interview with client A's legal representative/mother on 7/16/15 at 8:40 AM, client A's mother: ___ Stated, "I am not being informed of things going on with [client A]."</p>			

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	<p>__ Stated, "Don't you think at least they (the facility) would inform me of behaviors lasting over an hour? I was shocked when I saw those behavior sheets."</p> <p>__ Indicated she was not aware client A was having so many behaviors and stated, "I have asked them to call me with any issues and they know I want to be informed."</p> <p>__ Indicated she was very involved with client A's care and wanted to be informed when she was having behaviors.</p> <p>__ Indicated she had requested weekly emails or phone calls to let her know how client A was doing but was not receiving weekly updates.</p> <p>__ Indicated at a meeting in February with IDT members, she (client A's mother) was provided with a behavior summary report.</p> <p>During interview with the RM on 7/17/15 at 3:30 PM, the RM,</p> <p>__ Indicated client A's mother often would not return phone calls and/or acknowledge emails.</p> <p>__ Indicated client A's behaviors/incidents that were not reportable were not reported to client A's mother/legal representative within 24 hours of the behavior.</p> <p>__ Indicated she was not aware of client A's request for weekly updates via email</p>			

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W 0154 Bldg. 00	<p>and/or telephone. __ Indicated all documented communication with client A's mother had been provided for review.</p> <p>This federal tag relates to complaint #IN00173224.</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.</p> <p>Based on record review and interview for 1 of 5 allegations of abuse for clients A and D, the facility failed to conduct an investigation to ensure no abuse had occurred in regard to sexual conduct reported between clients A and D.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 7/13/15 at 2 PM. A facility Statement Form dated 4/11/15 completed by a night shift staff indicated "[Client A] would also have a sexual relationship with her roommate [client D]. They would play with each other's breasts, take each other's clothes off, cuddle and sleep together in one of their beds, perform oral</p>	W 0154	<p>Correctiveactionforresident(s)fou dtohavebeenaffected Staff and managerswill be retrained on the Benchmark Abuse/Neglect Policy as well as the IncidentReporting Policy. This will include whatis abuse, neglect, exploitation, incidents are reportable, and the mandate forimmediate reporting to the QIDP. Managers will beretrained that any report of inappropriate sexual activity will be reported toguardians. They will be retrained that clientscannot give consent for sexual contact, guardian approval must beobtained.</p> <p>Howfacilitywillidentifyotherreside ntspotentiallyaffectedandwhatmea surestaken All residentscould be affected</p>	08/21/2015

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	<p>sex on each other by the looks of it, kiss each other and hug each other in front of staff and clients, tell each other they love each other. [Client A] would also act like [client D] is her mom, sucks her own thumb and hug [client D] while says 'Mommy' repetitive (sic)."</p> <p>On 7/13/15 at 2 PM emails were reviewed from the Residential Manager (RM) and the Qualified Intellectual Disabilities Professional (QIDP). __The email dated 4/17/15 at 4:24 PM from the QIDP to the RM indicated "Did you receive written communication from both guardians regarding their desires to end this relationship? Did either of them (the guardians) determine extra steps were needed to prevent future incidents? What are the plans to separate them (clients A and D) due to sharing a room?" __The return email from the RM dated 4/20/15 at 8:05 AM indicated "I have written communication from [client D's guardian]. [Client A's guardian] never responded. [Client D's guardian] just asked that we keep a close eye on the situation. I (the RM) instructed staff that at no time were these two girls to be alone."</p> <p>The facility records indicated no investigation in regard to the allegations of sexual misconduct between clients A</p>		<p>andcorrective action willaddress the needsof all clients.</p> <p>Measuresorsystemicchangesfacility putinplacetoensurenorecurrence Staff and managerswill be retrained on the Benchmark Abuse/Neglect Policy as well as the IncidentReporting Policy. This will include whatis abuse, neglect, exploitation, incidents are reportable, and the mandate forimmediate reporting to the QIDP. Managers will beretrained that any report of inappropriate sexual activity will be reported toguardians. They will be retrained that clientscannot give consent for sexual contact, guardian approval must be obtained. Assessments will becompleted to discuss guardian wishes regarding sexual contact. The annual assessment and the ISP will be keptcurrent.</p> <p>Howcorrectiveactionswillbemonitordtoensurenorecurrence Incidents are to bereported to the regional director via email so there is a time stamp of thetime the incident was reported. All allegations of abuse or neglect or exploitation will bereported and investigated per Benchmark policy. If an allegation is found to not be substantiated that will bedocumented on the investigation and the incident report follow up.</p>	

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	<p>and D and/or to determine if sexual abuse had occurred.</p> <p>During telephone interview with client D's guardian on 7/20/15 at 1 PM, client D's guardian: ___ Stated, "I got a call from [name of RM] saying they (the facility) caught [client D and client A] in an improper relationship and they were going to move [client A]. They didn't go into detail." ___ Indicated he was not able to remember the date. ___ Indicated client A and client D had been sharing a bedroom and the RM had told him they were going to separate them.</p> <p>During telephone interview with the Qualified Intellectual Disabilities Professional (QIDP) on 7/20/15 at 2 PM, the QIDP: ___ Indicated clients A and D had been sharing a bedroom. ___ Indicated client A reported to her that client A and client D wanted to be sexually involved. ___ Indicated when she had spoken with client A her understanding of the situation was nothing had happened between the two clients. ___ Stated the statement obtained from the night shift staff "read like something did happen."</p>			

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W 0227 Bldg. 00	<p>__ Indicated client D was moved to another bedroom to share a room with client B.</p> <p>__ Indicated an investigation was not conducted.</p> <p>9-3-2(a)</p> <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.</p> <p>Based on observation, record review and interview for 2 of 3 sampled clients (B and C) and 2 additional clients (E and F), the clients' Individual Support Plans (ISPs) failed to address the clients' identified training need in regard to leisure skills.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/13/15 between 3:30 PM and 6:40 PM. The clients arrived home from the day program at 3:30 PM and emptied their lunch boxes.</p> <p>__ At 4 PM staff #2 began the meal preparation and staff #1 began the PM medication pass. Client F sat down in one</p>	W 0227	<p>Corrective action for resident(s) found to have been affected</p> <p>Staff are to provide active treatment, both formal and informal at all times. Staff will be retrained on the need for utilizing all teachable moments.</p> <p>Staff will be retrained that they need to prompt consumers to participate in an activity such as meal prep, cooking, games, books, etc unless it is otherwise specified in the ISP.</p> <p>Leisure activities should be offered several times throughout the day and any refusals should be documented.</p> <p>This retraining will also include the requirement to follow dining plans and offer substitutions as explained on the dining plans available in the home for each client.</p>	08/21/2015

