

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/20/2011
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 103 E HANCOCK MITCHELL, IN47446
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: October 17, 18, 19 and 20, 2011.</p> <p>Facility Number: 000924 Provider Number: 15G410 AIM Number: 100244510</p> <p>Surveyors: Steven Schwing, Medical Surveyor III-Team Leader Mark Ficklin, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/4/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0124	<p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>Based on observation, record review and interview, the facility failed for 3 of 4 sampled clients (#1, #3, #5) to ensure the</p>	W0124	Guardian signatures and approvals were obtained. Program Director completed in-service training obtaining	11/18/2011

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>clients' guardians were informed of locked knives at the group home and door alarms on the entrance/exit doors.</p> <p>Findings Include:</p> <p>1) An observation was done on 10/17/11 at the group home from 4:30p.m. to 6:38p.m. At 4:54p.m., direct care staff #3 took a sharp knife from the dishwasher and put it in a locked cabinet in the facility's staff office. Staff #3 was interviewed on 10/17/11 at 5:01p.m. Staff #3 indicated the group home kept the knives locked due to client #1's behavior. Staff #1 indicated the knives were double locked and only staff had access to the locked cabinet. At 4:50p.m., client #7 came inside from the back deck and the door alarm sounded when the back door was opened. Direct care staff #9 was interviewed on 10/17/11 at 5:50p.m. Staff #9 indicated there were door alarms on all entrance/exit doors due to client #6's behavior.</p> <p>The record for client #1 was reviewed on 10/18/11 at 12:18p.m. Client #1's individual support plan (ISP), dated 9/29/11, indicated client #1 had a guardian. Client #1's record did not have any documentation that client #1's guardian had been informed of the facility's practice to lock up the group</p>		<p>signatures for restrictions and ISP's. Area Director will continue review completed HRC approvals and ISP's for guardian signatures. Persons responsible: Program Director and Area Director</p>		

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	<p>home knives and to use door alarms on the entrance/exit doors.</p> <p>Professional staff #1 was interviewed on 10/18/11 at 12:52p.m. Staff #1 indicated there was no documentation client #1's guardian had been informed of the facility's practice to lock the knives and to use door alarms on the entrance/exit doors.</p> <p>2) An observation was conducted at the group home on 10/18/11 from 5:52 AM to 8:07 AM. During the observation, the sharp knives were locked. This affected clients #3 and #5. During the observation, when any of the 4 exit doors were opened, an audible alert sounded. This affected clients #3 and #5.</p> <p>A review of client #3's record was conducted on 10/19/11 at 1:10 PM. Her Individual Support Plan (ISP), dated 9/13/11, was not signed by her guardian. Her ISP indicated she had a guardian. There was no consent in her record from her guardian for the implementation of her ISP. There was no consent in her record for the sharp knives to be locked or for the audible alarms on the exit doors from her guardian.</p> <p>A review of client #5's record was conducted on 10/19/11 at 11:56 AM. His</p>				

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	<p>ISP, dated 12/2/10, was not signed by his guardian. The ISP indicated client #5 had a guardian. There was no consent in his record from his guardian for the implementation of his ISP. There was no consent in his record from the guardian for the sharp knives to be locked or for the audible alarms on the exit doors.</p> <p>An interview with Direct Care Staff (DCS) #8 was conducted on 10/18/11 at 6:54 AM. DCS #8 indicated the door alarms were on all the exit doors due to client #6's behavior of elopement/wandering.</p> <p>An interview with the Home Manager (HM) was conducted on 10/19/11 at 10:34 AM. The HM indicated the alarms were in place to address client #6's elopement/wandering behavior. The HM indicated she was unable to locate documentation in client #3 and #5's record indicating the guardians consented to the restriction. The HM indicated clients #3 and #5 did not need the restriction.</p> <p>An interview with Administrative staff (AS) #1 was conducted on 10/19/11 at 10:34 AM. AS #1 indicated the alarms were in place to address client #6's elopement. AS #1 indicated he was not able to locate documentation indicating client #6's guardian consented to the ISP,</p>			

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W0125	<p>door alarms, or the locking of the sharp knives. AS #1 indicated clients #3 and #5 did not need the sharp knives to be locked or the audible door alarms. On 10/19/11 at 4:18 PM, AS #1 indicated clients #3 and #5 were unable to access the knives without staff assistance.</p> <p>9-3-2(a)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3, #5), the facility failed to ensure the clients had the right to due process in regard to activated door alarms placed on the doors to enter/exit the facility, locked sharp knives and client #5 had a guardian.</p> <p>Findings include:</p> <p>1) An observation was done on 10/17/11 at the group home from 4:30p.m. to 6:38p.m. At 4:54p.m., direct care staff #3 took a sharp knife from the dishwasher and put it in a locked cabinet in the facility's staff office. Staff #3 was interviewed on 10/17/11 at 5:01p.m. Staff #3 indicated the group home kept the</p>	W0125	<p>Clients #1, #2, #3, and #5's ISP's have been updated to include use of restrictions. Program Director has been in-serviced in regards to addition of restrictions in client plans. Area Director will continue reviewing plans to ensure completion. Persons responsible: Program Director and Area Director</p>	11/18/2011

