

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/10/2012
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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
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W0000	<p>This visit was for a full recertification and state licensure survey.</p> <p>This visit was in conjunction with the post recertification revisit (PCR) to the PCR completed 8/4/11 to the investigation of complaint #IN00092167 completed on 7/1/11.</p> <p>This visit was in conjunction with the PCR to the PCR completed 8/4/11 to the investigation of complaints #IN00089801 and #IN00090212 completed on 5/6/11.</p> <p>Dates of Survey: January 3, 4, 5, 6, 9 and 10, 2012</p> <p>Facility number: 005592 Provider number: 15G736 AIM number: 200859130</p> <p>Surveyors: Tracy Brumbaugh, Medical Surveyor III-Team Leader Claudia Ramirez, Public Health Nurse Surveyor III</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/18/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
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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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W0100	<p>"Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if:</p> <p>(1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions;</p> <p>(2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and</p> <p>(3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the provision of active treatment services for 3 of 3 sampled clients (clients #1, #2, and #3) and 3 additional clients (clients #4, #5, and #6) for whom payment was requested.</p> <p>Findings include:</p> <p>Please see W195. The facility failed to ensure active treatment services were provided for 3 of 3 sampled clients (clients #1, #2, and #3) and 3 additional clients (clients #4, #5, and #6). The facility failed to provide active treatment services, including implementation of Individual Support Plans (ISP), dining plans, and failed to provide sufficient staff to implement identified training objectives. The facility failed to ensure sensorimotor assessments were completed</p>	W0100	<p>In regard to W100, there are several deficiencies with active treatment at Earl. The nurse is in the process of up-dating all High Risk and Care Plans and the incoming QDDP will be revising the active treatment schedules. While they are in place and staff have been trained, the training has not been really addressed how staff are to deliver the goals. On 2/9/12, the nurse and dietician will be doing an intensive training with Earl staff on medical, adaptive equipment, and dining expectations. All staff have been trained by the nurse and agency trainer on the correct Hoyer procedure and had to demonstrate correct use of the lift. The Leadership Team will be monitoring progress to implementation and sustaining the Plans of Correction at all group homes as part of their regularly scheduled bi-monthly meetings.</p>	02/01/2012			

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	for clients #1 and #2. The facility failed to ensure speech assessments were completed for clients #2 and #3. The facility failed to ensure client #2 and #3's communication needs were addressed in their ISPs. The facility failed to include specific guidelines for the use of a mechanical lift in client #2's ISP. The facility failed to ensure the Human Rights Committee (HRC) reviewed and approved restrictive practices (medications) in the clients' plans for clients #1, #2 and #3.			
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W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the governing body failed to exercise general direction in a manner that resulted in the facility being well maintained for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) who lived in the group home.</p> <p>Findings include:</p> <p>On 1-3-12 from 4:20 p.m. until 7:45 p.m. an observation at the home of clients #1, #2, #3, #4, #5, and #6 was conducted. At 4:45 p.m. the kitchen walls were observed to have 22 small holes and 1 large hole. The doorway from the kitchen to the living room had a 1 foot long area going up the wall, on both sides of the doorway, which had broken drywall with exposed wire mesh. The living room had a 3 inch by 3 inch hole by the television in the wall. The bathroom beside clients #1 and #5's room had a broken towel rack, broken toilet paper holder, and an area by the tub 1 foot by 3 inches which was bubbles drywall with an orange and black substance which covered it. The dresser in the hallway had the bottom drawer which was broken. Client #3's bedroom door and frame had paint which was scratched and chipped off over the entire door. Client #2's bedroom had an area</p>	W0104	<p>The governing body referenced in W104 is made up of the Executive Director, Director of Community Living, Director of Day and Placement Services, and Director of Administration. This group meets bi-monthly at regularly scheduled intervals and at one of those meetings will specifically address current and recently completed Plans of Corrections to make sure issues are continually addressed. This will be reflected in the Leadership meeting notes. The household issues identified will be corrected. In response to the follow-up question noted on 2/2/12, a representative from the agency's Safety Committee will conduct quarterly site visits of the GH to identify any maintenance concerns. This will be on top of the daily/weekly checks that the recently named Lead DSP, House Manager/Progrmaming Coordinator, and QDDP will be doing as part of their regular visits to the home.</p>	02/01/2012			

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	<p>under her window which had dents and chipped paint with black marks which covered a 3 foot by 10 inch area. The wall leading into the hall by the medication closet had 3 holes in it 2 inches by 2 inches in size. The window and door in the living room had unfinished drywall and wood around it. At 7:10 p.m. the dinner plates for clients #1, #2, #3, #4, #5, and #6, were warped, scratched, and had a white residue which covered the plates.</p> <p>On 1-4-12 from 6:45 a.m. until 9:10 a.m. an observation at the home of clients #1, #2, #3, #4, #5, and #6 was conducted. At 8:40 a.m. client #1 and #5's closet door had no handle and the paint was chipped and scratched. The hallway ceiling light had no fixture to cover the 2 exposed light bulbs.</p> <p>On 1-3-12 at 7:10 p.m. an interview with direct care staff #7 indicated the plates did have knife cuts in the plastic and were warped from the dishwasher.</p> <p>On 1-4-12 at 8:00 a.m. an interview with direct care staff (DCS) #3 indicated the window and door in the living room had been installed in August 2011.</p> <p>On 1-5-12 at 1:40 p.m. an interview with the Qualified Mental Retardation</p>						

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	<p>Professional indicated the maintenance issues in the home of clients #1, #2, #3, #4, #5, and #6 should be addressed and there were no work orders to review.</p> <p>9-3-1(a)</p>			
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W0125	<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.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client #1) to obtain a legally sanctioned representative for a client with an assessed need.</p> <p>Findings include:</p> <p>On 1-5-12 at 9:15 a.m. a record review for client #1 was conducted. His Individualized Support Plan (ISP) dated 12-9-10 indicated he was an emancipated adult. His ISP indicated his goal/objectives were: Client #1 would write his name 3 times a week, he would measure out his mouth wash, wash his hands prior to a meal, take his dirty clothes to the laundry room, cook an item in the microwave, wash a serving dish, identify coins, go to the bank to cash his check, order his food, clean his walker, write his phone number, and mop the kitchen floor. Client #1's Behavior Management Plan (BMP) dated 11-10 indicated he took Abilify for behaviors/aggression and Risperdal for aggression. The BMP indicated targeted behaviors included: refusing to take a bath and medications, physical</p>	W0125	In regard to the consumer identified in W125, the IDT is working with this consumer's family to see if there is someone available to assist in making decisions. The incoming QDDP will be working with this consumer to up-date goals and plans to ensure they are up-to-date with the clients level of functioning. In addition, Earl consumers will be transferring to a new Behavioral Specialist so it is likely that all BP will be revised.	02/01/2012			

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	<p>aggression, verbal aggression, and giving false information. Client 1's Comprehensive Functional Assessment dated 12-6-11 indicated client #1 needed assistance with community safety, finances, meal preparation, and medical/health needs.</p> <p>On 1-5-12 at 1:45 p.m. an interview with the Qualified Mental Retardation Professional indicated client #1 did need assistance with his medical and financial needs and he needed 24/7 supervision.</p> <p>On 1-5-12 at 1:45 p.m. an interview with the facility nurse indicated client #1 needed someone to assist him with his medical/health needs.</p> <p>9-3-2(a)</p>			
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W0130	<p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, the facility failed for 2 of 3 sampled clients (clients #1 and #2) to provide privacy during hygiene times.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 01/03/12 from 4:15 PM until 7:38 PM.</p> <p>On 01/03/12 at 5:35 PM client #1 was observed in the bathroom with staff #11 and the door was open. Client #1 was assisted to undress to prepare for his bath. At 5:40 PM client #1 was nude and the bathroom door was open. Client #6 walked by the bathroom during this time on several occasions while client #1 was naked.</p> <p>On 01/03/12 at 6:06 PM client #2 was taken to her room via wheelchair, placed on her bed via Hoyer lift and staff #7 was observed to change her adult brief with the door open. Client #6 was observed to walk by the bedroom during this time on several occasions while client #2 was lying on her bed naked from the waist down.</p>	W0130	<p>The privacy issues noted in W130 have been addressed with staff by the nurse during in-home checks. It will also be included in the 2/9/12 training that all staff at Earl will be required to attend. During the regularly scheduled monthly staff meetings, privacy issues will be addressed to ensure on-going compliance. In response to the question posed on 2/2/12 on this issue, on-going compliance with this monitored in several ways: * There is now a Lead DSP in place at Earl Group home who has the reposnibility to ensure privacy needs are addressed. This person works shifts in the home. * There is now a GH Manager, the Program Manager for Tippecanoe County, who will also be in the home monitiring compliance. * The new QDDP and the agency nurse will also be regularly in the home and monitoring compliance. * During the monthly Earl staff trainings, issues such as privacy will be reviewed and documented.</p>	02/01/2012			

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	<p>On 01/05/12 at 1:45 PM an interview with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated clients should given privacy for bathing and personal care.</p> <p>9-3-2(a)</p>			
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W0136	<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 record review and interview, the facility failed to ensure for 5 of 6 clients (clients #2, #3, #4, #5, and #6) who lived in the home by not developing a documentation system to verify all clients had opportunity to participate in grocery shopping.</p> <p>Findings include:</p> <p>On 1-5-12 at 12:00 p.m. a record review for client #5 was conducted. The Qualified Mental Retardation Professional's (QMRP) quarterly review dated August 2011 through October 2011 failed to indicate client #5 had participated in buying the groceries for his home. A list of community inclusions for the months of August 2011, September 2011, October 2011, November 2011, and December 2011, was not available for review.</p> <p>On 1-5-12 at 9:14 a.m. a record review for client #2 was conducted. The QMRP's quarterly review dated November 22, 2011 failed to indicate client #2 had participated in buying groceries for her home. A list of community inclusions for the months of</p>	W0136	Based on the scenarios described in W136, the incoming QDSP (who is primarily responsible for completing grocery shopping) has been trained on how to include consumers in regular grocery shopping. Also, the QDSP will be doing the monthly summary sheets related to goal activity which also includes a place to document all outings for the month. The will be monitored by the QDDP who completes the quarterly tracking/reports for all group home consumers.	02/01/2012			

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	<p>August 2011 through December 2011 was not available for review.</p> <p>On 1-5-12 at 12:18 p.m. a record review for client #3 was conducted. The QMRP's Quarterly review dated September, October, November 2011, failed to indicate client #3 had participated in buying groceries for her home. A list of community inclusions for the months of August 2011 through December 2011 was not available for review.</p> <p>On 1-5-12 at 10:30 a.m. a record review for client #6 was conducted. The QMRP quarterly dated September, October, November 2011, failed to indicate he had the opportunity to participate in buying groceries for his home. A list of community inclusions for the months of August 2011 through December 2011 was not available for review.</p> <p>On 1-5-12 at 12:30 p.m. a record review for client #4 was conducted. The QMRP quarterly dated September, October, and November 2011, failed to indicate client #4 had participated in buying groceries for her home. A list of community inclusions for the months of August 2011 through December 2011 was not available for review.</p>						

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	<p>On 1-4-12 at 9:00 a.m. an interview with direct care staff #3 stated client #1 had gone to the grocery store to purchase a few items but direct care staff purchased the "bulk" of the groceries for the home.</p> <p>On 1-5-12 at 11:55 a.m. an interview with the QMRP indicated there was no documentation to review to indicate clients #2, #3, #4, #5, and #6 were given the opportunity to purchase groceries for their home.</p> <p>On 1-5-12 at 11:55 a.m. the facility nurse stated direct care staff did not take the clients to buy groceries because it was "too hard to take anyone." The QMRP indicated clients #2, #3, #4, #5, and #6 were capable of buying the groceries for their home with assistance from direct care staff.</p> <p>9-3-2(a)</p>						