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	<p>of the love seats in the living room adjacent to the kitchen/dining area of the home.</p> <p>__ Between 4 PM and 4:30 PM clients B, C and E received their PM medications.</p> <p>__ At 4:30 PM a pot of ham and beans and a pot of spinach were cooking on the stove top. Staff #2 indicated client C had put the beans and the spinach in a pot to cook. Staff #2 stirred both pots and replaced the lids. Clients B and C were in and out of the dining area. Clients E and F were sitting in the living room. Client F continued to sleep.</p> <p>__ At 4:41 PM staff #2 asked staff #1 to retrieve napkins from the garage. Staff #1 asked client C, "You going to help me cook?" Client C did not respond to the staff's request. Client B sat at the dining room table watching the activity in the room.</p> <p>__ At 4:45 PM client C got two gallons of milk from the refrigerator, placed both gallons of milk on the dining room table, poured himself a glass of milk and then walked away from the dining area.</p> <p>__ At 4:50 PM staff #2 prompted client B to set the table. Client B placed plates, cups and silverware on the table and then returned to the living room and sat down in a lounge chair.</p> <p>__ At 4:55 PM the Residential Manager (RM) turned on the television and stated, "You like westerns [client C]?" Clients</p>		<p>How facility will identify other residents potentially affected and what measures taken</p> <p>All residents are affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>One member of management stays in the home at least weekly to observe meal time and provide on the spot training. This will include the necessity for teaching staff how to provide active treatment and how to follow formal training programs as well as informal teachable moments. The member of management will record their observations and any teachable moments on Manager In Home time in Provide.</p> <p>A TL will be in the home at least twice per week during meal times to observe and provide on the spot training. The TL will fill out a Meal Time Observation form and turn into the QIDP each time they are present during meal times.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The RD will ensure all staff are retrained on active treatment and formal training programs. The RD will monitor Provide, the time entry program, to ensure a member of management is observing in the home during meal times and that the TLs are in the homes at least twice</p>	
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	<p>B, C, E and F were sitting in the living room. None of the clients were actively watching the television.</p> <p>__At 5:10 PM staff #2 began cutting a medium sized watermelon into bite size pieces and placing the pieces into a bowl. Client B got up from the lounge chair and sat on a barstool nearby watching staff #2 cut up the watermelon. Client B stated, "Watch your thumb." Client E continued to sit on the couch facing the patio door not involved in any activity.</p> <p>__At 5:18 PM staff #2 asked staff #1, "You stirring those beans?" Staff #1 stated, "No, but I will."</p> <p>__At 5:19 PM staff #2 stated, "Shouldn't [client F] be doing something?" Staff #1 stated, "I hate to wake him up."</p> <p>__At 5:25 PM staff #2 asked staff #1, "You want me to start pouring anything or dipping up anything?" Staff #2 stated, "Yes." Staff #2 stated, "That milk shouldn't be setting out on the table like that." Staff #1 retrieved the two gallons of milk on the table and placed them back into the refrigerator.</p> <p>__At 5:30 PM staff #1 dipped up the ham and beans into a large bowl and placed the bowl on the table. Staff #1 then returned to the stove and dipped up the cooked spinach into a large bowl and placed it on the table.</p> <p>__At 5:38 PM staff #2 finished cutting up the watermelon and carried the bowl of</p>		weekly.	

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	<p>watermelon to the table and set it down. Staff #2 then placed slices of bread on a plate. Staff #2 indicated she had forgotten to fix the cornbread for the beans and was providing the clients with sliced bread instead. Staff #2 then set the plate of bread down on the table.</p> <p>__ At 5:41 PM staff #1 woke client F. Clients B, C, D, E and F were prompted to wash their hands and come to the table for their evening meal.</p> <p>During this observation period: __ Clients B and C were in and out of the kitchen and dining room area. __ Clients E and F sat in the living room adjacent to the kitchen. __ Client E slept throughout most of the observation. __ Clients B, C, E and F indicated no self motivation in regard to participating in leisure activities.</p> <p>Client B's record was reviewed on 7/14/15 at 1 PM. Client B's 4/14/15 Comprehensive Functional Assessment (CFA) indicated client B required verbal prompting in regard to leisure and recreational activities. Client B's Individualized Support Plan (ISP) dated 2/1/15 indicated no training objectives to assist client B with her identified need in regard to leisure skills.</p>			

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	<p>Client C's record was reviewed on 7/14/15 at 3 PM. Client C's 4/14/15 CFA indicated client C required verbal prompting in regard to leisure and recreational activities. Client C's ISP dated 6/1/15 indicated no training objectives to assist client C with his identified need in regard to leisure skills.</p> <p>Client E's record was reviewed on 7/15/15 at 1:30 PM. Client E's 4/14/15 CFA indicated client E required visual and verbal prompting in regard to leisure and recreational activities. Client E's ISP dated 6/1/15 indicated no training objectives to assist client E with his identified need in regard to leisure skills.</p> <p>Client F's record was reviewed on 7/15/15 at 2 PM. Client F's 4/14/15 CFA indicated client F required verbal prompting in regard to leisure and recreational activities. Client F's ISP dated 6/1/15 indicated no training objectives to assist client F with his identified need in regard to leisure skills.</p> <p>During interview with the Qualified Intellectual Disabilities Professional Designee (QIDPD) on 7/17/15 at 2 PM, the QIDPD indicated client B's, C's, E's and F's ISPs did not include specific training objectives in regard to leisure skills.</p>			

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W 0240 Bldg. 00	<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, record review and interview for 1 of 3 sampled clients (client A), the client's Individualized Support Plan (ISP) and Behavior Support Plan (BSP) failed to include how the staff were to monitor client A while at home and while at the day service program to ensure no engagement of inappropriate sexual behavior.</p> <p>Findings include:</p> <p>During observations at the workshop on 7/16/15 between 2 PM and 3 PM the following was observed: ___ The workshop area was a large L shaped room with many clients. ___ At 2 PM clients A and D left their work area together for their afternoon break. ___ Clients A and D sat at the same table during their break. ___ At 2:15 PM clients A and D returned to their work area.</p>	W 0240	<p>Corrective action for resident(s) found to have beenaffected Risk plans, ISPs,and BSPs for all consumers are updated annually and as needed when newdiagnoses or behaviors present. This willinclude how a client should be monitored when they have a behavior ofinappropriate sexual behavior. Assistant Directorwill update client A’s BSP in the historical section to include how staff are tomonitor client A for inappropriate sexual behavior. The updated BSP willbe sent to the day program and workshop and all staff will be retrained on thenew BSP.</p> <p>Howfacilitywillidentifyotherresidentspotentiallyaffectedandwhatmeasures taken All residentsare affected and correctiveaction will address theneeds of all clients.</p> <p>Measuresorsystemicchangesfacility putinplacetoensure norecurrence The RegionalDirector will retrain the QIDPs and the LPN on updating ISP,</p>	08/21/2015