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	<p>knives locked due to client #1's behavior. Staff #1 indicated the knives were double locked and only staff had access to the locked cabinet. At 4:50p.m., client #7 came inside from the back deck and the door alarm sounded when the back door was opened. Direct care staff #9 was interviewed on 10/17/11 at 5:50p.m. Staff #9 indicated there were door alarms on all entrance/exit doors due to client #6's behavior.</p> <p>Record review for client #1 was done on 10/18/11 at 12:18p.m. Client #1's 9/29/11 individual support plan (ISP) did not indicate the use of alarms on the facility's enter/exit doors and the facility practice to lock the sharp knives.</p> <p>Record review for client #2 was done on 10/18/11 at 10:50a.m. Client #2's 6/26/11 ISP did not indicate the use of alarms on the facility's enter/exit doors and the facility practice to lock sharp knives.</p> <p>Professional staff #1 was interviewed on 10/18/11 at 12:52p.m. Staff #1 indicated the activated door alarms were to address client #6's behavior and the locked knives were due to client #1's behavior. Staff #1 indicated these restrictions were not addressed in client #1, #2, #3 and #4's ISPs.</p>				

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	<p>2) An observation was conducted at the group home on 10/18/11 from 5:52 AM to 8:07 AM. During the observation, the sharp knives were locked. During the observation, when any of the 4 exit doors were opened, an audible alert sounded. This affected clients #3 and #5.</p> <p>A review of client #3's record was conducted on 10/19/11 at 1:10 PM. Her Individual Support Plan (ISP), dated 9/13/11, did not address the use of door alarms or the locking of sharp knives. Client #3's Behavior Support Plan (BSP), dated 9/1/10, did not address the use of door alarms or the locking of sharp knives.</p> <p>A review of client #5's record was conducted on 10/19/11 at 11:56 AM. His ISP, dated 12/2/10, did not address the use of door alarms or the locking of sharp knives. Client #5's BSP, dated 12/2/10, did not address the use of door alarms or the locking of sharp knives.</p> <p>An interview with Direct Care Staff (DCS) #8 was conducted on 10/18/11 at 6:54 AM. DCS #8 indicated the door alarms were on all the exit doors due to client #6's behavior of elopement/wandering.</p>			

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	<p>An interview with the Home Manager (HM) was conducted on 10/19/11 at 10:34 AM. The HM indicated the alarms were in place to address client #6's elopement/wandering behavior. The HM indicated clients #3 and #5 did not need the restrictions of sharp knives being locked and the use of door alarms. The HM indicated client #3 and #5's plans did not address the restrictions.</p> <p>An interview with Administrative staff (AS) #1 was conducted on 10/19/11 at 10:34 AM. AS #1 indicated the alarms were in place to address client #6's elopement. AS #1 indicated clients #3 and #5 did not need the sharp knives to be locked or the audible door alarms. AS #1 indicated client #3 and #5's plans did not address the restrictions.</p> <p>3) A review of client #5's record was conducted on 10/18/11 at 11:56 AM. His ISP, dated 12/2/10, indicated client #5 had a guardian. His ISP was not signed by the guardian. His BSP, dated 12/2/10, was not signed by the guardian. A review of his Informed Consent - Skills List assessment, dated 3/10/11, was conducted on 10/19/11 at 4:28 PM. His assessment indicated he was not independent in the following areas: photograph consent, finances, release of information, endangered adults, resident rights, dietary</p>			

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W0126	<p>needs, psychotropic medications, team membership, behavior assessment, house rules, medical treatment, supervision level, grievance policy and procedure and human rights committee membership. The assessment indicated client #5 was emancipated.</p> <p>An interview with Administrative staff #1 was conducted on 10/18/11 at 12:15 PM. AS #1 indicated client #5's guardian was deceased. AS #1 indicated the facility was seeking another guardian however one had not been appointed. AS #1 indicated client #5 needed a guardian.</p> <p>9-3-2(a)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sample clients (#2, #5) to ensure client #2 had a training program for his finances and client #5 received money skills training using real money.</p> <p>Findings include:</p> <p>1) The record of client #2 was reviewed on 10/18/11 at 10:50a.m. Client #2's</p>	W0126	<p>Client #2 has goal added to include money management. Client #5 oversized plastic coins have been replaced with actual coins. Staff has been in-serviced on both goals and use of actual coins. Program Director received training on writing goals and use of materials. Persons responsible: Home Manger, Program Director, and Area Director.</p>	11/18/2011