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W0138	<p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that each client is dressed in his or her own clothing each day.</p> <p>Based on observation and interview, the facility failed for 1 of 3 sampled clients (client #2) to ensure she wore her own clothing.</p> <p>Findings include:</p> <p>On 1-4-12 from 10:45 a.m. until 12:00 p.m. an observation at the facility owned day program of client #2 was conducted. At 11:10 a.m. client #2 was observed to have wet pants on. Direct care staff #10 and #15 had no clean dry pants for client #2 so they used a pair of client #2's housemate's pants.</p> <p>On 1-4-12 at 11:10 a.m. an interview with direct care staff #10 indicated clothes could be used for others as long as they lived in the same home.</p> <p>On 1-5-12 at 1:25 p.m. an interview with the facility nurse indicated clothes for client #2 should be sent to work with her so she doesn't have to wear her housemate's clothes.</p> <p>9-3-2(a)</p>	W0138	To address the issue noted in W138, all consumers are having an up-dated inventory of clothing items possessed as well as a "need to buy" list. These deficient items will be supplied for the consumers.	02/01/2012	

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W0140	<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 2 of 3 sample clients (clients #1 and #2) for whom the facility managed their personal funds accounts, the facility failed to maintain an accurate accounting system for each client's individual personal funds accounts.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Client #1's records were reviewed on 01/05/12 at 9:15 AM. Client #1's ISP (Individual Support Plan) dated 12/12/11 indicated client #1 was not able to independently handle his money and required assistance. <p>On 01/05/12 at 11:00 AM client #1's personal funds accounts were reviewed with the Qualified Mental Retardation Professional (QMRP). Client #1's current petty cash balance indicated client #1 had a balance of \$9.17. A money count with the QMRP indicated client #1 had \$9.06. Client #1's petty cash funds were off a total of \$0.11. The QMRP indicated client #1's funds did not balance.</p> <ol style="list-style-type: none"> Client #2's records were reviewed on 01/05/12 at 9:14 AM. Client #2's ISP (Individual Support Plan) dated 05/23/11 	W0140	<p>In regard to the consumer fund accounting system noted in W140, the design at Earl is in the process of being changed. Previously, there was little monitoring of funds coming/going and poor record-keeping was done. The new manager will be implementing a check and balance system to track the consumer funds as well as reduce the number of staff that have access to funds. In addition, a representative from the ASI business office will be auditing the system on a monthly basis to ensure compliance. In response to questions noted on 2/2/2012: The incoming Programming Coordinator/Manager will be overhauling the financial tracking system to include: * A new safe for consumer finances has been purchased and the Manager and Lead DSP will be the only ones with the keys to minimize access. * Each consumer will have a separate log and storage area for their personal funds that are kept in the safe. * The manager will be reconciling accounts on a bi-monthly basis. * A representative from ASI's fiscal department will be auditing the accounts on a monthly basis.</p>	02/01/2012			

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	<p>indicated client #2 was not able to independently handle her money and required assistance.</p> <p>On 01/05/11 at 11:09 AM client #2's personal funds accounts were reviewed with the QMRP. Client #2's current petty cash balance indicated client #2 had a balance of \$32.51. A money count with the QMRP indicated client #2 had \$76.51. Client #2's petty cash funds were off a total of \$44.00. The QMRP indicated client #2's funds did not balance.</p> <p>9-3-2(a)</p>			
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W0149	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review, the facility failed to develop and implement policy which resulted in an incident management system to assure all injuries of unknown source, client to client aggression, and exploitation of finances were thoroughly investigated for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) who lived in the home. The facility failed to develop a system which tracked or investigated reports of client to client aggression in order to rule out neglect, or to determine what additional supports and services were required to keep clients free from abuse/neglect/exploitation for 6 of 6 clients which lived in the group home (clients #1, #2, #3, #4, #5 and #6).</p> <p>Findings include:</p> <p>1. On 1-3-12 at 1:05 p.m. at the provider's office, the administrator indicated she would provide client records identified as all Bureau of Developmental Disabilities Services (BDDS) reports (reportable incidents) since 2/1/11. The Administrator indicated Accident/Illness/Seizure Reports and Behavior/Incident Reports were also available for review. At 2:00 p.m. 14 Accident/Illness/Seizure Reports were</p>	W0149	As of December 2011, a new Investigation Protocol was implemented in regard to allegations of abuse/neglect/exploitation which addressed staff-to-consumer allegations, consumer-to-consumer allegations, and injuries of unknown origin. The protocol outlines who is responsible for which investigations, how they are to be documented, and who does reporting. In regard to questions posed on 2/2/12, the agency's protocol outlines where the documentation for investigations is stored. For allegation of staff to consumer mistreatment, the records are stored with the Director of Adminsitration (who oversees HR functions). By involving her in all of these investigations, there will be consistent follow-up and intervention with staff so that staff correcticve actions are taken. Consumer to consumer allegations or unknown injury allegations are maintained in the consumer's file. They are reviewed by the members of the IDT so that any follow-up needs can be addressed.	02/01/2012	

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	<p>brought to review. At 2:20 p.m. 60 more Accident/Illness/Seizure Reports were brought to review. At 3:00 p.m. 11 more Accident/Illness/Seizure Reports were brought to review. At 3:50 p.m. there were still no BDDS reports available to review. At 3:50 p.m. 12 narrative reports were brought to review. At 4:00 p.m. no BDDS reports were available for review at the provider's office. At 4:45 p.m. the Qualified Mental Retardation Professional brought a 3 ring binder to the group home of clients #1, #2, #3, #4, #5, and #6 which contained the BDDS reports for the period of 2-1-11 through 1-3-12. Evening observations had begun and the BDDS reports were asked to be taken to the facility office for review on 1-4-12. On 1-4-12 at 10:45 a.m. the BDDS reports were not available for review. An interview on 1-4-12 at 10:45 a.m. with the Administrator indicated the BDDS reports were on the way and weren't left yesterday due to the QMRP not having a key to get into the provider office. At 11:11 a.m. the BDDS reports were brought in for review. On 1-5-11 at 9:30 a.m. a record review for clients #1, #2, #3, #4, #5, and #6 was conducted. During the record review more Accident/Illness/Seizure reports were located in the files. At 10:40 a.m. the QMRP brought 13 additional reports she found in the group home office.</p>			
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	<p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 1-5-12 at 1:00 p.m. She indicated the agency scanned the BDDS reports, the Accident/Illness/Seizure reports and the Behavior reports into the system. The QMRP indicated due to a change in employees some of the reports weren't scanned.</p> <p>On 1-3-12 at 2:20 p.m. an interview with the Administrator indicated she was trying to get a system in place to resolve the problems of investigations not being conducted and for locating documentation which should be part of each client's file.</p> <p>2. On 1-3-12 at 1:45 p.m. a review of the facility's Investigation Protocol dated and the Abuse/Neglect/Exploitation Policy dated 12-11 was completed. The protocol indicated all injuries of unknown injury must be thoroughly investigated. The Abuse/Neglect/Exploitation Policy indicated individuals served would be free from abuse, neglect, and exploitation.</p> <p>On 1-4-12 at 11:11 a.m. a review of the Bureau of Developmental Disability Services (BDDS) reports for clients #1, #2, #3, #4, #5, and #6 was conducted. The BDDS reports indicated the</p>			
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	<p>following client to client aggression reports:</p> <p>-A BDDS report dated 12-1-11 for client #3 indicated she was hit on her bottom by client #5. There was no investigation for client to client aggression available for review.</p> <p>-A BDDS report dated 7-27-11 for client #3 indicated client #5 pinched her on her chest. There was no investigation available for review.</p> <p>-A BDDS report dated 4-8-11 indicated client #6 was hit "repeatedly in the left shoulder" by client #5. There was no investigation available for review.</p> <p>-A BDDS report dated 1-27-11 indicated client #6 was hit in his face by client #5. There was no investigation available for review.</p> <p>-A BDDS report dated 12-1-11 indicated client #4 was pushed by client #5. There was no investigation available for review.</p> <p>-A BDDS report dated 2-12-11 indicated client #4 was hit in the back by a lamp, by client #6. There was no investigation available for review.</p> <p>The Accident/Illness/Seizure reports reviewed on 1-3-12 at 2:00 p.m. indicated the following reports for exploitation, unknown injury, and neglect:</p> <p>-An Accident/Illness/Seizure report dated</p>			
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	<p>9-16-11 indicated \$44.43 was lost from client #4's personal cash account. There was no BDDS report filed.</p> <p>-An Accident/Illness/Seizure report dated 9-16-11 indicated \$30.40 was lost from client #3's personal cash account. There was no BDDS report filed.</p> <p>-An Accident/Illness/Seizure report dated 9-16-11 indicated \$17.80 was lost from client #2's personal cash account. There was no BDDS report filed.</p> <p>-An Accident/Illness/Seizure report dated 7-11-11 indicated client #6 had a swollen left testicle. No BDDS report was filed and no investigation was completed.</p> <p>-A BDDS report dated 10-5-11 indicated client #4 had 3 red marks on her elbow. One of the cuts was open. There was no investigation available for review.</p> <p>-An Accident/Illness/Seizure report dated 4-13-11 indicated client #2 was left lying on the bed while staff went to the door to let another staff in. Client #2 rolled off the bed landing head first on the floor. Client #2 was transported to the hospital for evaluation.</p> <p>On 1-5-12 at 1:30 p.m. an interview with the QMRP indicated the facility's policy and protocol should be implemented by all staff, and investigations should be completed per their policy.</p>						

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W0153	<p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, the facility failed for 3 of 3 clients (clients #2, #3, and #4) who lived in the home, to ensure 3 of 3 allegations of financial exploitation (missing money) were reported to the Bureau of Developmental Disabilities Services (BDDS) in accordance with State law.</p> <p>Findings include:</p> <p>The Accident/Illness/Seizure reports reviewed on 1-3-12 at 2:00 p.m. indicated the following reports for financial exploitation, unknown injury, and neglect:</p> <p>-An Accident/Illness/Seizure report dated 9-16-11 indicated \$44.43 was lost from client #4's personal cash account. There was no Bureau of Developmental Disability Services (BDDS) report filed.</p> <p>-An Accident/Illness/Seizure report dated 9-16-11 indicated \$30.40 was lost from client #3's personal cash account. There was no BDDS report filed.</p> <p>-An Accident/Illness/Seizure report dated 9-16-11 indicated \$17.80 was lost from client #2's personal cash account. There</p>	W0153	As of December 2011, a new Investigation Protocol was implemented in regard to allegations of abuse/neglect/exploitation which addressed staff-to-consumer allegations, consumer-to-consumer allegations, and injuries of unknown origin. The protocol outlines who is responsible for which investigations, how they are to be documented, and who does reporting.	02/01/2012			