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	<p>__ At 2:20 PM client D left her work area and went to client A's work area. Client D sat down in a chair beside client A and talked to client A for five minutes before returning to her work area.</p> <p>__ No workshop staff intervened and/or prompted client D to return to her work area.</p> <p>The facility's records were reviewed on 7/13/15 at 2 PM. A facility Statement Form dated 4/11/15 completed by a night shift staff indicated "[Client A] would also have a sexual relationship with her roommate [client D]. They would play with each other's breasts, take each other's clothes off, cuddle and sleep together in one of their beds, perform oral sex on each other by the looks of it, kiss each other and hug each other in front of staff and clients, tell each other they love each other. [Client A] would also act like [client D] is her mom, sucks her own thumb and hug [client D] while says 'Mommy' repetitive (sic)."</p> <p>On 7/13/15 at 2 PM emails were reviewed from the Residential Manager (RM) and the Qualified Intellectual Disabilities Professional (QIDP).</p> <p>__ The email dated 4/17/15 at 4:24 PM from the QIDP to the RM indicated "Did you receive written communication from both guardians regarding their desires to</p>		<p>BSPs and Risk plans annually and as needed. This will include a list of what staff are to do when they see inappropriate behaviors.</p> <p>QIDPs and LPN will send any new or updated ISPs, BSPs, or Risk Plans to day service programs via email as proof of receipt.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The IDT meets quarterly and more frequently as needed. At these quarterly meetings the team will review and discuss any new illnesses, risks, or behaviors, and record meeting notes on the meeting notes form.</p>	

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	<p>end this relationship? Did either of them (the guardians) determine extra steps were needed to prevent future incidents? What are the plans to separate them (clients A and D) due to sharing a room?"</p> <p>__The return email from the RM dated 4/20/15 at 8:05 AM indicated "I have written communication from [client D's guardian]. [Client A's guardian] never responded. [Client D's guardian] just asked that we keep a close eye on the situation. I (the RM) instructed staff that at no time were these two girls to be alone."</p> <p>Client A's record was reviewed on 7/14/15 at 2 PM.</p> <p>Client A's ISP dated 6/1/15 indicated "In the past [client A] has been noted to have inappropriate sexual behavior especially at work or in private locations. She (client A) will display affection to either sex and will perform sexual acts for and towards others; it is thought that these actions are to gain affection. Her guardian does not want [client A] to engage in this type of behavior; therefore staff must intervene if it is seen or heard about."</p> <p>Client A's BSP dated 1/1/15 indicated "Important history to note: [client A] has a history of engaging in inappropriate</p>			

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	<p>sexual behaviors that at times are unwanted by others, a goal is needed to assist her in understanding consent and recognizing what actions to take when an individual says 'no.' This is addressed in her ISP."</p> <p>Client A's ISP and BSP failed to include how the staff were to monitor client A while at home and while at the day service program to ensure no engagement of inappropriate sexual behavior.</p> <p>During interview with the Residential Manager (RM) on 7/14/15 at 2:30 PM, the RM: ___ Indicated client A and client D had been sharing a room. ___ Stated client D was moved to another room "As soon as [client G] was moved to another house and a bed was freed up." ___ Indicated until client G moved to another home the night shift staff was told to do 15 minute bed checks on clients A and D. ___ Indicated after clients A and D were separated into different bedrooms and no longer shared a room there was no need to continue doing the 15 minute bed checks. ___ When asked how client A was to be supervised while at the workshop, the RM stated, "There should be somebody watching her at all times."</p>			

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	<p>__ When asked how the staff at the home was to supervise client A, the RM stated, "They (the facility staff) are supposed to keep a close eye on her to make sure nothing happens."</p> <p>During interview with the workshop supervisor on 7/16/15 at 2:20 PM, the supervisor indicated he was not aware of any issues sexually related between clients A and D.</p> <p>During interview with workshop staff #1 on 7/16/15 at 2:50 AM, staff indicated: __ She was the work area supervisor for clients A and D. __ She did not see client D leave her work after break time and go to client A's work area. __ She was not aware of any issues between clients A and D in regard to inappropriate sexual behavior.</p> <p>During telephone interview with client D's guardian on 7/20/15 at 1 PM, client D's guardian: __ Stated, "I got a call from [name of RM] saying they (the facility) caught [client D and client A] in an improper relationship and they were going to move [client A]. They didn't go into detail." __ Indicated client A and client D had been sharing a bedroom and the RM had told him they were going to separate</p>			

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W 0249 Bldg. 00	<p>them.</p> <p>During telephone interview with the Qualified Intellectual Disabilities Professional (QIDP) on 7/20/15 at 2 PM, the QIDP:</p> <p>__ Indicated clients A and D had been sharing a bedroom.</p> <p>__ Indicated client A reported to her that client A and client D wanted to be sexually involved.</p> <p>__ Indicated client D was moved to another bedroom.</p> <p>__ Indicated client A's ISP and BSP had been revised to include the history of inappropriate sexual behavior.</p> <p>__ Indicated client A's ISP/BSP did not specify specifically how the staff were to monitor client A to ensure no further incidents of inappropriate sexual behavior.</p> <p>9-3-4(a)</p> <p>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.</p>			
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	<p>Based on observation, interview and record review for 2 of 3 sample clients (B and C) and 3 additional clients (D, E and F), the facility failed to ensure the clients were offered formal and informal training opportunities and/or choices of leisure activities when time permitted.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/13/15 between 3:30 PM and 6:40 PM. The clients arrived home from the day program at 3:30 PM and emptied their lunch boxes. Client A was on a home visit with her family.</p> <p>__At 4 PM staff #2 began the meal preparation and staff #1 began the PM medication pass. Client F sat down in one of the love seats in the living room adjacent to the kitchen/dining area of the home.</p> <p>__Between 4 PM and 4:30 PM clients B, C, D and E received their PM medications.</p> <p>__At 4:30 PM a pot of ham and beans and a pot of spinach were cooking on the stove top. Staff #2 indicated client E had put the beans and the spinach in a pot to cook. Staff #2 stirred both pots and replaced the lids. Clients B, C and D were in and out of the dining area. Clients E and F were sitting in the living room. Client F continued to sleep.</p>	W 0249	<p>Corrective action for resident(s) found to have beenaffected</p> <p>Staff are to provideactive treatment, both formal and informal at all times. Staff will be retrained on the need forutilizing all teachable moments.</p> <p>Staff will beretrained that they need to prompt consumers to participate in an activity suchas meal prep, cooking, games, books, etc unless it is otherwise specified inthe ISP. Leisure activities should beoffered several times throughout the day and any refusals should bedocumented. This training willinclude the requirement to follow dining plans and offer substitutions asexplained on the dining plans available in the home for each client.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken</p> <p>All residents areaaffected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place toensure no recurrence</p> <p>One member ofmanagement stays in the home at least weekly to observe meal time and provideon the spot training. This will includethe necessity for teaching staff how to provide active treatment and how tofollow formal training programs as well as informal teachable moments. The member of management will record theirobservations and any</p>	08/21/2015			