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	<p>6/26/11 individual support plan (ISP) indicated client #2 lacked financial knowledge and was in need of goals developed for money management. Client #2 did not have any money skills training programs currently in place.</p> <p>Interview of professional staff #1 on 10/18/11 at 12:52p.m. indicated client #2 had money training needs and did not have a current money training program in place.</p> <p>2) A review of client #5's record was conducted on 10/18/11 at 11:56 AM. Client #5's program documentation book contained a clear plastic storage bag with oversized plastic coins representing a penny, nickel, dime and a quarter. His Individual Support Plan (ISP), dated 12/2/10, indicated he had a training objective to increase his comfort with money by holding a coin in his hand while staff state the name of the coin.</p> <p>An interview with the Home Manager (HM) was conducted on 10/18/11 at 12:36 PM. The HM indicated the staff used the large plastic coins in order to get client #5 to hold the coins. The HM indicated client #5 was not able or would not hold real coins.</p>				

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W0140	<p>An interview with Professional Staff (PS) #1 was conducted on 10/18/11 at 12:36 PM. The PS indicated the staff used the large plastic coins to get client #5 to hold the coins. The PS indicated client #5 would not hold real coins.</p> <p>An interview with Administrative staff (AS) #1 was conducted on 10/19/11 at 4:18 PM. AS #1 indicated client #5's training should be conducted with real money.</p> <p>9-3-2(a)</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 4 of 6 clients living in the group home (#1, #2, #3 and #7), the facility failed to ensure the clients did not incur finance charges on their savings accounts.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 10/19/11 at 11:35 AM. -Client #1 incurred \$4.00 service charges for having a balance less than \$300.00 on 9/30/11, 8/31/11, 7/29/11, 6/30/11 and</p>	W0140	<p>Area Director has contacted Hoosier Hills Credit Union in Mitchell, Indiana and they have agreed to provide service free bank accounts for the Mitchell consumers. All the accounts will be transferred over from current bank to Hoosier Hills Credit Union by November 23, 2011. Home Manager will monitor accounts with Program Director review to ensure that no fees are charged. Persons Responsible: Home Manager, Program Director, and Area Director</p>	11/18/2011

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W0149	<p>5/31/11.</p> <p>-Client #2 incurred \$4.00 service charges for having a balance less than \$300.00 on 9/30/11, 8/31/11, 7/29/11, 6/30/11 and 5/31/11.</p> <p>-Client #3 incurred \$4.00 service charges for having a balance less than \$300.00 on 9/30/11, 8/31/11 and 4/29/11.</p> <p>-Client #7 incurred \$4.00 service charges for having a balance less than \$300.00 on 9/30/11 and 8/31/11.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 10/20/11 at 11:27 AM. AS #1 indicated the facility did not have documentation of steps taken to eliminate the service charges on the clients' savings accounts. AS #1 indicated the clients were receiving service charges of \$4.00 when the balance fell below \$300.00 during the month. AS #1 indicated the clients needed to switch banks to avoid having service charges.</p> <p>9-3-2(a)</p> <p>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 1 of 4 investigations reviewed affecting client #7, the facility neglected to implement its policies and procedures to prevent neglect.</p>	W0149	Staff #9 was given corrective action in regards to not following client #7's behavior plan. Area Director and Quality Assurance Manager will continue to review investigations in regards to	11/18/2011

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	<p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/17/11 at 2:45 PM. The BDDS (Bureau of Developmental Disabilities Services) report indicated on 10/7/11 at 7:55 PM, client #7 left the group home and used her wheelchair to go down the street. Direct Care Staff (DCS) #9 went to get her in the facility's van. When the DCS reached client #7 and attempted to assist her into the van, an onlooker contacted local law enforcement indicating DCS #9 was being aggressive with client #7. No charges were pressed by the police against the DCS. The investigative report, dated 10/14/11, indicated client #7 had a Behavior Support Plan (BSP) addressing vacating. The report indicated, "she does not have a plan to address a specific level of supervision when in the home or on the porch... Her plan states she has vacated in the past with staff present...". The investigative report indicated that prior to the incident, client #7 went into the kitchen 2-3 times looking for something to eat after dinner. The report indicated client #7 got upset and indicated she had not eaten and she was hungry. Staff #6 prompted her to get cereal and she did. While staff #6 was passing meds, she</p>		<p>recommendations. Persons Responsible: Program Director, Area Director, and Quality Assurance Manager</p>		