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	<p>was no BDDS report filed.</p> <p>On 1-5-12 at 1:30 p.m. an interview with the Qualified Mental Retardation Professional indicated a BDDS report should be filed when money was missing.</p> <p>9-3-2(a)</p>			
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W0154	<p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) who lived in the home, to ensure client to client aggression, exploitation of finances, and injuries of unknown origin were thoroughly investigated.</p> <p>Findings include:</p> <p>On 1-4-12 at 11:11 a.m. a review of the Bureau of Developmental Disability Services (BDDS) reports for clients #1, #2, #3, #4, #5, and #6 was conducted. The BDDS reports indicated the following client to client aggression reports:</p> <p>-A BDDS report dated 12-1-11 for client #3 indicated she was hit on her bottom by client #5. There was no investigation for client to client aggression available for review.</p> <p>-A BDDS report dated 7-27-11 for client #3 indicated client #5 pinched her on her chest. There was no investigation available for review.</p> <p>-A BDDS report dated 4-8-11 indicated client #6 was hit "repeatedly in the left shoulder" by client #5. There was no investigation available for review.</p>	W0154	As of December 2011, a new Investigation Protocol was implemented in regard to allegations of abuse/neglect/exploitation which addressed staff-to-consumer allegations, consumer-to-consumer allegations, and injuries of unknown origin. The protocol outlines who is responsible for which investigations, how they are to be documented, and who does reporting.	02/01/2012			

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	<p>-A BDDS report dated 1-27-11 indicated client #6 was hit in his face by client #5. There was no investigation available for review.</p> <p>-A BDDS report dated 12-1-11 indicated client #4 was pushed by client #5. There was no investigation available for review.</p> <p>-A BDDS report dated 2-12-11 indicated client #4 was hit in the back by a lamp, from client #6. There was no investigation available for review.</p> <p>The Accident/Illness/Seizure reports reviewed on 1-3-12 at 2:00 p.m. indicated the following reports for exploitation, unknown injury, and neglect:</p> <p>-An Accident/Illness/Seizure report dated 9-16-11 indicated \$44.43 was lost from client #4's personal cash account. There was no investigation available for review</p> <p>-An Accident/Illness/Seizure report dated 9-16-11 indicated \$30.40 was lost from client #3's personal cash account. There was no investigation available for review.</p> <p>-An Accident/Illness/Seizure report dated 9-16-11 indicated \$17.80 was lost from client #2's personal cash account. There was no investigation available for review.</p> <p>-An Accident/Illness/Seizure report dated 7-11-11 indicated client #6 had a swollen left testicle. No BDDS report was filed and no investigation was completed.</p>						

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	<p>-A BDDS report dated 10-5-11 indicated client #4 had 3 red marks on her elbow. One of the cuts was open. There was no investigation available for review.</p> <p>On 1-5-12 at 1:30 p.m. an interview with the Qualified Mental Retardation Professional indicated investigations should be completed and due to a change in staff some investigations did not get done.</p> <p>9-3-2(a)</p>			
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W0159	<p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on record review and interview, the QMRP (Qualified Mental Retardation Professional) failed for 3 of 3 sampled clients (clients #1, #2 and #3) and 3 additional clients (clients #4, #5 and #6) to ensure a legal sanctioned representative for client #1 was obtained, participation of grocery shopping for clients #2, #3, #4, #5, and #6, to ensure an accurate accounting system for clients #1 and #2 was developed and implemented, to ensure adequate staffing was available for clients #1, #2, #3, #4, #5, and #6, to ensure assessments were completed for clients #1, #2, and #3, to ensure specific Crisis Physical Intervention (CPI) holds were specified in Behavior Management Plans for clients #1 and #6, to ensure a continuous active treatment schedule was implemented for clients #1, #2, #3, #4, #5, and #5, to ensure the Human Rights Committee (HRC) reviewed and approved restrictive measures for clients #1, #2, and #3, to promote dignity and respect for clients #1, #2, #3, #4, and #5, to provide a comfortable mattress for client #6, to ensure wheelchairs/walkers were repaired and clean, to ensure prescribed diets were followed for clients #4 and #5, and to ensure clients #1, #2, #3, #4, #5, and #6 prepared their supper meal.</p> <p>Findings include:</p> <p>Please refer to W125. The QMRP failed to provide a legally sanctioned representative for 1 of 3 sampled clients (client #1).</p> <p>Please refer to W130. The QMRP failed for 2 of 6 clients (clients #1 and #2) to ensure privacy when being assisted with personal hygiene.</p>	W0159	As evidenced in citing for W159, there is a need to overhaul the active treatment at Earl. There is an incoming QDDP, QDSP (staff on shift to assist in running goals) and Manager who will be addressing active treatment as a priority. The Nurse is doing new High Risk and Care Plans for all consumers and there will be new goals for consumers as part of revised active treatment. The element that the new QDDP brings is the expertise in training staff to work with consumers on delivering the goals -- not just assuming that having them on paper is sufficient for staff. Also, the agency trainer will be doing an Earl-specific CPI training and there is a new Behavior Specialist coming to work with Earl consumers in February. On the ninth, the Nurse and Dietary Speciaalist will be conducting an intensive training on medical, dietary, and adaptive equipment issues.	02/01/2012			

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	<p>Please refer to W136. The QMRP failed for 5 of 6 clients (clients #2, #3, #4, #5, and #6) to ensure they purchased groceries for the home.</p> <p>Please refer to W140. The QMRP failed to maintain an accurate accounting system for each client's (clients #1 and #2) individual personal funds accounts.</p> <p>Please refer to W186. The QMRP failed to ensure adequate staffing was available to provide a continuous active treatment program for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) who lived in the home.</p> <p>Please refer to W218. The QMRP failed for 2 of 2 sampled clients (clients #1 and #2) who required equipment for mobility, to have a sensorimotor assessment.</p> <p>Please refer to W227. The QMRP failed to ensure 2 of 3 sample clients (clients #2 and #3), to address the clients' identified communication needs.</p> <p>Please refer to W295. The QMRP failed for 2 of 2 clients (clients #1 and #6) who had physical aggression in their Behavior Management Plan to ensure the specific techniques were incorporated in the plan.</p> <p>Please refer to W249. The QMRP failed to ensure staff implemented programming goals for clients #1, #2 and #3 and 3 additional clients (clients #4, #5 and #6).</p> <p>Please refer to W262. The QMRP failed to ensure the facility's Human Rights Committee (HRC) for 3 of 3 sampled clients (clients #1, #2 and #3) who required Behavior Support Plans (BSP) due to behaviors, to review, approve, and monitor</p>						

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	<p>restrictive practices.</p> <p>Please refer to W268. The QMRP failed for 3 of 3 sampled clients (clients #1, #2 and #3) and 2 additional clients (clients #4 and #5) who live in the group home, to promote their dignity by ensuring clients wear clean clothing, clothing that fits well, and wore appropriate clothes for their gender and physical appearance.</p> <p>Please refer to W418. The QMRP failed for 1 of 6 clients living in the home (client #6), to provide a comfortable mattress.</p> <p>Please refer to W436. The QMRP failed for 3 of 3 clients (clients #1, #2, and #5) who used adaptive equipment for mobility, to ensure wheelchairs/walkers were repaired and clean.</p> <p>Please refer to W460. The QMRP failed for 2 of 6 clients (clients #4 and #5) to ensure their diets were followed.</p> <p>Please refer to W488. The QMRP failed for 6 of 6 clients who lived in the home (clients #1, #2, #3, #4, #5, and #6) to ensure participation in meal preparation.</p> <p>9-3-3(a)</p>						

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W0186	<p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview, the facility failed for 3 of 3 sampled clients requiring staff assistance (clients #1, #2 and #3) and 3 additional clients (clients #4, #5 and #6) to provide sufficient numbers of direct care staff to supervise and implement active treatment activities and client programming.</p> <p>Findings include:</p> <p>1. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and internal incident reports were reviewed on 01/04/12 at 2:25 PM and included the following reports:</p> <p>A BDDS report submitted 08/15/11 for an incident dated 08/15/11 at 11:03 AM indicated the following: "Day Service staff walked into a small habilitation room to find [client #6] with his penis out and another consumer with their hand on [client #6's] penis. This occurred during in an (sic) approximate five minute window when staff were not present to supervise the two of them. Staff was</p>	W0186	<p>The issues noted in W186 included staffing concerns at day services and at the group home. The issue that involved day services was addressed by that program's Director at the time of the incident and staff have been scheduled to ensure supervision is no longer a problem. The Director of Community Living is working with the agency's recruiter to ensure that adequate staffing and back-up is available so that there are three staff at the home during awake hours and two staff during sleeping hours.</p>	02/01/2012			

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	<p>covering/supervising 2 rooms while another staff was assisting consumers to the bathroom and the other staff was on break."</p> <p>2. Observations were conducted in the group home on 01/03/12 from 4:15 PM until 7:38 PM. Client #2's activity during the observation included the following: sitting in the recliner in the living room with the TV on; being taken to her room to change her adult brief; drinking an orange liquid with staff assistance and eating supper. During the observation period staff #6, #7 and #11 were on duty. Client #2 went to the table to eat supper at 6:50 PM and at 7:23 PM she received food to eat. Staff #6 was observed during the observation in the kitchen cooking supper while staff #11 assisted clients #1 and #6 with a bath. Staff #7 sat at the kitchen table with client #3 during the time she did a puzzle, changed client #2's adult brief and assisted to set the table. Client #3's activity during the observation included the following: sitting at the kitchen table working puzzles for 15 minutes, opening 2 cans of mandarin oranges and the remainder of the time was spent by herself in her room without staff checking on her or prompting her every 15 minutes to do an activity. Client #3 came out of her room at 7:13 PM to eat supper. During the</p>			
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	<p>observation period staff #6, #7 and #11 were on duty.</p> <p>Observations were conducted in the group home on 01/04/12 from 7:00 AM until 9:00 AM. Client #2 was at the kitchen table sitting in her wheelchair at 7:00 AM. Client #2's activity during the observation included the following: eating breakfast, taking medications and leaving to go to dayservice program. During the observation period staff #1 and #3 were on duty. Staff #1 indicated there were to be 3 staff on duty, but someone called in ill. Staff #1 was observed to give AM medications and make breakfast. Staff #3 was observed to assist with the clients' breakfasts and place splints on client #2. Staff #3 stated, "you should come back when we're staffed."</p> <p>On 01/04/12 at 8:11 AM, staff #1 prepared client #2's oral medications and fed it to her in applesauce and held on to the cup and gave her a drink of water after the medications. Client #2 was not observed to hold the cup. During the AM observation staff #1 and #3 indicated they were having a hard time getting everything done with only the two of them. They both indicated they were running behind schedule and they would clean the kitchen up when they returned</p>						

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	<p>from taking the clients to dayservices. No clients were observed in assisting to clean the kitchen or table from breakfast.</p> <p>On 1-4-12 from 6:45 a.m. until 9:10 a.m. an observation at the home of client #1 was conducted. During this observation period client #1 was observed to look at a video box and take his medications. Client #1 sat at the kitchen table or on the couch during the observation except when he went to the medication closet to get his medications.</p> <p>Observations were conducted in the group home on 01/04/12 from 7:00 AM until 9:00 AM. Client #3 was dressed and sitting on the couch at 7:00 AM. Client #3's activity during the observation included the following: taking off her shoes and scratching her feet, eating breakfast and leaving to go to dayservice program. Direct care staff #1 and #3 failed to provide training to client #3 by assisting her to bring her dishes to the sink, put her toys in her tote, and to wipe off the table per objectives in her ISP. During the observation period staff #1 and #3 were on duty. Staff #1 indicated there was to be 3 staff on duty, but someone called in ill. Staff #3 stated, "You should come back when we're staffed."</p>			
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	<p>Client #2's records were reviewed on 01/05/12 at 9:14 AM.. A review of client #2's 05/23/11 ISP (Individual Support Plan) indicated the active treatment schedule for client #2 was the following for the PM: 4:00 PM - arrive home from hab; 4:15 PM - picks a snack/eat/then clean up; 4:30 PM - fold towels - goal; 5:15 PM - wash hands/help set table; 5:45 PM - come to table for supper; 6:00 PM supper/goals; 6:45 PM - leisure activity; 7:15 PM - free time - mom usually visits and brings a snack and 8:00 PM - meds/goal.</p> <p>Client #2's active treatment schedule for the AM included the following: 7:00 AM - awakened by staff; 7:15 AM - picks clothes; 7:30 AM - showers; 8:00 AM - meds - complete med goal; 8:10 AM breakfast; 8:45 AM - clean-up and 9:00 AM - 3:00 PM - habilitation.</p> <p>Client #2's ISP dated 05/23/11 contained a goal which indicated client #2 was to hold onto her cup and take a drink of water after taking her medications.</p> <p>Client #3's records were reviewed on 01/05/12 at 12:18 PM.. A review of client #3's 08/18/11 ISP indicated the active treatment schedule for client #2 was the following: 4:00 PM - arrive home from hab. Choose a snack, clean up from snack; 4:30 PM - leisure activity then free time; 5:00 PM - wash</p>						