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	<p>__At 4:41 PM staff #2 asked staff #1 to retrieve napkins from the garage. Staff #1 asked client C, "You going to help me cook?" Client C did not respond to the staff's request. Client B sat at the dining room table watching the activity in the room.</p> <p>__At 4:45 PM client C got two gallons of milk from the refrigerator, placed both gallons of milk on the dining room table, poured himself a glass of milk and then walked away from the dining area.</p> <p>__At 4:50 PM staff #2 prompted client B to set the table. Client B placed plates, cups and silverware on the table and then returned to the living room and sat down in a lounge chair.</p> <p>__At 4:55 PM the Residential Manager (RM) turned on the television and stated, "You like westerns [client C]?" Clients B, C, D, E and F were sitting in the living room. None of the clients were actively watching the television.</p> <p>__At 5:10 PM staff #2 began cutting a medium sized watermelon into bite size pieces and placing the pieces into a bowl. Client B got up from the lounge chair and sat on a barstool nearby watching staff #2 cut up the watermelon. Client B stated, "Watch your thumb." Client E continued to sit on the couch facing the patio door not involved in any activity.</p> <p>__At 5:18 PM staff #2 asked staff #1, "You stirring those beans?" Staff #1</p>		<p>teachable moments on the Manager In Home time in Provide. A TL will be in thehome at least twice per week during meal times to observe and provide on thespot training. Each time a TL is presentduring meal time they will fill out a Meal Time Observation form and turn it into the QIDP.</p> <p>How corrective actions will be monitored to ensure norecurrence The RD will ensureall staff are retrained on active treatment and formal training programs. The RD will monitor Provide, the time entryprogram, to ensure a member of management is observing in the home during mealtimes and that the TLs are in the homes at least twice weekly.</p>		

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	<p>stated, "No, but I will." __At 5:19 PM staff #2 stated, "Shouldn't [client F] be doing something?" Staff #1 stated, "I hate to wake him up." __At 5:25 PM staff #2 asked staff #1, "You want me to start pouring anything or dipping up anything?" Staff #2 stated, "Yes." Staff #2 stated, "That milk shouldn't be setting out on the table like that." Staff #1 retrieved the two gallons of milk on the table and placed them back into the refrigerator. __At 5:30 PM staff #1 dipped up the ham and beans into a large bowl and placed the bowl on the table. Staff #1 then returned to the stove and dipped up the cooked spinach into a large bowl and placed it on the table. __At 5:38 PM staff #2 finished cutting up the watermelon and carried the bowl of watermelon to the table and set it down. Staff #2 then placed slices of bread on a plate. Staff #2 indicated she had forgotten to fix the cornbread for the beans and was providing the clients with sliced bread instead. Staff #2 then set the plate of bread down on the table. __At 5:41 PM staff #1 woke client F. Clients B, C, D, E and F were prompted to wash their hands and come to the table for their evening meal.</p> <p>During this observation period: __Clients B, C and D were in and out of</p>			

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	<p>the kitchen and dining room area.</p> <p>__ Clients E and F sat in the living room adjacent to the kitchen.</p> <p>__ Client E slept throughout most of the observation.</p> <p>__ The staff failed to offer clients B, C, D, E and F training and/or choices of leisure activity when opportunity was available.</p> <p>Client B's record was review on 7/14/15 at 1 PM. Client B's Individualized Support Plan (ISP) dated 2/1/15 indicated the following objectives:</p> <p>To clean and trim her fingernails.</p> <p>To complete her laundry with prompting.</p> <p>To assist staff in making one dinner item.</p> <p>Client C's record was reviewed on 7/14/15 at 3 PM. Client C's ISP dated 6/1/15 indicated the following objectives:</p> <p>To set the dining room table at dinner time.</p> <p>To gather two items needed for meals.</p> <p>To place his dirty laundry in a basket.</p> <p>Client D's record was reviewed on 7/15/15 at 1 PM. Client D's ISP dated 6/1/15 indicated the following objectives:</p> <p>To dispose of trash from her room.</p> <p>To put her laundry away.</p> <p>To walk before or after work to exercise for 10 - 15 minutes a day.</p> <p>Client E's record was reviewed on</p>			

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W 0331 Bldg. 00	<p>7/15/15 at 1:30 PM. Client E's ISP dated 6/1/15 indicated the following objectives: To measure his food for lunch. To put his dirty clothes in the washer. To assist with meal preparation.</p> <p>Client F's record was reviewed on 7/15/15 at 2 PM. Client F's ISP dated 6/1/15 indicated the following objectives: To dispose of collected paper. To assist with preparing at least one side dish.</p> <p>During interview with the Qualified Intellectual Disabilities Professional Designee (QIDPD) on 7/17/15 at 2 PM, the QIDPD: __ Indicated the staff were to prompt and/or provide the clients with informal and formal training at every available opportunity. __ Indicated clients should not be sitting for long periods of time without being prompted to an activity or training.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 3 sampled clients</p>	W 0331	<p>Corrective action for resident(s) found to have been affected The LPN has updated client A's high</p>	08/21/2015

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	<p>(client A), the facility's health care services failed to ensure client A's High Risk Plan (HRP) included client A's specific pain indicators, when and how the staff at the group home and at the day services were to assess client A for pain and what the day service staff were to do when client A required her Tylenol with Codeine for pain.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/13/15 between 3:15 PM and 6:40 PM and on 7/14/15 between 5:30 AM and 8:15 AM and at the workshop on 7/16/15 between 2 PM and 3:15 PM. During all observations the following was observed:</p> <p>__ Client A was a young short heavy set female that ambulated independently with a pronounced side to side awkward gait while using a wheeled walker for stability.</p> <p>__ Client A was verbal and difficult to understand and her words slurred together.</p> <p>Client A's record was reviewed on 7/14/15 at 2 PM.</p> <p>Client A's 2015 monthly physician's orders indicated:</p> <p>__ Tylenol #3 (a narcotic used for pain</p>		<p>risk plan to includespecific pain indicators and what staff are to do when Client A is in pain. The updated plan will be sent via email to dayprograms. All staff will be trained on the updated high riskplan.</p> <p>Howfacilitywillidentifyotherresidentspotentiallyaffectedandwhatmeasuresstaken Client A is the only client affected.</p> <p>Measuresorsystemicchangesfacility putinplacetoensurenorecurrence QIDPs and LPN will be retrained that when a guardian isconcerned about a specific situation, that situation will be added to the ISP,BSP, or high risk plan.</p> <p>Howcorrectiveactionswillbemonitoredtoensurenorecurrence The Regional Director will ensure allstaff receive the updated risk plan training by the LPN. The RegionalDirector will train the QIDPs and LPN on adding steps to be taken regardingguardian concerns to ISPs, BSPs, and high risk plans. The director will ensure these documented retrainingsare located in the employee HR file.</p>		

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	<p>control) 1 tablet every six hours as needed for hip pain or extra-curricular activities.</p> <p>__ Tylenol 325 milligrams two tablets every six hours as needed for fever or pain.</p> <p>__ Client A was to use a walker.</p> <p>__ "For long distances, [client A] needs to be provided with resting periods along with a wheelchair."</p> <p>Client A's 4/1/15 pelvic x-ray indicated bilateral severe hip dysplasia (the enlargement of an organ) and secondary degenerative osteoarthritic changes associated with bilateral hip dysplasia. No dislocation noted.</p> <p>Client A's High Risk Plan (HRP) for bilateral hip dislocation indicated "[Client A] has a diagnosis of bilateral hip dislocation. This is a condition where the femur (the bone in the thigh) becomes completely displaced from the hip joint. This is a condition related to [client A] having Downs Syndrome. [Client A] takes Glucosamine routinely and PRN (as needed) Tylenol #3 as ordered by Physician on MAR (Medication Administration Record). Symptoms to monitor for: Pain Swelling Hip or leg deformity</p>			