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	<p>heard staff #9 talking with client #7 about overeating and client #7 again stated she wanted more to eat. Staff #6 indicated she observed client #7 getting upset with staff #9 but staff #9 assisted her to get another snack. Client #7 took the snack to the back porch. Staff #6 indicated about 15 to 20 minutes later, there was a knock on the door. The neighbor indicated client #7 was at their house and asked if someone could come to get her. Staff #6 asked staff #9 to get client #7. Staff #9 returned a little while later without client #7 and asked staff #6 to go get client #7 because the neighbors were upset due to thinking staff #9 slapped client #7. Staff #6 indicated staff #9 had a scratch on his left cheek and he indicated client #7 had slapped and scratched him. Staff #9 indicated when he arrived at the neighbor's house to pick up client #7, she started yelling at him and indicating she was not going to leave. Staff #9 indicated in his statement that he told her she did not have a choice and for her safety, she had to go to the group home. Staff #9 indicated he pushed her wheelchair to the side of the van, put his arms under her arms, and lifted her into the first bench seat of the van. Client #7 then slapped staff #9. Staff #9 denied slapping client #6. Client #7, in the report, indicated staff #9 did not slap her. Client #7 indicated she slapped staff #9. The</p>			

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	<p>allegation of abuse was unsubstantiated.</p> <p>A review of client #7's BSP, dated 10/7/10, was conducted on 10/18/11 at 12:23 PM. The BSP indicated she had a targeted behavior of vacating. Vacating was defined as leaving without informing staff or leaving a program area and not returning when called. The Responding to Targeted Behaviors section indicated instead of directing client #7 to cease the behavior or to come back, approach her and ask her where she was going. Regardless of whether client #7 responds, tell client #7 that you will go with her. Do not talk with client #7, just stay with her. Do not chase client #7; shadow her from behind. If you chase client #7, she will move away from you faster and may be in danger of tipping over her wheelchair. About once every 5 minutes, ask her if she was ready to return. Stay with client #7 until she had returned to a safe location and keep her under observation until you were sure she will not vacate again.</p> <p>A review of the facility's abuse and neglect policy, dated June 2007, was conducted on 10/17/11 at 2:41 PM. The policy indicated the following, "The following actions are prohibited by employees of Indiana Mentor: 1) abuse, neglect, exploitation or mistreatment or an</p>			

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W0157	<p>individual; or 2) violation of an individual's right."</p> <p>An interview with Administrative staff (AS) #1 was conducted on 10/19/11 at 4:18 PM. AS #1 indicated client #7 had a plan for vacating. AS #1 indicated when staff #9 checked on client #7 while outside prior to vacating, client #7 told staff #9 to go back into the house. AS #1 indicated there had been no corrective or disciplinary action taken with staff #9. AS #1 indicated staff #9 did not implement client #7's BSP as written. AS #1 indicated moving her wheelchair and picking client #7 up and putting her into the van was not part of her BSP. AS #1 stated the incident "may have been avoided" if staff #9 followed client #7's BSP.</p> <p>9-3-2(a)</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 1 of 4 investigations reviewed affecting client #7, the facility failed to implement appropriate corrective action.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was</p>	W0157	<p>Staff #9 was given corrective action in regards to not following client #7's behavior plan. Area Director and Quality Assurance Manager will continue to review investigations in regards to recommendations. Persons Responsible: Program Director, Area Director, and Quality Assurance Manager</p>	11/18/2011

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	<p>conducted on 10/17/11 at 2:45 PM. The BDDS (Bureau of Developmental Disabilities Services) report indicated on 10/7/11 at 7:55 PM, client #7 left the group home and used her wheelchair to go down the street. Direct Care Staff (DCS) #9 went to get her in the facility's van. When the DCS reached client #7 and attempted to assist her into the van, an onlooker contacted local law enforcement indicating DCS #9 was being aggressive with client #7. No charges were pressed by the police against the DCS. The investigative report, dated 10/14/11, indicated client #7 had a Behavior Support Plan (BSP) addressing vacating. The report indicated, "she does not have a plan to address a specific level of supervision when in the home or on the porch... Her plan states that she has vacated in the past with staff present...". The investigative report indicated prior to the incident, client #7 went into the kitchen 2-3 times looking for something to eat after dinner. The report indicated client #7 got upset and indicated she had not eaten and she was hungry. Staff #6 prompted her to get cereal and she did. While staff #6 was passing meds, she heard staff #9 talking with client #7 about overeating and client #7 again stated she wanted more to eat. Staff #6 indicated she observed client #7 getting upset with staff #9 but staff #9 assisted her to get</p>			