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	<p>hands/assist with setting the table, meal prep, mix drink for the evening meal, etc; 6:00 PM - supper-meal clean-up; 7:00 PM - work on a puzzle or activity out of her room; 7:30 PM - pick out pajamas; 7:45 to 8:00 PM - showered by staff, dress in the bathroom.</p> <p>Client #3's active treatment schedule for the AM included the following: 6:00 AM - awoken by staff - 6:15 AM - picks out clothes and takes to the bathroom, staff assists with shower; 6:30 AM - dresses in the bathroom/complete bra goal; 7:00 AM - breakfast, breakfast clean-up; 8:00 AM - meds - med goal; 8:15 AM make bed, pick up bedroom; 8:30 AM - leave for hab program and 9:00 AM - 3:30 PM - habilitation program.</p> <p>On 1-5-12 at 9:15 a.m. a record review for client #1 was conducted. The Individualized Support Plan (ISP) dated 12-12-11 indicated his goals were to mop the kitchen floor, wipe down the kitchen counters, use his check ledger, identify his soap and shampoo box, put the plates away, and to shave his face.</p> <p>Client #6's records were reviewed on 01/05/12 at 12:45 PM. A review of client #6's 08/18/11 ISP indicated the active treatment schedule for client #6 was the following: 4:00 PM - arrive home/get off van; 4:45 PM picks out a drink and a low</p>			
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	<p>calorie snack (pickles, tomatoes, banana, apple, 100 calorie snack pack, etc); money goal; put clothes away goal; Leisure time (watch a movie, take a walk, swing, draw, write name, etc); 5:30 PM - wash hands/help with meal prep; 6:00 PM - eat dinner; 6:30 PM - dinner clean up; 6:45 PM - dancing, laps in the house, exercise tape; 7:15 PM - pick out P.J.'s/take a bath/brush teeth and 8:00 PM - meds (med goal).</p> <p>On 01/05/12 at 1:42 PM an interview with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated clients should be involved in active treatment all the time during waking hours and goals should be implemented at all opportunities and not just for documentation purposes. She indicated staff should be interacting with clients no less than every 15 minutes.</p> <p>9-3-3(a)</p>			
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W0194	<p>Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.</p> <p>Based on observation, interview and record review, the facility failed to assure staff demonstrated skills and techniques to implement program plans for 1 of 3 sampled clients (client #2) in regard to the use of a mechanical lift.</p> <p>Findings include:</p> <p>Client #2 was observed at her home on 1-3-12 from 4:20 p.m. to 7:45 p.m. Client #2 was observed to sit in her recliner located in the living room. At 6:05 p.m. direct care staff (DCS) #6 brought the mechanical lift to the recliner and lifted client #2 out of her recliner and placed her in her wheelchair. Client #2 dangled in the sling as DCS #6 positioned the mechanical lift over the wheelchair and lowered client #2 into her wheelchair. DCS #6 then positioned the mechanical lift around client #2's wheelchair as she sat in her bedroom. DCS #6 lifted client #2 from her wheelchair, in her sling, with the mechanical lift, then lowered her to her bed.</p> <p>A record review was completed on 1-5-12 at 9:14 a.m. Client #2's Hoyer Lift Training instructions (no date available) indicated the mechanical lift should</p>	W0194	As noted in another POC, staff have been trained by the nurse and agency training on the correct use of the Hoyer Lift and had to demonstrate understanding. In addition, the training scheduled for 2/9/12 will include use of all adapative equipment. During the monthly group home staff meetings, the nurse will be addressing equipment and the manager addressing safety issues on an on-going basis.	02/01/2012			

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	<p>"always" be used with 2 people. One staff should hold client #2 while the other staff operated the mechanical lift. The Individualized Support Plan dated 5-23-11 did not indicate when staff were to use the mechanical lift to assist client #2 with her transfer needs. The physician's orders dated 12-30-11 did not indicate client #2 used a mechanical lift.</p> <p>On 1-5-12 at 9:20 a.m. a signature page of staff trained on client #2's mechanical lift was reviewed. The signature page had a signature from DCS #6 on 4-11-10 which indicated she had been trained on the use of the lift.</p> <p>On 1-5-12 at 1:25 p.m. an interview with the facility nurse indicated the mechanical lift for client #2 should be used with 2 people so client #2 is not left in the sling with no support. The nurse also indicated staff had been trained and should be using client #2's mechanical lift per the directions.</p> <p>9-3-3(a)</p>				

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W0195	<p>The facility must ensure that specific active treatment services requirements are met.</p> <p>Based on observation, record review and interview for 6 of 6 clients who resided in the home (clients #1, #2, #3, #4, #5, and #6), the facility failed to meet the Condition of Participation: Active Treatment Services. The facility failed to ensure each client received a continuous, aggressive active treatment program, to ensure staff was deployed in a manner to provide continuous active treatment, to ensure sensorimotor and speech assessments were completed, to ensure communication needs were addressed with a plan and to ensure the Human Rights Committee reviewed and monitored all restrictive programs included in Behavior Management Plans.</p> <p>Findings include:</p> <p>Please refer to W186. The facility failed for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) to provide a sufficient number of direct care staff deployed in a manner to provide continuous active treatment.</p> <p>Please refer to W218. The facility failed for 2 of 2 sampled clients (clients #1 and #2) who required equipment for mobility, to have a sensorimotor assessment.</p> <p>Please refer to W220. The facility failed</p>	W0195	As evidenced in citing for W195, there is a need to overhaul the active treatment at Earl. There is an incoming QDDP, QDSP (staff on shift to assist in running goals) and Manager who will be addressing active treatment as a priority. The Nurse is doing new High Risk and Care Plans for all consumers and there will be new goals for consumers as part of revised active treatment. The element that the new QDDP brings is the expertise in training staff to work with consumers on delivering the goals -- not just assuming that having them on paper is sufficient for staff.	02/01/2012			

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	<p>to ensure clients #2 and #3 had updated speech assessments.</p> <p>Please refer to W227. The facility failed to ensure 2 of 3 sample clients (clients #2 and #3), to address the clients' identified communication needs in their Individualized Support Plans.</p> <p>Please refer to W240. The facility failed for 1 of 3 sampled clients (client #2) to ensure the use of her hoyer lift was incorporated into her Individualized Support Plan.</p> <p>Please refer to W249. The facility failed to insure staff implemented programming goals for clients #1, #2 and #3 and 3 additional clients (clients #4, #5 and #6).</p> <p>Please refer to W262. The facility failed to ensure the facility's Human Rights Committee (HRC) for 3 of 3 sampled clients (clients #1, #2 and #3) who required Behavior Support Plans (BSP) due to behaviors, to review, approve, and monitor restrictive practices.</p> <p>9-3-4(a)</p>			
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W0196	<p>Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward:</p> <p>(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and</p> <p>(ii) The prevention or deceleration of regression or loss of current optimal functional status.</p> <p>Based on observation, record review and interview for 6 of 6 clients who resided in the home (clients #1, #2, #3, #4, #5, and #6), the facility failed to ensure each client received a continuous active treatment program which included aggressive, consistent implementation of a program of specialized training and related services to ensure clients #1 and #2 had sensorimotor assessments, client #2 and #3's communication needs were met in their plans, to ensure the use of a mechanical lift for client #2 was incorporated into her Individualized Support Plan, to implement programming goals, and to ensure the Human Rights Committee reviewed and approved restrictive measures for clients #1, #2, and #3.</p> <p>Findings include:</p> <p>Please refer to W186. The facility failed</p>	W0196	As evidenced in citing for W196 there is a need to overhaul the active treatment at Earl. There is an incoming QDDP, QDSP (staff on shift to assist in running goals) and Manager who will be addressing active treatment as a priority. The Nurse is doing new High Risk and Care Plans for all consumers and there will be new goals for consumers as part of revised active treatment. The element that the new QDDP brings is the expertise in training staff to work with consumers on delivering the goals -- not just assuming that having them on paper is sufficient for staff.	02/01/2012			

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	<p>for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) to provide a sufficient number of direct care staff deployed in a manner to provide continuous active treatment.</p> <p>Please refer to W218. The facility failed for 2 of 2 sampled clients (clients #1 and #2) who required equipment for mobility, to have a sensorimotor assessment.</p> <p>Please refer to W220. The facility failed to ensure clients #2 and #3 had updated speech assessments.</p> <p>Please refer to W227. The facility failed to ensure 2 of 3 sample clients (clients #2 and #3), to address the clients' identified communication needs in a plan.</p> <p>Please refer to W240. The facility failed for 1 of 3 sampled clients (client #2) to ensure the use of her hoyer lift was incorporated into her Individualized Support Plan.</p> <p>Please refer to W249. The facility failed to ensure staff implemented programming goals for clients #1, #2 and #3 and 3 additional clients (clients #4, #5 and #6).</p> <p>Please refer to W262. The facility failed to ensure the facility's Human Rights Committee (HRC) for 3 of 3 sampled clients (clients #1, #2 and #3) who</p>			

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	<p>required Behavior Support Plans (BSP) due to behaviors, to review, approve, and monitor restrictive practices.</p> <p>9-3-4(a)</p>			
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W0218	<p>The comprehensive functional assessment must include sensorimotor development.</p> <p>Based on observation, record review, and interview, the facility failed for 2 of 2 sampled clients (clients #1 and #2) who required equipment for mobility, to have a sensorimotor assessment.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 01/03/12 from 4:15 PM until 7:38 PM and on 01/04/12 from 7:00 AM until 9:00 AM. During the observation times, client #1 used a walker when he ambulated. Client #1 picked up the walker and set it down with each step he took. Client #2 used a non-powered wheelchair and required staff for mobility.</p> <p>Client #1's records were reviewed on 01/05/12 at 9:15 AM. Client #1's Individual Support Plan (ISP) dated 12/12/11 indicated client #1 was to ambulate with a walker. Client #1's record did not contain a Physical Therapy (PT) evaluation.</p> <p>Client #2's records were reviewed on 01/05/12 at 9:14 AM. Client #2's Individual Support Plan (ISP) dated 05/23/11 indicated client #2's condition required a wheelchair and she was</p>			W0218	As identified in W218, the consumers in question will be scheduled for a PT/OT evaluation. This will be completed by the nurse.		02/01/2012