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	<p>Hip immobility</p> <p>If there is a concern observed staff will notify nurse and document recommendations on nursing notes.</p> <p>[Client A] has a PRN for pain medication that can be administered anytime [client A] c/o (complains of) pain and with extracurricular activity."</p> <p>Client A's HRP failed to include client A's specific pain indicators, when and how the staff at the group home and at the day services were to assess client A for pain and what the day service staff were to do when client A required her Tylenol with Codeine for pain.</p> <p>Client A's Medication Administration Records for January 2015 through July 2015 indicated client A had not received any Tylenol #3 for pain.</p> <p>Client A's Behavior Data Sheets (BDS) indicated an increase in client A's behaviors in January of 2015. The BDS indicated the following: __1/2/15 at 6:05 AM - Client A began slamming and tipping chairs over. She went back to eating. Periodically client A would start crying and yelling with no provocation. While going back to her bedroom, client A began hitting the doors and walls and slamming her bedroom door repeatedly.</p>			

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	<p>__1/6/15 at 7:30 AM - Client A was at the breakfast table and for no apparent reason became angry and started yelling at her housemates. The staff asked client A not to yell and not to be speaking to other clients in a harsh manner. Client A started throwing chairs. The staff asked client A again to calm down. Client A walked to her room punching the walls and screaming. Approximately 30 minutes went by and client A was still screaming. Client B went to her room to get her coat and client A came out of her room and started aggressively screaming in client B's face. The staff went back and told client A to stop and not to come out of her room being mean at client B as she had done nothing to client A. Client A continued to scream and throw things and punch walls. The BDS indicated client A's behaviors lasted one hour and thirty minutes.</p> <p>__1/7/15 at 5:30 PM - Client A "complained" client B was bothering her. Client B had done nothing nor said anything to client A. Client A got angry and "threw down a chair" then ran down the hall yelling that client B was bothering her. The BDS indicated client A's behaviors lasted one hour.</p> <p>__1/8/15 at 7:30 AM - Client A got into a dispute with other clients saying other clients were bothering her. Client A was "crying and upset." The BDS indicated</p>			

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	<p>client A's behaviors lasted thirty minutes.</p> <p>__1/9/15 at 7:30 AM - Client A was angry and frustrated at another client. Client A threw furniture and stormed off to her bedroom. The BDS indicated client A's behaviors lasted thirty minutes.</p> <p>__1/11/15 at 9:15 AM - Client A was "angry and mad. She was crying a whole lot and said how [client B] was bothering her." Client A threw a chair, banged the table and threw silverware. The BDS indicated client A's behaviors lasted thirty minutes.</p> <p>__1/20/15 at 5:30 PM - Client A was having dinner with her peers when she began "complaining" that everyone at the dinner table was "bothering her. She kept fussing and whining to everyone."</p> <p>__1/22/15 at 6 AM - Client A began hitting the table and throwing furniture, "placing herself and others at risk. She did this because she was mad and upset." The BDS indicated client A's behaviors lasted two hours.</p> <p>__2/20/15 at 6:10 AM - Client A got into a fight with another client. Client A was yelling, screaming and crying and threw a chair. The BDS indicated client A's behaviors lasted thirty minutes.</p> <p>__2/27/15 at 6:25 AM - Client A got into a confrontation with one of her housemates and they began arguing. When staff intervned and tried to stop the verbal altercation client A got up</p>			

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	<p>from the kitchen table and started tipping the dining room chairs over and "trying to destroy things." The BDS indicated client A's behaviors lasted ten minutes.</p> <p>__3/17/15 at 7:30 AM - While everyone in the group home was eating their breakfast, client A began screaming and hollering at her housemates. Client A threw cereal containers, the group home telephone across the floor and slid a chair across the floor. Client A sat down to finish her breakfast "running her mouth saying everyone was bothering her." Client A pushed and hit the staff. The BDS indicated client A's behaviors lasted thirty minutes.</p> <p>__4/18/15 at 5:35 PM - Client A threw down the chair next to her and began crying. Client A refused to pick up the chair and prior to the staff getting the chair picked up, client A tripped and fell over the chair.</p> <p>__6/1/15 at 4:30 PM - Client A was yelling at client B to leave her alone and to quit bothering her. Client B was doing nothing to client A. Client A provoked client B to the point of swearing and yelling.</p> <p>__6/4/15 at 5:30 PM - Client A was having dinner with her house mates when she started yelling at a female house mate to leave her alone. The other house mate wasn't bothering client A. Client A then threw a chair and the cup she was</p>			

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	<p>drinking from.</p> <p>__6/6/15 at 5:30 PM - Client A was told she couldn't have a second piece of pizza. The staff gave her a choice to have more salad or fruit. Client A got upset and threw a bottle of salad dressing. Client A then got up and threw a chair, slamming it into the floor and breaking it and threatening harm to the staff. The BDS indicated client A's behaviors lasted thirty minutes.</p> <p>Client A's record indicated no assessment for pain when client A was displaying aggressive behaviors, upset and crying.</p> <p>Client A's Individualized Support Plan (ISP) dated 6/1/15 indicated client A had training objectives "To increase independence and overall health through enhancing her knowledge in the areas of medication administration and wellness. [Client A] will use a 1-10 pain scale to rate her pain levels with verbal prompts and [client A] will inform staff when she feels like she needs a PRN (as needed) medication such as a pain medication or cold medication with verbal prompts."</p> <p>Client A's Interdisciplinary Team (IDT) meeting of 4/13/15 indicated "Confusion or reason for Tylenol 3 (a narcotic for pain) - [client A] needs to confirm that she is in pain and in need of meds.</p>			

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	<p>Mother feels she is in pain and we are not recognizing."</p> <p>During interview with the facility's LPN on 7/14/15 at 1 PM, the LPN: ___ Indicated client A rarely if ever complained of pain. ___ Indicated Tylenol #3 was no longer kept at the day services because client A rarely if ever requires it. ___ Indicated client A's mother was asking the staff to give client A Tylenol #3 prior to walking to and from the day services. ___ Indicated she had explained to the client A's mother that client A was not complaining of pain and walking to day services was a normal activity for client A. ___ Indicated client A will say that she hurts when she is in pain and stated, "She (client A) will say something like, 'My tummy hurts'." ___ Indicated the staff give client A regular Tylenol for menstrual cramps.</p> <p>During interview with client A's workshop supervisor on 7/16/15 at 3 PM, the supervisor: ___ Indicated if client A were to complain of pain, she (the supervisor) would be the one to give client A the medication. ___ When asked how do you assess client A for pain, the supervisor stated, "She will tell us if she's hurting."</p>			