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	<p>another snack. Client #7 took the snack to the back porch. Staff #6 indicated about 15 to 20 minutes later, there was a knock on the door. The neighbor indicated client #7 was at their house and asked if someone could come to get her. Staff #6 asked staff #9 to get client #7. Staff #9 returned a little while later without client #7 and asked staff #6 to go get client #7 because the neighbors were upset due to thinking staff #9 slapped client #7. Staff #6 indicated staff #9 had a scratch on his left cheek and he indicated client #7 had slapped and scratched him. Staff #9 indicated when he arrived at the neighbor's house to pick up client #7, she started yelling at him and indicating she was not going to leave. Staff #9 indicated in his statement that he told her she did not have a choice and for her safety, she had to go to the group home. Staff #9 indicated he pushed her wheelchair to the side of the van, put his arms under her arms, and lifted her into the first bench seat of the van. Client #7 then slapped staff #9. Staff #9 denied slapping client #6. Client #7, in the report, indicated staff #9 did not slap her. Client #7 indicated she slapped staff #9. The allegation of abuse was unsubstantiated. The investigation did not address staff #9 not implementing client #7's BSP as written.</p>			

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	<p>A review of client #7's BSP, dated 10/7/10, was conducted on 10/18/11 at 12:23 PM. The BSP indicated she had a targeted behavior of vacating. Vacating was defined as leaving without informing staff or leaving a program area and not returning when called. The Responding to Targeted Behaviors section indicated instead of directing client #7 to cease the behavior or to come back, approach her and ask her where she was going. Regardless of whether client #7 responds, tell client #7 that you will go with her. Do not talk with client #7, just stay with her. Do not chase client #7; shadow her from behind. If you chase client #7, she will move away from you faster and may be in danger of tipping over her wheelchair. About once every 5 minutes, ask her if she was ready to return. Stay with client #7 until she had returned to a safe location and keep her under observation until you were sure she will not vacate again.</p> <p>An interview with Administrative staff (AS) #1 was conducted on 10/19/11 at 4:18 PM. AS #1 indicated client #7 had a plan for vacating. AS #1 indicated when staff #9 checked on client #7 while outside prior to vacating, client #7 told staff #9 to go back into the house. AS #1 indicated there had been no corrective or disciplinary action taken with staff #9.</p>				

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W0227	<p>AS #1 indicated staff #9 did not implement client #7's BSP as written. AS #1 indicated moving her wheelchair and picking client #7 up and putting her into the van was not part of her BSP. AS #1 indicated the incident may have been avoided if staff #9 followed client #7's BSP.</p> <p>9-3-2(a)</p> <p>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, interview and record review for 3 of 6 clients living in the group home (#2, #3 and #5), the facility failed to ensure clients #2, #3 and #5 had plans to access sharp knives.</p> <p>Findings include:</p> <p>An observation was conducted at the</p>	W0227	<p>Clients #2, #3, and #5 have had additions to plans in regards to accessing sharp knives that are kept locked. This includes goals reflecting developmental skills. Staff has been in-serviced on implementation on these goals. Program Director was in-serviced on client rights and restrictions. Persons Responsible: Home Manager, Program Director, and Area Director</p>	11/18/2011

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	<p>group home on 10/18/11 from 5:52 AM to 8:07 AM. During the observations the sharp knives were locked. Clients #2, #3, and #5 were unable to access the sharp knives.</p> <p>Record review for client #2 was done on 10/18/11 at 10:50a.m. Client #2's 6/26/11 ISP indicated client #2 did not have a training program to address how client #2 could access the locked cabinet (in staff office) that contained the group home's sharp knives.</p> <p>A review of client #3's record was conducted on 10/18/11 at 11:12 AM. Her Individual Support Plan (ISP), dated 9/13/11, and BSP, dated 9/1/10, did not include a plan for client #3 to be able to access the sharp knives. There was no documentation in her record indicating client #3 needed to have sharp knives locked.</p> <p>A review of client #5's record was conducted on 10/18/11 at 11:56 AM. His ISP, dated 12/2/10, and BSP, dated 12/2/10, did not include a plan for client #5 to be able to access the sharp knives. There was no documentation in his record indicating client #5 needed to have sharp knives locked.</p> <p>An interview with the Home Manager</p>				