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	<p>nonambulatory. Client #2's record did not contain a PT evaluation.</p> <p>On 01/05/12 at 1:42 PM an interview with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated there were no physical therapy evaluations for clients #1 or #2 and she did not know when the last one had been conducted. She indicated clients #1 and #2 needed to have an updated PT evaluations.</p> <p>9-3-4(a)</p>			
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W0220	<p>The comprehensive functional assessment must include speech and language development.</p> <p>Based on observation, record review and interview for 2 of 2 non-verbal sample clients (clients #2 and #3) who lived in the group home, the facility failed to ensure speech assessments were completed for clients with identified communication needs.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 01/03/12 from 4:15 PM until 7:38 PM and on 01/04/12 from 7:00 AM until 9:00 AM. During the observation times clients #2 and #3 were observed to be nonverbal and did not speak.</p> <p>Client #2's records were reviewed on 01/05/12 at 9:14 AM. Client #2's Individual Support Plan (ISP) dated 05/23/11 indicated she was nonverbal. Client #2's record did not contain a speech evaluation.</p> <p>Client #3's records were reviewed on 01/05/12 at 9:15 AM. Client #3's record did not contain a speech evaluation.</p> <p>On 01/05/12 at 1:42 PM an interview with the QMRP (Qualified Mental Retardation Professional) was conducted.</p>	W0220	<p>The consumers identified in W220 will be scheduled for speech evaluations by the nurse. In response to questions posed on 2/2/12 on this issue, the nuse will be monitoring consumers via quarterly assessments which would help identify if anyone needed an outside consultation in the future.</p>	02/01/2012			

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	<p>The QMRP indicated there were not speech evaluations on clients #2 and #3 and she did not know when the last evaluations had been conducted. She indicated clients #2 and #3 needed to have updated speech evaluations.</p> <p>9-3-4(a)</p>			
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W0227	<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, record review and interview for 2 of 2 non-verbal sample clients (clients #2 and #3) who lived in the group home, the facility failed to ensure the Individualized Support Plan (ISP) addressed the clients' identified communication needs.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 01/03/12 from 4:15 PM until 7:38 PM and on 01/04/12 from 7:00 AM until 9:00 AM. During the observation times clients #2 and #3 were observed to be nonverbal and did not speak.</p> <p>Client #2's records were reviewed on 01/05/12 at 9:14 AM. Client #2's Individual Support Plan (ISP) dated 05/23/11 indicated she was nonverbal. Client #2's ISP did not contain a communication goal or objective.</p> <p>Client #3's records were reviewed on 01/05/12 at 9:15 AM. Client #3's Individualized Support Plan dated 8-18-11 did not contain a communication goal/objective.</p>	W0227	<p>The incoming QDDP will up-date consumer plans, in conjunction with the Nurse's revision of the High Risk and Care Plans to ensure that communication goals are accurate. In response to questions posed on 2/2/12, the primary means for on-going compliance on this issue is that there will be weekly telephone staffings for Earl GH consumers. The calls will involve the GH nurse, GH Manager (Programming Coordinator), QDDP, Lead DSP, and the Behavioral Specialist. This will promote on-going and up-to-date conversations about what is working and not working with goals and plans so that changes can be made in a timely manner and communicated to the staff.</p>	02/01/2012	

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	<p>On 01/05/12 at 1:42 PM an interview with the QMRP (Qualified Mental Retardation Professional) was conducted. She indicated clients #2 and #3 did not have a goal or objective to tell staff what they should do in order to assist the clients with their identified communication needs.</p> <p>9-3-4(a)</p>			
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W0240	<p>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, interview and record review, the facility failed for 1 of 3 sampled clients (client #2) to ensure the use of her adaptive equipment (lift) was included in her Individualized Support Plan (ISP).</p> <p>Findings include:</p> <p>Client #2 was observed at her home on 1-3-12 from 4:20 p.m. to 7:45 p.m. Client #2 was observed to sit in her recliner located in the living room. At 6:05 p.m. direct care staff (DCS) #6 brought the mechanical lift to the recliner and lifted client #2 out of her recliner and placed her in her wheelchair. Client #2 dangled in the sling as DCS #6 positioned the mechanical lift over the wheelchair and lowered client #2 into her wheelchair. DCS #6 then positioned the mechanical lift around client #2's wheelchair as she sat in her bedroom. DCS #6 lifted client #2 from her wheelchair, in her sling, with the mechanical lift, then lowered her to her bed.</p> <p>A record review was completed on 1-5-12 at 9:14 a.m. Client #2's Hoyer Lift Training instructions (no date available) indicated the mechanical lift should</p>	W0240	<p>The Nurse will be revising all High Risk and Care Plans for Earl consumers. This will include adaptive equipment information. Staff will be trained on these new plans and training will be revisited on a monthly basis during the regularly scheduled group home staff meetings. In response to questions posed on 2/2/12, on-going compliance with this monitored in several ways: *</p> <p>There is now a Lead DSP in place at Earl Group home who has the reposnsibility to ensure equipment issues are addressed. This person works shifts in the home. *</p> <p>There is now a GH Manager, the Program Manager for Tippecanoe County, who will also be in the home monitoring compliance. *</p> <p>The new QDDP and the agency nurse will also be regularly in the home and monitoring compliance. *</p> <p>During the monthly Earl staff trainings, issues such as privacy will be reviewed and documented. In addition, there will be weekly telephone staffings for Earl GH consumers. The calls will involve the GH nurse, GH Manager (Programming Coordinator), QDDP, Lead DSP, and the Behavioral Specialist. This will promote on-going and up-to-date conversations about what is working and not working with goals and plans so that changes</p>	02/01/2012			

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	<p>"always" be used with 2 people. One staff should hold client #2 while the other staff operated the mechanical lift. Her Individualized Support Plan dated 5-23-11 did not indicate when staff were to use the mechanical lift to assist client #2 with her transfer needs. The physician's orders dated 12-30-11 did not indicate client #2 used a mechanical lift.</p> <p>On 1-5-12 at 1:25 p.m. an interview with the Qualified Mental Retardation Professional indicated guidelines for the use of her hoyer lift were not specified in her ISP.</p> <p>9-3-4(a)</p>		can be made in a timely manner and communicated to the staff.		

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W0249	<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 observation, record review, and interview, the facility failed to implement active treatment objectives and interventions during times of opportunity for 3 of 3 sampled clients (clients #1, #2 and #3) and 3 additional clients (clients #4, #5 and #6).</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 01/04/12 at 7:56 AM, staff #1 poured client #1's Listerine mouthwash into a cup and gave it to him to take to the bathroom. Client #1's records were reviewed on 01/05/12 at 9:15 AM. Client #1's ISP (Individual Support Plan) dated 12/12/11 contained a goal which indicated client #1 was to measure his mouthwash. Observations were conducted in the group home on 01/03/12 from 4:15 PM until 7:38 PM. Client #2's activity during the observation included the following: sitting in the recliner in the living room with the TV on; being taken to her room to change her adult brief; drinking an 	W0249	<p>As evidenced in citing for W249, there is a need to overhaul the active treatment at Earl. There is an incoming QDDP, QDSP (staff on shift to assist in running goals) and Manager who will be addressing active treatment as a priority. The Nurse is doing new High Risk and Care Plans for all consumers and there will be new goals for consumers as part of revised active treatment. The element that the new QDDP brings is the expertise in training staff to work with consumers on delivering the goals -- not just assuming that having them on paper is sufficient for staff. In response to questions posed on 2/2/12, there will be weekly telephone staffings for Earl GH consumers. The calls will involve the GH nurse, GH Manager (Programming Coordinator), QDDP, Lead DSP, and the Behavioral Specialist. This will promote on-going and up-to-date conversations about what is working and not working with goals and plans so that changes can be made in a timely manner and communicated to the staff.</p>	02/01/2012			

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	<p>orange liquid with staff assistance and eating supper. During the observation period staff #6, #7 and #11 were on duty. Client #2 went to the table to eat supper at 6:50 PM and at 7:23 PM she received food to eat. Client #2's goals were not implemented during the evening observation.</p> <p>Observations were conducted in the group home on 01/04/12 from 7:00 AM until 9:00 AM. Client #2 was at the kitchen table sitting in her wheelchair at 7:00 AM. Client #2's activity during the observation included the following: eating breakfast, taking medications and leaving to go to dayservice program. During the observation period staff #1 and #3 were on duty. Staff #1 indicated there was to be 3 staff on duty, but someone called in ill. Staff #3 stated, "You should come back when we're staffed."</p> <p>On 01/04/12 at 8:11 AM, staff #1 prepared client #2's oral medications and fed them to her in applesauce and held on to the cup and gave her a drink of water after the medications. Client #2 did not hold the cup.</p> <p>Client #2's records were reviewed on 01/05/12 at 9:14 AM.. A review of client #2's 05/23/11 ISP (Individual Support Plan) indicated the active treatment schedule for client #2 was the following</p>			
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	<p>for the PM: 4:00 PM - arrive home from hab; 4:15 PM - picks a snack/eat/then clean up; 4:30 PM - fold towels - goal; 5:15 PM - wash hands/help set table; 5:45 PM - come to table for supper; 6:00 PM supper/goals; 6:45 PM - leisure activity; 7:15 PM - free time - mom usually visits and brings a snack and 8:00 PM - meds/goal.</p> <p>Client #2's active treatment schedule for the AM included the following: 7:00 AM - awakened by staff; 7:15 AM - picks clothes; 7:30 AM - showers; 8:00 AM - meds - complete med goal; 8:10 AM breakfast; 8:45 AM - clean-up and 9:00 AM - 3:00 PM - habilitation.</p> <p>Client #2's ISP dated 05/23/11 contained a goal which indicated client #2 was to hold onto her cup and take a drink of water after taking her medications.</p> <p>3. Observations were conducted in the group home on 01/03/12 from 4:15 PM until 7:38 PM. Client #3's activity during the observation included the following: sitting at the kitchen table working puzzles for 15 minutes, opening 2 cans of mandarin oranges and the remainder of the time was spent by herself in her room without staff checking on her or prompting her every 15 minutes to do an activity. Client #3 came out of her room at 7:13 PM to eat supper. During the observation period staff #6, #7 and #11</p>						

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	<p>were on duty.</p> <p>Observations were conducted in the group home on 01/04/12 from 7:00 AM until 9:00 AM. Client #3 was dressed and sitting on the couch at 7:00 AM. Client #3's activity during the observation included the following: taking off her shoes and scratching her feet, eating breakfast and leaving to go to dayservice program. Direct care staff #1 and #3 failed to provide training to client #3 by assisting her to bring her dishes to the sink, put her toys in her tote, and to wipe off the table per objectives in her ISP. During the observation period staff #1 and #3 were on duty. Staff #1 indicated there was to be 3 staff on duty, but someone called in ill. Staff #3 stated, "You should come back when we're staffed."</p> <p>Client #3's records were reviewed on 01/05/12 at 12:18 PM.. A review of client #3's 08/18/11 ISP indicated the active treatment schedule for client #2 was the following: 4:00 PM - arrive home from hab. Choose a snack, clean up from snack; 4:30 PM - leisure activity then free time; 5:00 PM - wash hands/assist with setting the table, meal prep, mix drink for the evening meal, etc; 6:00 PM - supper-meal clean-up; 7:00 PM - work on a puzzle or activity out of her room; 7:30 PM - pick out pajamas; 7:45</p>			
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	<p>to 8:00 PM - showered by staff, dress in the bathroom.</p> <p>Client #3's active treatment schedule for the AM included the following: 6:00 AM - awoken by staff - 6:15 AM - picks out clothes and takes to the bathroom, staff assists with shower; 6:30 AM - dresses in the bathroom/complete bra goal; 7:00 AM - breakfast, breakfast clean-up; 8:00 AM - meds - med goal; 8:15 AM make bed, pick up bedroom; 8:30 AM - leave for hab program and 9:00 AM - 3:30 PM - habilitation program.</p> <p>4. Observations were conducted in the group home on 01/03/12 from 4:15 PM until 7:38 PM. Client #6's activity during the observation included the following: walking around the group home, scooting on the floor, stealing food from the pantry and taking it to his room to eat, taking a shower and eating supper. Client #6 ate supper at 7:20 PM. During the observation period staff #6, #7 and #11 were on duty and failed to provide training or to implement goals per his ISP.</p> <p>Observations were conducted in the group home on 01/04/12 from 7:00 AM until 9:00 AM. Client #6 was sitting in his room on his bed, bouncing up and down on the mattress. Client #6's activity during the observation included the following: walking around the home,</p>						