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	<p>__ When asked what if she would need the Tylenol #3, the supervisor stated, "I don't know, I guess I would have to call [name of LPN]."</p> <p>__ Indicated the facility's LPN requested Tylenol #3 no longer be stored at the workshop.</p> <p>During telephone interview with client A's legal representative/mother on 7/16/15 at 8:40 AM, client A's mother:</p> <p>__ Indicated she would email this surveyor with client A's specific pain indicators that she has noticed through past experience.</p> <p>__ Indicated client A was not always reliable in reporting her pain.</p> <p>__ Indicated client A walked daily to and from the day services and stated, "I've asked them to give her a Tylenol #3 before leaving because I consider that to be an extra-curricular activity but [name of LPN] said that is not extra-curricular since she does it every day and they (the facility) would not give it to her."</p> <p>__ Indicated she had been told by staff that client A cries frequently while at day services which is a sign she could be in pain but was told by the Residential Manager (RM) that she rarely if ever cries while at day services.</p> <p>__ Stated, "If [client A] were to be in pain while at the center (day services), there isn't any Tylenol #3 for her (client A) to</p>			

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	<p>take. [Name of LPN] said there was no reason to keep it there anymore because she doesn't use it."</p> <p>During email interview with the LPN on 7/17/15 at 2 PM, the LPN: ___ Indicated client A's increase in behaviors was considered to be due to behavioral/psychiatric problems. ___ Indicated the facility wanted client A to have a psychiatric assessment due to the increase in behaviors and the hallucinations but client A's mother refused. ___ Indicated client A was not assessed for pain when a change in behavior was noted or when client A was crying, screaming or yelling. ___ Indicated client A's risk plan did not include client A's specific pain indicators, when and how the staff at the group home, the staff at day services and the staff at the workshop were to assess client A for pain and what the day service staff were to do when client A required her Tylenol with Codeine for pain while at the day services.</p> <p>An email from client A's legal representative/mother sent 7/18/15 at 10:22 AM to this surveyor and reviewed on 7/20/15 at 8 AM indicated the following: ___ "Some of [client A's] indicators for</p>			

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	<p>pain include: Facial expression, vigorous rocking in sitting position while hands and forearms are folded over pressing on hip/groin area, increased restlessness/anxiety including hypervigilance (an enhanced state of sensory sensitivity accompanied by an exaggerated intensity of behaviors), easily annoyed, cranky. I (client A's mother) have also been noticing increased isolation, decrease in activity or not wanting to help us (client A's family) do chores. She (client A) may not initiate a complaint of being in pain. If you ask her what is wrong, she will tell you she 'hurts.' I have heard her say in the group home, 'I don't feel good.' If you ask her, 'What doesn't feel good?' she will answer, 'My hip hurts (a little bit)' and 'My stomach hurts- cramps-that's all' She is not able to accurately gage (sic) pain verbally. She seems to always say '2' on 1-10. Facial pictures are not helpful-tend to pick the same every time. As stated above a little bit, that's all. I have seen her crying with pain and still say 'that's all.' [Client A] does not rock much when she is home but I usually see her rocking at the center or group home. She very rarely gets aggressive at home. I cannot remember her ever falling at home. I am attentive to limiting time on her feet; standing & walking. She rides a tricycle instead of walking and uses a wheel chair</p>			

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W 0368 Bldg. 00	<p>or buggy on outings."</p> <p>This federal tag relates to complaint #IN00173224.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 2 of 3 sampled clients (A and B) and 3 additional clients (E, F and G), the facility failed to ensure all drugs were administered to the clients in compliance with the clients' physician's orders.</p> <p>Findings include:</p> <p>The facility's reportable records were reviewed on 7/13/15 at 2 PM.</p> <p>The 7/26/14 BDDS (Bureau of Developmental Disabilities Services) report indicated client E did not receive his 10 PM dose of Ativan (for anxiety and depression) 0.5 mg (milligrams) on 7/25/14. The report indicated the staff responsible for the error and the staff</p>	W 0368	<p>Correctiveactionforresident(s)foun dtohavebeenaffected</p> <p>All staff willbe retrained on MedicationAdministration in a refreshercourse taught by theGroup Home LPN. This medicationadministration training willinclude the appropriate way to pass medicationand the appropriate way to ensure medications are properly labeled. The TLs willobserve one medicationpass for each staffquarterly. The LPN will observe one medication pass for each TLquarterly.</p> <p>Howfacilitywillidentifyotherreside ntspotentiallyaffectedandwhatmea surestaken</p> <p>All residentsare affected and correctiveaction will address</p>	08/21/2015

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	<p>responsible for doing the medication check were suspended from giving any further medications until retrained.</p> <p>The 7/29/14 BDDS report indicated client G did not receive her Isoptocartine 2% (eye drops to treat glaucoma) at 4 PM and 8 PM on 7/28/14 and on 7/29/14 at 7 AM and 4 PM due to the medication not being refilled. The report indicated the staff would be retrained and disciplined if necessary.</p> <p>The 8/6/14 BDDS report indicated client F did not receive his 7 AM Loratadine (for allergies) 10 mg on 8/6/14. The report indicated staff responsible for this error will be retrained and disciplinary action will be taken if necessary.</p> <p>The 8/12/14 BDDS report indicated client E did not receive his PM dose of Ativan. The report indicated the staff popped the medication from the packet and went to get client E and found the client in the shower. The staff locked the medication back up in the medication cabinet and forgot to give the medication once client E was out of the shower.</p> <p>The 9/25/14 BDDS report indicated on 9/25/14 a staff reported to the day service supervisor that client G did not receive her Erythromycin (an antibiotic) at 10</p>		<p>theneeds of all clients.</p> <p>Measuresorsystemicchangesfacility putinplacetoensurenorecurrence The Team Leaderswill observe one medicationpass for each staffquarterly. This will ensurestaff are continuallypassing medicationsas trained in CoreA Core B. The LPN will observe one medication pass foreach TL quarterly. These medication pass observations will be turned into the QIDPfor tracking and to ensure compliance.</p> <p>Howcorrectiveactionswillbemonitredtoensurenorecurrence The Team Leaderswill sign off ona medication observationsheet and turn itinto the LPN and QIDPquarterly to ensurethey are doing allrequired medicationobservations quarterly. The Regional Director will ensure allGroup Home staff receive this retraining will sign off on all Record ofTrainings.</p>		

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	<p>AM on 9/18/14 and 9/19/14 while at the day services. The report indicated the group home staff and the day service staff would be retrained.</p> <p>The 12/15/14 BDDS report indicated client A did not receive her Glucosamine Chondroitin (for degenerative joint disease) 500/400 mg at 4 PM on 12/14/14. The report indicated the staff will be retrained on packing medications for client outings.</p> <p>The 1/18/15 BDDS report indicated client B was not given her 8 PM dose of OxyContin (for pain) 10 mg (milligrams) on 1/17/15. The report indicated staff that failed to give client B her medication would receive retraining and disciplinary action if necessary.</p> <p>The 1/27/15 BDDS report indicated client G was not given her Erythromycin 250 mg, Pilocarpine 5 MG and Oyster Shell Calcium 500 mg on 1/25/15 PM. The report indicated "We (the facility) will look into this medication error and staff will receive the appropriate actions."</p> <p>During interview with the facility's LPN on 7/14/15 at 2 PM, the LPN indicated all clients were to receive their medications as ordered by their physician.</p>			