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W0240	<p>(HM) was conducted on 10/19/11 at 10:34 AM. The HM indicated clients #3 and #5 did not need the restrictions of sharp knives being locked. The HM indicated client #3 and #5's plans did not address the restriction. The HM indicated clients #3 and #5 did not have access or plans to access to the sharp knives.</p> <p>Interview of professional staff #1 on 10/18/11 at 12:52p.m. indicated the sharp knives were kept in the office in a locked cabinet due to client #1's behavior. Staff #1 indicated client #2 did not have a training program in place regarding his ability to access the group sharp knives kept locked in the staff office.</p> <p>An interview with Administrative staff (AS) #1 was conducted on 10/19/11 at 10:34 AM. AS #1 indicated clients #3 and #5 did not need the sharp knives to be locked. AS #1 indicated client #3 and #5's plans did not address the restrictions. AS #1 indicated clients #3 and #5 did not have access or plans to access to the sharp knives.</p> <p>9-3-4(a)</p> <p>The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for</p>	W0240	Client #7's plan dated 10/10/2011 to include supervision levels and	11/18/2011	

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	<p>1 of 3 non-sampled clients (#7), the facility failed to ensure her Behavior Support Plan (BSP) was revised after an incident of elopement.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/17/11 at 2:45 PM. The BDDS (Bureau of Developmental Disabilities Services) report indicated on 10/7/11 at 7:55 PM, client #7 left the group home and used her wheelchair to go down the street. Direct Care Staff (DCS) #9 went to get her in the facility's van. When the DCS reached client #7 and attempted to assist her into the van, an onlooker contacted local law enforcement indicating that the DCS #9 was being aggressive with client #7. No charges were pressed by the police against the DCS. The BDDS report indicated, "In order to prevent such incidents from occurring in the future, staff will monitor [client #7] at all times when she goes outside to smoke. The home has alarms on the doors, therefore, it is not necessary to complete 15 minute checks. However, if the alarm sounds, staff will check on [client #7]."</p> <p>A review of client #7's record was conducted on 10/18/11 at 10:45 AM.</p>		<p>staff have been in-serviced on new plan. Program Director has been in-serviced on facilitating IDT meetings prompting new Behavior Support Plans in a timely manner. Area Director will review IDT meeting notes to ensure above is being met. Persons Responsible: Program Director and Area Director</p>		

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	<p>There was no documentation in client #7 record indicating her plan was revised to include supervision while client #7 smoked. There was no documentation in client #7's record to indicate staff were to respond to door alarms to check on client #7's location. A Individual Habilitation Plan special review, dated 10/11/11, was reviewed on 10/20/11 at 8:32 AM. The review indicated the following, "New BSP added - all remaining plus adding manipulative beh (behavior), v (verbal) abuse, p (physical) assault, temper outburst, line of sight at all times." The BSP was not in client #7's record for review.</p> <p>An interview with the Home Manager (HM) was conducted on 10/19/11 at 10:34 AM. The HM indicated she trained the staff to check on client #7's location when a door alarm sounded and to keep client #7 within line of sight when she was smoking. The HM indicated she could not recall if she made an addendum to client #7's plan with this information.</p> <p>An interview with Administrative staff (AS) #1 was conducted on 10/19/11 at 10:34 AM. AS #1 indicated he thought there was an addendum to client #7's plan adding line of sight when she was smoking and to check on her location when an alarm sounded. AS #1 indicated</p>				

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W0249	<p>this should be in client #7's plan.</p> <p>9-3-4(a)</p> <p>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> <p>Based on record review and interview for 1 of 3 non-sampled clients (#7), the facility failed to ensure staff implemented client #7's behavior plan for vacating, as written.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 10/17/11 at 2:45 PM. The BDDS (Bureau of Developmental Disabilities Services) report indicated on 10/7/11 at 7:55 PM, client #7 left the group home and used her wheelchair to go down the street. Direct Care Staff (DCS) #9 went to get her in the facility's van. When the DCS reached client #7 and attempted to assist her into the van, an onlooker contacted local law enforcement indicating DCS #9 was being aggressive with client #7. No charges were pressed</p>	W0249	Staff #9 was given corrective action in regards to not following client #7's behavior plan. Area Director and Quality Assurance Manager will continue to review investigations in regards to recommendations. Persons Responsible: Program Director, Area Director, and Quality Assurance Manager	11/18/2011