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	<p>eating breakfast and taking his medications. During the observation period staff #1 and #3 were on duty and failed to provide training or to implement goals per his ISP. Staff #1 indicated there was to be 3 staff on duty, but someone called in ill. Staff #3 stated, "You should come back when we're staffed."</p> <p>Client #6's records were reviewed on 01/05/12 at 12:45 PM. A review of client #6's 08/18/11 ISP indicated the active treatment schedule for client #6 was the following: 4:00 PM - arrive home/get off van; 4:45 PM picks out a drink and a low calorie snack (pickles, tomatoes, banana, apple, 100 calorie snack pack, etc); money goal; put cloths away goal; Leisure time (watch a movie, take a walk, swing, draw, write name, etc); 5:30 PM - wash hands/help with meal prep; 6:00 PM - eat dinner; 6:30 PM - dinner clean up; 6:45 PM - dancing, laps in the house, exercise tape; 7:15 PM - pick out P.J.'s/take a bath/brush teeth and 8:00 PM - meds (med goal).</p> <p>On 01/05/12 at 1:42 PM an interview with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated clients should be involved in active treatment all the time during waking hours and goals should be implemented at all opportunities.</p>						

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	<p>5. On 1-3-12 from 4:20 p.m. until 7:45 p.m. an observation at the home of clients #4 and #5 was conducted. At 7:10 p.m. clients #4 and #5 ate their supper meal with no adaptive silverware.</p> <p>On 1-4-12 from 6:45 a.m. until 9:10 a.m. an observation at the home of clients #4 and #5 was conducted. At 7:00 a.m. client #5 was observed to have a spoon and fork with a large round foam handle which he used to eat his breakfast. At 7:15 a.m. direct care staff #3 took the large round foam piece off of client #5's fork and put it on client #4's spoon for her to use to eat her breakfast.</p> <p>On 1-5-12 at 12:00 p.m. a record review for client #5 was conducted. The physician's orders dated 12-30-11 did not indicate client #5 had adaptive silverware at mealtimes. Client #5's dining plan dated 2-24-11 indicated client #5 used regular utensils.</p> <p>On 1-5-12 at 12:30 p.m. a record review for client #4 was conducted. The physician's orders dated 12-30-11 did not indicate client #4 used adaptive silverware at meal times. Client #4's dining plan (no date available) did not indicate what type of silverware client #4 was to use at meal times.</p>			
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	<p>On 1-5-12 at 1:20 p.m. an interview with the facility nurse indicated clients #4 and #5 did not use adaptive silverware and staff should implement the dining plans as written.</p> <p>6. On 1-4-12 from 6:45 a.m. until 9:10 a.m. an observation at the home of client #1 was conducted. During this observation period client #1 was observed to look at a video box and take his medications. Client #1 sat at the kitchen table or on the couch during the observation except when he went to the medication closet to get his medications. Client #1's ISP indicated his goals were to mop the kitchen floor, wipe down the kitchen counters, use his check ledger, identify his soap and shampoo box, put the plates away, and to shave his face.</p> <p>On 1-5-12 at 1:40 p.m. an interview with the Qualified Mental Retardation Professional indicated clients #1 should be offered active treatment and his goals should be implemented.</p> <p>9-3-4(a)</p>			
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W0262	<p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on record review and interview, the facility's Human Rights Committee (HRC) failed for 3 of 3 sampled clients (clients #1, #2 and #3) who lived in the home and required Behavior Support Plans (BSP) due to behaviors, to review, approve, and monitor restrictive practices (psychotropic medications).</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 01/05/12 at 9:15 AM. Client #1's Individual Support Plan (ISP) was dated 12/12/11. Client #1's BSP was dated 11/2011 and indicated client #1 was on the behavioral medication Abilify 5 mgs (milligrams) for the following behaviors: verbal/physical aggression and refusal to bathe. The BSP did not contain signatures of the HRC to indicate the committee had reviewed and approved the plan.</p> <p>Client #2's records were reviewed on 01/05/12 at 9:14 AM. Client #2's ISP was dated 05/23/11. Client #2's BSP was dated 11/2011 and indicated client #2 was</p>	W0262	HRC was revised in the fall 2010 to ensure that issues were not lost so the issues cited in W262 will be reviewed by the HRC on 2/2/12 to clarify and correct the issues. This is the responsibility of the Community Living Director. In response to concerns posed on 2/2/12, the Director of Community Living is adding a cross-referencing feature to the HRC minutes to ensure that no follow up is lost from the meetings. Also, the Director will be sending out emails to the appropriate parties for follow up following each HRC session.	02/01/2012			

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	<p>on the behavioral medication Fluoxetine Cap 20 mg for the following behaviors: refusals. The BSP did not contain signatures of the HRC to indicate the committee had reviewed and approved the plan.</p> <p>Client #3's records were reviewed on 01/05/12 at 12:18 PM. Client #3's ISP was dated 08/18/11. Client #3's BSP was dated 11/2011 and indicated client #3 was on the behavioral medication Paxil 10 mgs for the following behaviors: incontinence in the closet, repetitive movements, SIB (self injurious behaviors), public indecency, emotional outbursts and property destruction. The BSP did not contain signatures of the HRC to indicate the committee had reviewed and approved the plan.</p> <p>On 01/05/12 at 1:45 PM an interview with the Qualified Mental Retardation Professional (QMRP) was conducted. The QMRP indicated there were no further documents for review to indicate the HRC committee had reviewed the BSPs.</p> <p>9-3-4(a)</p>				

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W0268	<p>These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2 and #3) and 2 additional clients (clients #4 and #6) who live in the group home, to promote their dignity by ensuring clients wear clothing that fits well, wore appropriate clothes for their gender and physical appearance and provide privacy during hygiene times.</p> <p>Findings include:</p> <p>1. Observations were conducted in the group home on 01/03/12 from 4:15 PM until 7:38 PM and on 01/04/12 from 7:00 AM until 9:00 AM.</p> <p>On 01/03/12 and 01/04/12 client #3 was observed during the entire observation times wearing a t-shirt with no bra.</p> <p>On 01/03/12 client #1 was observed to wear a pair of brown pants which were too big for him. His belt gathered a large amount of material around his waist and the length of his pants fell beneath his shoes. Client #1 used a walker to assist in ambulation.</p> <p>On 01/03/12 at 4:49 PM client #6 went to the bathroom to take a shower. After his</p>	W0268	To address the issue noted in W268, all consumers are having an up-dated inventory of clothing items possessed as well as a "need to buy" list. These deficient items will be supplied for the consumers.	02/01/2012			

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	<p>bath he wore a blue superman t-shirt. On 01/04/12 during the observation time client #6 wore the same shirt and left the house for dayservices with the same shirt on.</p> <p>On 1-3-12 at 6:45 p.m. direct care staff (DCS) #7 assisted client #4 from the couch and walked her to the kitchen. Client #4's pants fell down as she was walked. DCS #7 was told by DCS #6 that client #4's pants had fallen down as she was walking. DCS #7 stopped walking client #4 and pulled her pants up. DCS #7 walked client #4 to the stove, assisted her with stirring the peppers, and assisted her back to the couch as she held client #4's pants up. Direct care staff #6 and #7 did not assist client #4 in changing into pants which would fit client #4.</p> <p>On 1-4-12 at 11:55 a.m. direct care staff #15 placed a clothing protector on client #2 which had worn, thin material with a large hole in it.</p> <p>On 01/05/12 at 1:45 PM an interview with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated clients should be dressed appropriately for their gender, and wear clothing that fit properly.</p> <p>9-3-5(a)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W0295	<p>The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.</p> <p>Based on record review and interview the facility failed for 2 of 2 clients (clients #1 and #6), who had a targeted behavior of physical aggression, to ensure the specific Crisis Physical Intervention (CPI) hold/restraint was included in the Behavior Support Plan.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 1-5-12 at 10:30 a.m. a record review for client #6 was conducted. His Behavior Management Plan (BMP) dated 5-6-11 indicated he had a target behavior of physical aggression. The BMP indicated if client #6 had physical aggression CPI could be used. The BMP did not specify what kind of CPI hold/restraint to use for the targeted behavior of physical aggression. <p>On 1-4-11 at 1:00 p.m. a review of client #6's Bureau of Developmental Disability Services (BDDS) reports was conducted. A BDDS report dated 7-22-11 indicated a CPI hold was used on client #6 due to a behavior. The report did not indicate what hold was utilized.</p>	W0295	<p>As part of the nurse revising all High Risk and Care Plans, the consumer noted in W295 will have an up-dated plan regarding the use of CPI 2 interventions. The agency trainer is also scheduling an Earl-specific CPI training. In response to questions posed on 2/2/12, ASI's trainer is a "train the trainer" for CPI 2 and is well-versed in the kinds of techniques that module allows. He is able to identify the least restriction intervention given the size, mobility, and functioning level of the consumer. It is also based on the type of aggressive behavior that particular consumer is likely to show. All consumer plans that include CPI 2 measures must be approved by HRC which is inclusive a wide representation of the agency.</p>	02/01/2012			

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	<p>2. On 1-5-12 at 9:15 a.m. a record review for client #1 was conducted. His BMP dated 11-10 indicated he had the targeted behavior of physical aggression. The BMP did not indicated what CPI hold was to be used on client #1 if he became physically aggressive.</p> <p>On 1-5-12 at 1:30 p.m. an interview with the Qualified Mental Retardation Professional indicated client #1 and #6's BMPs did not specify what hold to use for the targeted behavior of physical aggression. She also indicated a 2 person control hold was used on 7-22-11 to restrain client #6.</p> <p>9-3-5(a)</p>						

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W0318	<p>The facility must ensure that specific health care services requirements are met.</p> <p>Based on record review and interview, the Condition of Participation, Health Care Services, is not met as the facility failed to provide adequate health care monitoring and nursing services for 3 of 3 sample clients (clients #1, #2 and #3).</p> <p>Findings include:</p> <p>Please refer to W323. The facility failed for 3 of 3 sampled clients (clients #1, #2 and #3) to have annual physical, vision and hearing screening examinations.</p> <p>Please refer to W331. The facility failed for 3 of 3 sampled clients (clients #1, #2 and #3) and one additional client (client #5) by not ensuring the nurse monitored medical and nursing needs and medications.</p> <p>Please refer to W336. The facility failed for 3 of 3 sampled clients (clients #1, #2 and #3) with medical conditions not requiring a medical care plan, to have quarterly nursing assessments completed in a timely fashion.</p> <p>Please refer to W346. The facility failed to ensure a formal arrangement was in place with a registered nurse for verbal or onsite consultation to the licensed</p>	W0318	As indicated in W318, there are a number of overdue consumer medical appointments. The Nurse has scheduled these appointments, however, they may not all be completed prior to February 9. This includes regular and specialized medical appointments. All medical appointments are entered into a central tracking system now so that they will not be overdue in the future.	02/01/2012			