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W 0436 Bldg. 00	<p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients with adaptive equipment (B), the facility failed to ensure client B was provided training to care for and to wear her prescription eye glasses.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/13/15 between 3:15 PM and 6:40 PM. During this observation period client B wore her prescription eyeglasses. At 4 PM staff #2 complimented client B on her eyeglasses and indicated client B had broken several of her previous pairs of eyeglasses and client B was currently wearing a new pair of eyeglasses that had just been picked up that day.</p> <p>Observations were conducted at the</p>	W 0436	<p>Corrective action for resident(s) found to have beenaffected</p> <p>It is the facilitiesresponsibility to keep in repair all adaptive equipment includingeyeglasses. The eyeglasses in questionwere repaired and returned to the client. The client broke them again that evening and the glasses had to be takenback to the eye doctor for repair again. Since then the eyeglasses have been broken two more times. The Assistant Director will add adesensitization plan to the BSP about breaking eyeglasses for client B. This updated BSPwill be sent to day program as well and all staff will be trained on Client B'supdated BSP.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken</p> <p>All residents couldpotentially be affected and corrective action will address the needs of allclients.</p> <p>Measures or systemic changes</p>	08/21/2015

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	<p>group home on 7/14/15 between 5:30 AM and 8:15 AM. During this observation period client B did not wear her prescription eyeglasses.</p> <p>Observations were conducted at the workshop on 7/16/15 between 2 PM and 3:15 PM. During this observation period client B wore non prescription sun glasses. At 2:30 PM client B indicated she broke her eyeglasses and was wearing the tinted non prescription eyeglasses her father had given her.</p> <p>Client B's record was reviewed on 7/14/15 at 1 PM. Client B's Individualized Support Plan (ISP) dated 2/1/15 indicated client B required prescription eye glasses at all times. Client B's ISP indicated no training objectives to assist client B in wearing and caring for her eyeglasses.</p> <p>During interview with the Residential Manager (RM) on 7/14/15 at 2:30 PM, the RM: ___ Indicated client B had a history of breaking her sunglasses. ___ Indicated client B had just received a new pair of glasses 7/13/15 and had broken them after one day of use.</p> <p>During interview with the Qualified Intellectual Disabilities Professional</p>		<p>facility put in place to ensure no recurrence</p> <p>The Director will retrain the Management staff on the need to include any issues in the BSP, ISPor HRP. Also they will be retrained that any adaptive equipment must be repaired as soon as possible. The direct care staff will be retrained that they must report any broken adaptive equipment or client difficulties to the QIDP or LPN immediately.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The director will retrain the management staff and ensure the record of trainings are in their HR file.</p> <p>The director will ensure all DSPs are retrained on reporting any issues or concerns to a member of management immediately. The director will also ensure all staff are trained on Client B's updated BSP.</p>	

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W 0460 Bldg. 00	<p>Designee (QIDPD) on 7/17/15 at 2 PM, the QIDPD: ___ Indicated currently client B's ISP did not include any objectives to assist client B in wearing and/or caring for her eyeglasses. ___ Indicated this would be addressed in client B's upcoming annual meeting.</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 2 of 3 sampled clients (B and C) and 3 additional clients (D, E and F), the facility failed to ensure the staff followed the facility menu and to ensure clients were offered substitutions for menu items that were refused and/or not eaten.</p> <p>Findings include: Observations were conducted at the group home on 7/13/15 between 3:30 PM and 6:40 PM. ___ Clients B, C, D, E and F were served ham and bean soup, cooked spinach,</p>	W 0460	<p>Corrective action for resident(s) found to have beenaffected Staff will beretrained on following diet plans, offering substitutions and portion controlat an all staff meeting by the LPN and QIDPs. The record of trainings will be signed by the RD and placed in theemployee HR file. The dietician visitsthe group home at least quarterly and communicates with the LPN as needed.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken All consumers couldpotentially be affected and corrective action plans will address the needs ofall clients.</p> <p>Measures or systemic changes</p>	08/21/2015			

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	<p>sliced bread and cubed watermelon for their evening meal.</p> <p>___ Three boxes of cornbread mix were on the shelf in the food supply closet off of the dining room.</p> <p>___ At 5:54 PM staff #2 stated, "I forgot to fix the corn bread. That's why they are having bread instead." Client D wanted two slices of bread. Staff #2 explained to client D two slices of bread were not on her diet plan. Staff #1 got up from the table and stated, "I'll see what else I can find." Staff #1 retrieved a small styrofoam cup of fruit from the refrigerator and gave it to client D.</p> <p>___ At 6:15 PM client D asked for a different vegetable other than the spinach. Staff #1 stated, "We don't have anything else to give you." Client D stated, "Then can I have some more beans?" Client D picked up the bowl the beans were served in and found it was empty. Client C had 4 portions of beans and had finished eating the remainder of the beans in the bowl. Staff #2 stated, "I guess a little more watermelon won't hurt." Staff #2 handed client D the bowl with the remainder of the watermelon.</p> <p>___ Clients C, D, E and F refused to eat the spinach. The staff did not offer the clients a vegetable substitution for the spinach that was refused.</p> <p>___ The staff did not provide and/or offer the clients margarine for their bread.</p>		<p>facility put in place to ensure no recurrence</p> <p>Staff will be retrained on following diet plans, offerings substitutions, and portion control by the LPN and QIDP at an all staff meeting.</p> <p>Team Leaders will be in the home at least twice weekly to observe meal time and offer on the spot training. A member of management will be in the home at least weekly to observe meal times and provide on the spot training. These visits will be documented on Manager InHome time in Provide.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The Regional Director will sign off on the record of training and will ensure the trainings are placed in the employee HR file.</p> <p>The TL will complete a meal observation form each time they observe meals and will turn that in to the QIDP.</p> <p>The RD will monitor Provide time entry to ensure management staff are present in the home at least weekly to observe meal time and provide on the spot training.</p>		

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W 0488 Bldg. 00	<p>Review of the facility's 4/2/12 week #5 1500 calorie menu on 7/13/15 at 3:45 PM indicated the clients were to have the following for their evening meal:</p> <p>1 cup of ham and bean soup 1 cup of spinach or greens 1 corn muffin with 1 teaspoon of margarine 1/2 cup of unsweetened peaches 1 cup of water 1 cup of skim milk 8 - 12 ounces of punch.</p> <p>During interview with the Qualified Intellectual Disabilities Professional Designee (QIDPD) on 7/17/15 at 2 PM, the QIDPD:</p> <p>__ Indicated the staff were to offer all of the food indicated on the menu for each meal unless the food was not available at which time the staff would substitute an appropriate food item for the food that was not available.</p> <p>__ Indicated the staff were to offer clients a similar food substitution for food not eaten or refused.</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats</p>			