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	by the police against the DCS. The investigative report, dated 10/14/11, indicated client #7 had a Behavior Support Plan (BSP) addressing vacating. The report indicated, "she does not have a plan to address a specific level of supervision when in the home or on the porch... Her plan states she has vacated in the past with staff present...". The investigative report indicated that prior to the incident, client #7 went into the kitchen 2-3 times looking for something to eat after dinner. The report indicated client #7 got upset and indicated she had not eaten and she was hungry. Staff #6 prompted her to get cereal and she did. While staff #6 was passing meds, she heard staff #9 talking with client #7 about overeating and client #7 again stated she wanted more to eat. Staff #6 indicated she observed client #7 getting upset with staff #9 but staff #9 assisted her to get another snack. Client #7 took the snack to the back porch. Staff #6 indicated about 15 to 20 minutes later, there was a knock on the door. The neighbor indicated client #7 was at their house and asked if someone could come to get her. Staff #6 asked staff #9 to get client #7. Staff #9 returned a little while later without client #7 and asked staff #6 to go get client #7 because the neighbors were upset due to thinking staff #9 slapped client #7. Staff #6 indicated staff #9 had a				

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	<p>scratch on his left cheek and he indicated client #7 had slapped and scratched him. Staff #9 indicated when he arrived at the neighbor's house to pick up client #7, she started yelling at him and indicating she was not going to leave. Staff #9 indicated in his statement that he told her she did not have a choice and for her safety, she had to go to the group home. Staff #9 indicated he pushed her wheelchair to the side of the van, put his arms under her arms, and lifted her into the first bench seat of the van. Client #7 then slapped staff #9. Staff #9 denied slapping client #6. Client #7, in the report, indicated staff #9 did not slap her. Client #7 indicated she slapped staff #9. The allegation of abuse was unsubstantiated.</p> <p>A review of client #7's BSP, dated 10/7/10, was conducted on 10/18/11 at 12:23 PM. The BSP indicated she had a targeted behavior of vacating. Vacating was defined as leaving without informing staff or leaving a program area and not returning when called. The Responding to Targeted Behaviors section indicated instead of directing client #7 to cease the behavior or to come back, approach her and ask her where she was going. Regardless of whether client #7 responds, tell client #7 that you will go with her. Do not talk with client #7, just stay with her. Do not chase client #7; shadow her</p>				

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	<p>from behind. If you chase client #7, she will move away from you faster and may be in danger of tipping over her wheelchair. About once every 5 minutes, ask her if she was ready to return. Stay with client #7 until she had returned to a safe location and keep her under observation until you were sure she will not vacate again.</p> <p>An interview with Administrative staff (AS) #1 was conducted on 10/19/11 at 4:18 PM. AS #1 indicated client #7 had a plan for vacating. AS #1 indicated when staff #9 checked on client #7 while outside prior to vacating, client #7 told staff #9 to go back into the house. AS #1 indicated staff #9 did not implement client #7's BSP as written. AS #1 indicated moving her wheelchair and picking client #7 up and putting her into the van was not part of her BSP. AS #1 indicated the incident may have been avoided if staff #9 followed client #7's BSP.</p> <p>9-3-4(a)</p>				

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W0264	<p>The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, record review and interview, the facility's Human Rights Committee (HRC) failed for 4 of 4 sampled clients (#1, #2, #3, #5) to review restrictive interventions: the facility practice of restricting client access to sharp knives and the use of door alarms on the facility entrance/exit doors.</p> <p>Findings include:</p> <p>1) An observation was done on 10/17/11 at the group home from 4:30p.m. to 6:38p.m. At 4:54p.m., direct care staff #3 took a sharp knife from the dishwasher and put it in a locked cabinet in the facility's staff office. Staff #3 was interviewed on 10/17/11 at 5:01p.m. Staff #3 indicated the group home kept the knives locked due to client #1's behavior. Staff #1 indicated the knives were double locked and only staff had access to the locked cabinet. At 4:50p.m., client #7 came inside from the back deck and the door alarm sounded when the back door was opened. Direct care staff #9 was</p>	W0264	<p>Clients #1, #2, #3, and #5's ISP's have been updated to include use of restrictions. Program Director has been in-serviced in regards to addition of restrictions in client plans. Area Director will continue reviewing plans to ensure completion. Persons responsible: Program Director and Area Director</p>	11/18/2011

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	<p>interviewed on 10/17/11 at 5:50p.m. Staff #9 indicated there were door alarms on all entrance/exit doors due to client #6's behavior.</p> <p>Record review of the facility's HRC reviews from 10/1/10 to 10/18/11 was done on 10/18/11 at 12:42p.m. There was no documentation the HRC had reviewed the facility's restrictive practice of restricting client access to sharp knives and no documentation the facility's HRC had reviewed the restrictive practice of activated entrance/exit door alarms for clients #1, #2, #3 and #5.</p> <p>Interview of professional staff #1 on 10/18/11 at 12:52p.m. indicated the facility restriction of clients #1, #2, #3 and #5 not having access to sharp knives and the use of entry/exit door alarms had not been presented to and reviewed by the facility's HRC.</p> <p>2) An observation was conducted at the group home on 10/18/11 from 5:52 AM to 8:07 AM. During the observation, the sharp knives were locked. During the observation, when any of the 4 exit doors were opened, an audible alert sounded. This affected clients #3 and #5.</p>				