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	<p>practical nurse.</p> <p>Please refer to W352. The facility failed for 2 of 3 sampled clients (clients #2 and #3) to provide annual dental examinations.</p> <p>Please refer to W362. The facility failed for 3 of 3 sampled clients (clients #1, #2 and #3) to have a quarterly pharmacist review completed in a timely fashion.</p> <p>Please refer to W369. The facility failed to ensure staff administered client medication (client #6), as ordered without error.</p> <p>9-3-6(a)</p>				

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W0323	<p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2 and #3) to have annual physical, vision and hearing screening examinations.</p> <p>Findings include:</p> <p>1. Client #1's records were reviewed on 01/05/12 at 9:15 AM. Client #1's record did not contain any documentation of an annual physical or vision screening examinations.</p> <p>On 01/05/12 at 1:42 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client #1 did not have a physical or an annual vision examination for review.</p> <p>2. Client #2's records were reviewed on 01/05/12 at 9:14 AM. Client #2's record did not contain any documentation of an annual physical, vision or hearing screening examinations.</p> <p>On 01/05/12 at 1:42 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client #2 did not have a physical or an annual</p>	W0323	All Earl consumers have been scheduled by the nurse for the overdue medical exams. They will take place at the earliest convenience of the medical staff doing the services. All medical appointments are entered into a central tracking system now so that they will not be overdue in the future.	02/01/2012			

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	<p>vision and hearing examinations for review.</p> <p>3. Client #3's records were reviewed on 01/05/12 at 12:18 PM. Client #3's record did not contain any documentation of an annual physical, vision or hearing screening examinations.</p> <p>On 01/05/12 at 1:42 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client #3 did not have a physical or an annual vision and hearing examinations for review.</p> <p>9-3-6(a)</p>			
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W0331	<p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2 and #3) and one additional client (client #5) by not ensuring the nurse monitored medical and nursing needs and medications.</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 01/05/12 at 9:15 AM. Client #1's record review indicated client #1 lacked the following examinations in the past year: physical examination, nursing quarterlies and vision screening. Client #1's record contained a picture of the walker he was to use and information which indicated he was using the incorrect walker in the group home. Client #1's record indicated he had a psychiatric medication review on 11/03/11 with a medication increase for his Abilify to increase from 5 mg to 7.5 mg. The medication increase was not noted on the November, December 2011 MARs (Medication Administration Record) or on the January 2012 MAR.</p> <p>Client #2's records were reviewed on 01/05/12 at 9:14 AM. Client #2's record review indicated client #2 lacked the following examinations in the past year:</p>	W0331	<p>There are a number of nursing deficiencies noted in W331 that are in the process of being corrected. All medical appointments have been scheduled and will be entered into a central screening system so that they are not missed/overdue in the future. She will be monitoring MARS on a monthly basis to ensure they are correct as well as observing staff do med passes.</p>	02/01/2012			

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	<p>physical examination, nursing quarterlies, vision screening and dental examination. Client #2's record contained information which indicated she had a power wheelchair ordered but was not using it at the group home. Client #2's record indicated she had seen her neurologist for her seizures control on 10/25/11. The MD had ordered a change in her Valium order and had ordered it increased. The November 2011, December 2011 and January 2012 MAR did not indicate the Valium order had been changed. Client #2's record indicated client #2 was non-ambulatory, required a Hoyer lift, required a wheel-chair for her mobility and was unable to propel it herself.</p> <p>Client #3's records were reviewed on 01/05/12 at 9:15 AM. Client #3's record review indicated client #3 lacked the following examinations in the past year: physical examination, nursing quarterlies, vision screening and dental examination. Client #3's record indicated she had a psychiatric medication review on 10/06/11 with a new medication ordered. The medication was started on 11/01/11 and was written incorrectly on the MAR. The November 2011 MAR indicated client #3 took Paxil Elix 5 ml (milliliter) by mouth every day. The MAR did not indicated the milligram of the Paxil.</p>			
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	<p>Client #5's records were reviewed on 01/05/12 at 12:30 PM. Client #5's record indicated client #5 was non-ambulatory and required a wheel-chair for his mobility and depended upon staff to assist him in and out of it.</p> <p>On 1-5-12 at 1:42 p.m. the nurse indicated she had been with the company for 7 months and the examinations had not been completed. She indicated she did not know the status of the medication increase on client #1 and why it had not happened yet. She indicated most of the medical examinations had not been completed on clients #1, #2 and #3. She also indicated the orders for client #3's Paxil and the order for client #2's Valium were incorrect.</p> <p>9-3-6(a)</p>						

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W0336	<p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>Based on record review and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2 and #3) with medical conditions not requiring a medical care plan, to have quarterly nursing assessments completed in a timely fashion.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Client #1's records were reviewed on 01/05/12 at 9:15 AM. Client #1's record did not contain evidence of a need for a medical care plan. The record review failed to indicate the quarterly nursing assessments had been completed in 2011. There were no quarterly nursing assessments in the record. Client #2's records were reviewed on 01/05/12 at 9:14 AM. Client #2's record did not contain evidence of a need for a medical care plan. The record review failed to indicate the quarterly nursing assessments had been completed in 2011. There were no quarterly nursing assessments in the record. Client #3's records were reviewed on 	W0336	<p>The concerns noted in W336 will be addressed by the Nurse writing all new High Risk and Care plans which will medical care instructions. In response to questions posed on 2/2/12, the Director of Community Living who supervised the GH Nuse will meet with her bi-monthly to discuss a variety of issues. This will include the status of quarterly assessments and referrals. These supervisory meetings will be documented. ASI's Leadership Team is also working on an agency-wide system to conduct qualitative chart audits which would also identify any documentation deficiencies. This plan has not been fully worked out.</p>	02/01/2012
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	<p>01/05/12 at 12:18 PM. Client #3's record did not contain evidence of a need for a medical care plan. The record review failed to indicate the quarterly nursing assessments had been completed in 2011. There were no quarterly nursing assessments in the record.</p> <p>On 01/05/12 at 1:42 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated indicated there were no quarterly nursing assessments for 2011.</p> <p>9-3-6(a)</p>			
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W0346	<p>If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse.</p> <p>Based on record review and interview for 3 of 3 sampled clients (clients #1, #2 and #3), the facility failed to ensure a formal arrangement was in place with a registered nurse for verbal or onsite consultation to the licensed practical nurse.</p> <p>Findings include:</p> <p>The record review for client #1 was conducted on 01/05/12 at 9:15 AM. There was no documentation to indicate a registered nurse was available for consultation to assist in management of client #1's health.</p> <p>The record review for client #2 was conducted on 01/05/12 at 9:14 AM. There was no documentation to indicate a registered nurse was available for consultation to assist in management of client #2's health.</p> <p>The record review for client #3 was conducted on 01/05/12 at 12:18 PM. There was no documentation to indicate a registered nurse was available for</p>	W0346	A contract with a Registered Nurse was signed in January 2012 to address the W346 deficiency. The contract outlines regular consultation by telephone as well as quartlery face-to-face supervision with the agency's LPN.	02/01/2012			

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	<p>consultation to assist in management of client #3's health.</p> <p>On 01/05/12 at 4:05 PM an interview with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated there was currently no registered nurse available for consultation.</p> <p>9-3-6(a)</p>			
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W0352	<p>Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually.</p> <p>Based on record review and interview, the facility failed for 2 of 3 sampled clients (clients #2 and #3) to provide annual dental examinations.</p> <p>Findings include:</p> <p>1. Client #2's records were reviewed on 01/05/12 at 9:14 AM. Client #2's records did not indicate when client #2 had her last dental examination.</p> <p>On 01/05/12 at 1:42 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated she could not locate any records to indicate client #2 was current with her dental examination. The LPN indicated she did not have any dental examination available for review.</p> <p>2. Client #3's records were reviewed on 01/05/12 at 12:18 PM. Client #3's records did not indicate when client #3 had her last dental examination.</p> <p>On 01/05/12 at 1:42 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated she could not locate any records to indicate client #3 was current with her dental</p>			W0352	<p>The nurse has scheduled all missing dental services and appointments are now being tracked in a centralized system so they are not missed in the future.</p>		02/01/2012

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	<p>examination. The LPN indicated she did not have any dental examination available for review.</p> <p>9-3-6(a)</p>			
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W0362	<p>A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on record review and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2 and #3) to have a quarterly pharmacist review completed in a timely fashion.</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 01/05/12 at 9:15 AM. The physician orders dated 01/2012 indicated client #1 was prescribed medications. The record review failed to indicate the pharmacist quarterly reviews had been completed timely from 01/2011 through 01/05/12. Client #1's record contained no pharmacy reviews.</p> <p>Client #2's records were reviewed on 01/05/12 at 9:14 AM. The physician orders dated 01/2012 indicated client #2 was prescribed medications. The record review failed to indicate the pharmacist quarterly reviews had been completed timely from 01/2011 through 01/05/12. Client #2's record contained no pharmacy reviews.</p> <p>Client #3's records were reviewed on 01/05/12 at 12:18 PM. The physician orders dated 01/2012 indicated client #3</p>	W0362	The pharmacy used by ASI conducts quarterly reviews, however, the nurse has implemented a centralized filing system with the pharmacy reports to ensure they are available for review.	02/01/2012			

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	<p>was prescribed medications. The record review failed to indicate the pharmacist quarterly reviews had been completed timely from 01/2011 through 01/05/12. Client #3's record contained no pharmacy reviews.</p> <p>On 01/05/12 at 1:42 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated she started the agency in 05/2011. She indicated she thought the pharmacy reviews had been done but the documents were not available for review.</p> <p>9-3-6(a)</p>			
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W0369	<p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 1 of 22 medication doses administered at the 8:00 AM medication administration, the facility failed to ensure staff administered client medication (client #6), as ordered without error.</p> <p>Findings include:</p> <p>On 01/04/12 from 8:20 AM until 8:22 AM staff #1 was observed to prepare and administer client #6's medications to him. Client #6's medication included the medication Omeprazole Cap (capsule) 20 mg (milligram) (GERD) (Gastroesophageal reflux disease). The medication card which contained the capsules indicated the medication was to be taken 1 hour before a meal. Client #6 was observed to eat breakfast at 8:15 AM prior to coming to the medication area. Client #6's January 2012 Medication Administration Record (MAR) which contained the physician's orders was reviewed on 01/04/12 at 8:22 AM. The MAR indicated the order for the medication, "Omeprazole Cap (capsule) 20 mg (milligram) (GERD) (Gastroesophageal reflux disease); give 1</p>	W0369	All staff are required to pass Med Core A and B prior to employment as well as on an annual basis. The nurse will be monitoring med administration by monitoring med passes. In addition, the house QDSP and manager will be monitoring MAR documentation for accuracy. All medication errors are referred to Human Resources for progressive disciplinary action and/or retraining. In response to the follow-up questions dated 2/2/12, the nurse will be monitoring med passes in each group home on a bi-weekly basis.	02/01/2012			