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	<p>in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 2 of 3 sampled clients (B and C) and 3 additional clients (D, E and F), the facility failed to ensure the staff provided training in meal preparation when formal and informal training opportunities existed.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/13/15 between 3:30 PM and 6:40 PM. Ham and bean soup, cooked spinach, sliced bread and cubed watermelon were served for the evening meal.</p> <p>___At 4 PM client F sat down in one of the love seats in the living room adjacent to the kitchen/dining area of the home. Client F's eyes were closed and he was not involved in any activities.</p> <p>___At 4:30 PM a pot of ham and beans and a pot of spinach were on the stove cooking. Staff #2 indicated client E had helped to put the beans and the spinach in a pot to cook. Staff #2 stirred both pots and replaced the lids. Clients B, C and D were in and out of the dining area. Clients E and F were sitting in the living room. Client F continued to sleep.</p> <p>___At 4:41 PM staff #2 asked staff #1 to retrieve napkins from the garage. Staff #1</p>	W 0488	<p>Corrective action for resident(s) found to have beenaffected Staff are to provideactive treatment, both formal and informal at all times. Staff will be retrained on the need forutilizing all teachable moments. This training willinclude the requirement to follow dining plans and offer substitutions asexplained on the dining plans available in the home for each client.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken All residents areaffected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place toensure no recurrence One member ofmanagement stays in the home at least weekly to observe meal time and provideon the spot training. This will includethe necessity for teaching staff how to provide active treatment and how tofollow formal training programs as well as informal teachable moments. The member of management will record theirobservations and any teachable moments on the Manager In Home time in Provide. A TL will be in thehome at least twice per week during meal times to observe and provide on thespot training.</p>	08/21/2015
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	<p>asked client C, "You going to help me cook?" Client C did not respond as client B sat at the dining room table watching.</p> <p>__At 4:45 PM client C got two gallons of milk from the refrigerator, placed both gallons of milk on the dining room table, poured himself a glass of milk and then walked away from the dining room.</p> <p>__At 4:50 PM staff #2 prompted client B to set the table. Client B placed plates, cups and silverware on the table and then returned to the living room and sat down in a lounge chair.</p> <p>__At 5:10 PM staff #2 began cutting a medium sized watermelon into bite size pieces and placing the pieces into a bowl. Client B got up from the lounge chair and sat on a barstool nearby watching staff #2 cut up the watermelon. Client B stated, "Watch your thumb."</p> <p>__At 5:18 PM staff #2 asked staff #1, "You stirring those beans?" Staff #1 stated, "No, but I will."</p> <p>__At 5:25 PM staff #2 asked staff #1, "You want me to start pouring anything or dipping up anything?" Staff #2 stated, "Yes." Staff #2 stated, "That milk shouldn't be setting out on the table like that." Staff #1 retrieved the two gallons of milk on the table and placed them back into the refrigerator.</p> <p>__At 5:30 PM staff #1 dipped up the ham and beans into a large bowl and placed the bowl on the table. Staff #1 then</p>		<p>How corrective actions will be monitored to ensure norecurrence</p> <p>The Director will ensure all staff are retrained on active treatment and formal training programs. The Director will also monitor Provide, the time entry program, to ensure a member of management is observing in the home during meal times and that the TLs are in the homes at least twice weekly.</p>	
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	<p>returned to the stove and dipped up the cooked spinach into a large bowl and placed it on the table.</p> <p>__At 5:38 PM staff #2 finished cutting up the watermelon and carried the bowl of watermelon to the table and set it down. Staff #2 then placed slices of bread on a plate and set the plate of bread down on the table.</p> <p>__At 5:41 PM staff #1 woke client F to wash his hands and prompted clients B, C, D and E to wash their hands and come to the table for their evening meal. Staff #2 realized no bowls had been placed on the table for the soup beans and stated, "I think the wiser choice of dinnerware would have been bowls." Staff #2 returned to the kitchen and retrieved soup bowls for everyone and brought them back to the table and gave each client a bowl.</p> <p>During this observation period: __Clients B, C and D were in and out of the kitchen/dining room area. __Clients E and F sat in the living room adjacent to the kitchen. __The staff did not prompt and/or provide clients B, C, D, E and F training with meal preparation when opportunity was available.</p> <p>During interview with the Residential Manager (RM) on 7/15/15 at 3 PM, the</p>			

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W 9999 Bldg. 00	<p>RM:</p> <p>__ Indicated clients B, C, D, E and F were not independent with meal preparation and required staff supervision and prompting.</p> <p>__ Indicated the staff were to provide the clients with training in meal preparation at every available opportunity.</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 9-3-1 Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>__ A service delivery site with a structural or environmental problem that jeopardizes or compromises the health or welfare of an individual.</p>	W 9999	<p>Corrective action for resident(s) found to have been affected</p> <p>Regional Director will assure that all staff are retrained all group home staff at staff meetings on the Benchmark Abuse/Neglect Policy as well as the Incident Reporting Policy. This will include what is abuse, neglect, exploitation, and injuries of unknown origin, what incidents are reportable, and the mandate for immediate reporting to the QIDP.</p> <p>The director will retrain the QIDP and LPN on necessary components of investigations. This will include conducting thorough interviews of all relevant individuals, and immediate reporting, no less than within 24 hours.</p>	08/21/2015			

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	<p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 3 of 3 sample clients (A, B and C) and 3 additional clients (D, E and F), the facility failed to notify the Bureau of Developmental Disabilities Services (BDDS) within 24 hours in accordance with state law of bedbugs in the group home.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 7/13/15 at 2 PM. The records indicated the following:</p> <p>An invoice dated 2/24/15 from a local professional pest extermination company indicated the home of clients A, B, C, D, E and F was inspected by a professional exterminator. The record indicated "Found 1 live bedbug on bedspring. Signs and a couple exoskeleton on bed. Recommend treatment."</p> <p>A 3/6/15 Bureau of Developmental Disabilities Services (BDDS) report indicated "On Friday February 27th an exterminator was called in to inspect for bed bugs. The exterminator found 1 bug at that time. Preventative measures and</p>		<p>How facility will identify other residents potentially affected and what measures taken</p> <p>All residents are affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure recurrence</p> <p>This has always been a policy at Benchmark. No systemic changes are needed. Staff retraining will remind staff of the importance and necessity of reporting immediately and within 24 hours to all relevant individuals.</p> <p>How corrective actions will be monitored to ensure recurrence</p> <p>Incidents are to be reported to BDDS and the Regional Director immediately. This should be sent via email as proof of the time sent. The Director will review 100% of incident reports.</p>	

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	<p>laundering was done on that day. The exterminator came back on Monday 3/2/15 and found two additional bugs."</p> <p>During interview with the Residential Manager (RM) on 7/17/15 at 4 PM, the RM indicated BDDS was to be notified within 24 hours of knowledge of environmental problems that jeopardize or compromise the health or welfare of the clients and stated, "I can't explain the discrepancy of dates on the BDDS report."</p> <p>9-3-1(b)</p>				