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	<p>A review of client #3's record was conducted on 10/19/11 at 1:10 PM. Her Individual Support Plan (ISP), dated 9/13/11, did not address the use of door alarms or the locking of sharp knives. Client #3's Behavior Support Plan (BSP), dated 9/1/10, did not address the use of door alarms or the locking of sharp knives. There was no documentation in her record or presented during the survey indicating the HRC consented to the restrictions.</p> <p>A review of client #5's record was conducted on 10/19/11 at 11:56 AM. His ISP, dated 12/2/10, did not address the use of door alarms or the locking of sharp knives. Client #5's BSP, dated 12/2/10, did not address the use of door alarms or the locking of sharp knives. There was no documentation in his record or presented during the survey indicating the HRC consented to the restrictions.</p> <p>An interview with Direct Care Staff (DCS) #8 was conducted on 10/18/11 at 6:54 AM. DCS #8 indicated the door alarms were on all the exit doors due to client #6's behavior of elopement/wandering.</p> <p>An interview with the Home Manager (HM) was conducted on 10/19/11 at 10:34 AM. The HM indicated the alarms were</p>			

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W0371	<p>in place to address client #6's elopement/wandering behavior. The HM indicated clients #3 and #5 did not need the restrictions of sharp knives being locked and the use of door alarms. The HM indicated client #3 and #5's plans did not address the restrictions. The HM indicated she was unable to locate documentation from the HRC that they approved of the restrictions.</p> <p>An interview with Administrative staff (AS) #1 was conducted on 10/19/11 at 10:34 AM. AS #1 indicated the alarms were in place to address client #6's elopement. AS #1 indicated clients #3 and #5 did not need the sharp knives to be locked or the audible door alarms. AS #1 indicated client #3 and #5's plans did not address the restrictions. AS #1 indicated he was unable to locate documentation from the HRC that they approved of the restrictions.</p> <p>9-3-4(a)</p> <p>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. Based on record review and interview, the facility failed for 1 of 4 sampled clients</p>	W0371	Med administration training has been added to client #2's plan.	11/18/2011	

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W0454	<p>(#2) to provide client #2 with a medication administration training program.</p> <p>Findings include:</p> <p>The record of client #2 was reviewed on 10/18/11 at 10:50a.m. Client #2's 6/26/11 individual support plan (ISP) indicated client #2 received the medication Risperdal, Thioridazine and Depakote for behaviors and did not have a training program in place to address the administration of the medication. The ISP indicated client #2 had training needs with the self administration of medications.</p> <p>Interview on 10/18/11 at 12:52p.m. of professional staff #1, indicated client #2 was in need of medication administration training and did not have training in place at this time.</p> <p>9-3-6(a)</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation and record review for 1 of 3 clients observed to receive medication (#5), the facility failed to ensure the staff did not administer a pill that was dropped onto client #5's lap.</p>	W0454	<p>Staff has been in-serviced on implementation of plan.Home Manager and Program Director will monitor for completion.Program Director was in-serviced on providing goals per client ISP.Persons Responsible:Home Manager and Program Director.</p> <p>Staff #5 received corrective action for not following med administration procedures. Group Home staff were in-serviced on med administration policy. Home Manager and</p>	11/18/2011

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	<p>Findings include:</p> <p>An observation was conducted at the group home on 10/18/11 from 5:52 AM to 8:07 AM. At 7:22 AM, client #5 received his medications from staff #5. During the med pass, staff #5 dropped client #5's Buspirone (depression) onto client #5's lap. Staff #5 administered the pill to client #5.</p> <p>An interview with Direct Care Staff (DCS) #5 was conducted on 10/18/11 at 7:28 AM. DCS #5 indicated if the pill would have landed on the floor she would have obtained a new pill to administer.</p> <p>An interview with the Home Manager (HM) was conducted on 10/19/11 at 10:34 AM. The HM indicated the staff should have obtained a pill that was not dropped to client #5.</p> <p>An interview with Administrative staff (AS) #1 was conducted on 10/19/11 at 10:34 AM. AS #1 indicated the staff should not have administered the medication that was dropped to client #5 due to it being unsanitary. AS #1 indicated the staff should have administered a different pill to client #5.</p> <p>9-3-7(a)</p>		<p>Program Director will continue to monitor. Persons Responsible: Home Manager, Program Director, and Area Director.</p>	

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