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	<p>(20 mg) capsule by mouth 1 time per day."</p> <p>On 01/04/12 at 8:25 AM an interview was conducted with staff #1. Staff #1 indicated client #6 had already eaten breakfast before the medication was given.</p> <p>On 01/05/12 at 1:42 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client #6 should have received this medication 1 hour before breakfast.</p> <p>9-3-6(a)</p>			
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W0418	<p>The facility must provide each client with a clean, comfortable mattress.</p> <p>Based on observation and interview, for 1 of 6 clients living in the home (client #6), the facility failed to provide a comfortable mattress.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 01/03/12 from 4:15 PM until 7:38 PM and on 01/04/12 from 7:00 AM until 9:00 AM. During the observation times client #6 was observed to go to his room several times, sit on the edge of the bed and bounce up and down. Client #6's bed was observed to contain a circular dip in the mattress approximately 18 inches in circumference.</p> <p>On 01/05/12 at 1:42 PM an interview with the QMRP (Qualified Mental Retardation Professional) was conducted in client #6's bedroom. The QMRP indicated client #6 liked to bounce on his bed and the mattress had a dip in it from his bouncing and "probably" was not comfortable due to the large dip.</p> <p>9-3-7(a)</p>	W0418	A new mattress will be purchased for the consumer identified in W418.	02/01/2012			

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W0436	<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, the facility failed to furnish and maintain a power wheelchair, keep a manual wheelchair clean, and ensure the correct walker was used for 3 of 3 clients (clients #1, #2, and #5) who used adaptive equipment to assist them with mobility.</p> <p>Findings include:</p> <p>On 1-3-12 from 4:20 p.m. until 7:45 p.m. an observation at the home of clients #1, #2, and #5 was conducted. At 6:00 p.m. client #5's wheelchair had dried food on the lap belt and on the seat. During the entire observation client #2 required staff for mobility due to her power chair being broken. Client #1 used a walker which had 2 wheels and 2 tennis balls on it. Client #1 picked up the walker and set it down when walking. Client #1 was bent over as he used the walker throughout the entire observation.</p> <p>Record review on 1-5-12 at 9:14 a.m. for client #2 indicated no documented evidence for a date of the power wheelchair being removed for repair or</p>	W0436	<p>The nurse and incoming QDSP will be completing an inventory of all consumer's adaptive equipment and making sure that replacements/purchases are done as needed. The nurse will be addressing adaptive equipment care in a training scheduled for 2/9/12. In response to the question posed on 2/2/12 on this issue, on-going compliance with this monitored in several ways: * There is now a Lead DSP in place at Earl Group home who has the responsibility to ensure adaptive equipment needs are addressed. This person works shifts in the home. * There is now a GH Manager, the Program Manager for Tippecanoe County, who will also be in the home monitoring compliance. * The new QDDP and the agency nurse will also be regularly in the home and monitoring compliance. * During the monthly Earl staff trainings, issues such as equipment will be reviewed and documented.</p>	02/01/2012
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	<p>when the wheelchair would be repaired and returned to client #2.</p> <p>Record review on 1-5-12 at 9:15 a.m. for client #1 was conducted. A medicaid form dated 4-11 indicated client #1 received a walker with 4 wheels, a hand brake, and a seat.</p> <p>On 1-5-12 at 1:15 p.m. an interview with the facility nurse indicated client #5's wheelchair should be kept clean.</p> <p>On 1-5-12 at 9:45 a.m. an interview with the facility nurse indicated client #1 was not using the correct walker and staff should ensure the walker which was ordered for him was available for his use.</p> <p>On 1-4-12 at 7:50 a.m. an interview with direct care staff #3 stated client #2's power wheel chair was supposed to be fixed last week and it was "not as easy" for client #2 to get around with out her power wheel chair.</p> <p>On 1-5-12 at 1:20 p.m. an interview with the facility nurse was conducted. The facility nurse indicated client #2 was using a non powered wheelchair due to her power wheelchair being repaired. The facility nurse indicated she was not sure of the date when client #2's wheelchair was broken or when client #2 would be</p>						

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	getting her power wheelchair back. The facility nurse also indicated there was no documentation to track when the parts were ordered or when the chair would be available for client #2 to use again. 9-3-7(a)			
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W0440	<p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based on record review and interview, the facility failed for 6 of 6 clients (clients #1, #2, #3, #4, #5 and #6) who resided in the home, by not ensuring an evacuation drill was conducted at least every 90 days on the day and the night shifts.</p> <p>Findings include:</p> <p>On 01/03/12 at 2:50 PM, record reviews were completed of the facility's evacuation drills for the period of 01/05/11 through 01/03/12. The review of the evacuation drill records included evacuation drills which were conducted for personnel and clients #1, #2, #3, #4, #5 and #6. The first day shift drill occurred on 09/18/11 and there were no documented drills recorded for the day shift prior to that time.</p> <p>A night shift drill was conducted on 03/29/11 and there were no documented night drills until 08/25/11.</p> <p>On 01/04/12 at 11:00 AM an interview with the Residential Director (RD) was conducted. The RD indicated there were no additional documents for review.</p> <p>9-3-7(a)</p>	W0440	The incoming manager will prepare a fire/safety manual that includes documentation of fire and sprinkler systems, fire drills, evacuation plans, etc. This will be maintained on a monthly basis.	02/01/2012			

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W0455	<p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation, record review, and interview, the facility failed for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) to ensure proper hand washing was implemented to assist in the prevention of infection during meal times and medication administration and to ensure unused juice was not poured back into the container.</p> <p>Findings include:</p> <p>On 1-3-12 from 4:20 p.m. until 7:45 p.m. an observation at the home of clients #1, #2, #3, #4, #5, and #6 was conducted. At 6:55 p.m. direct care staff (DCS) #7 was observed to go outside and smoke then she came back in, touched the raw meat, cut it up with scissors but she did not wash her hands between smoking and touching the food. At 7:10 p.m. clients #1, #2, #3, #4, #5, and #6 were observed to sit at the table to eat. Clients #1, #2, #3, #4, #5, and #6 were not prompted to wash their hands or their table before sitting down at the supper table to eat.</p> <p>On 1-4-12 from 6:45 a.m. until 9:10 a.m. an observation at the home of client #4 was conducted. At 8:15 a.m. DCS #3 poured the unused portion of client #4's</p>	W0455	The agency trainer will be completing a Bloodborne Pathogens/Infection Control re-training with Earl staff in conjunction with their Earl-specific CPI 2 training. This topic is also covered in annual recertifications.	02/01/2012
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	<p>juice from her cup she had drunk from, back into the juice pitcher then placed the container into the refrigerator.</p> <p>On 01/04/12 from 7:46 AM until 7:56 AM staff #1 was observed to prepare and administer client #1's medications to him. Client #1's medication included the medication Keppra (for seizures). The Keppra tablet was a large white pill. Client #1 indicated he could not swallow the pill whole and asked staff #1 to cut the pill in half. Staff #1 cut the pill in half using a pill cutter and then took the pill out of the pill cutter using his bare fingers.</p> <p>On 01/05/12 at 1:42 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated staff #1 should not have touched the pill with his bare fingers.</p> <p>On 1-5-12 at 12:45 p.m. an interview with the facility nurse indicated clients should wash their hands and the table before each meal, staff should wash their hands before handling raw meat and unused juice from a cup should not be poured back into the juice container.</p> <p>9-3-7(a)</p>			
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W0460	<p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review, and interview, for 2 of 6 clients (clients #4 and #5) who lived in the home, the facility failed to ensure their foods were prepared according to their prescribed diet and to ensure substitutions were offered for 6 of 6 clients living in the home (clients #1, #2, #3, #4, #5 and #6).</p> <p>Findings include:</p> <p>1. On 1-3-12 from 4:20 p.m. until 7:45 p.m. an observation at the home of clients #4 and #5 was conducted. At 7:10 p.m. direct care staff (DCS) #6 took thin strips of meat, cheese, and lettuce and placed it in the food processor. DCS #6 placed the ground meat, cheese, and lettuce on client #4's plate. No liquid was added to her meat. At 7:20 PM client #5 was observed to take a bite of his 6 inch burrito which contained thin beef strips which ranged from 1" to 3" in length. Client #5 took a bite of burrito and a piece of beef 3" hung from his mouth as he attempted to chew it and get it into his mouth. Client #5 was not able to reach up and take the piece of beef from his mouth. Client #5 continued to draw the piece of meat into his mouth until is cheeks puffed out and he was observed to attempt to swallow several</p>	W0460	<p>The nurse is working with the agency's dietary services provider to do up-dated menu and dining plans for all consumers. The dietary provider will be a part of the February 9 training to address the issues noted in W460. In response to the question posed on 2/2/12 on this issue, on-going compliance with this monitored in several ways: * There is now a Lead DSP in place at Earl Group home who has the reposnibility to ensure dinina/meal issues are addressed. This person works shifts in the home. * There is now a GH Manager, the Program Manager for Tippecanoe County, who will also be in the home monitiring compliance. * The new QDDP and the agency nurse will also be regularly in the home and monitoring compliance. * During the monthly Earl staff trainings, issues such as dining/meals will be reviewed and documented.</p>	02/01/2012			

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	<p>times in order to clear his mouth from the large amount of food. Clients #1, #2, #3, #4, #5 and #6 were seated at the dining room table at 7:00 PM for the supper meal. The menu included pepper steak, rice, corn/lima beans, whole wheat bread, margarine, mandarin oranges and 2% milk. Clients #1, #2, #3, #4, #5 and #6 were observed to not eat the corn/lima bean mixture. Clients #1 and #5 indicated they did not like it they threw it into the trash from their plates. There was no 2% milk on the table during the meal. No food substitutions were made or offered for the corn/lima bean mixture. No milk was offered.</p> <p>Client #5's record was reviewed on 01/05/11 at 12:45 PM. Client #5's 02-24-11 Dining Plan indicated his food, "needs to be cut into bite size pieces for him to consume (the visual size would be that of a quarter)."</p> <p>On 1-5-12 at 12:30 p.m. a record review for client #4 was conducted. Her dining plan (no date available) indicated her food was to be "chopped, ground, or blenderized and prepared with added liquids to make them easier to eat." Client #4's dining protocol indicated she was on a mechanical soft diet and foods which were hard to chew such as raw vegetables and tough meats should be</p>			
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	<p>avoided.</p> <p>On 1-5-12 at 1:30 p.m. the facility nurse indicated the dining protocols for clients #4 and #5 should be implemented by direct care staff at all meals.</p> <p>2. Observations were conducted in the group home on 01/03/12 from 4:15 PM until 7:38 PM. Clients #1, #2, #3, #4, #5 and #6 were seated at the dining room table at 7:00 PM for the supper meal. The menu included pepper steak, rice, corn/lima beans, whole wheat bread, margarine, mandarin oranges and 2% milk. Clients #1, #2, #3, #4, #5 and #6 were observed to not eat the corn/lima bean mixture. Clients #1 and #5 indicated they did not like it they threw it into the trash from their plates. There was no 2% milk on the table during the meal. No food substitutions were made or offered for the corn/lima bean mixture. No milk was offered.</p> <p>On 1-3-12 at 4:45 p.m. a record review of the menu dated winter 2011 indicated pepper steak, buttered rice, corn and lima bean, whole wheat bread, and oranges were on the menu.</p> <p>An interview on 01/05/12 at 1:45 PM with the Qualified Mental Retardation</p>						

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	<p>Professional (QMRP) was conducted. The QMRP indicated the menu should be followed and when the clients did not like an item, a like food substitution should be offered.</p> <p>9-3-8(a)</p>			
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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
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W0488	<p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, record review, and interview, the facility failed for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) who lived in the home, to ensure they assisted with the preparation of the supper meal.</p> <p>Findings include:</p> <p>On 1-3-12 from 4:20 p.m. until 7:45 p.m. an observation at the home of clients #1, #2, #3, #4, #5, and #6, was conducted. At 5:00 p.m. direct care staff (DCS) #7 took the meat out of the refrigerator and ran water over it. At 5:50 p.m. DCS #7 put the seasoning on the meat as client #6 walked around his home, and clients #2 and #4 sat in their living room. At 5:35 p.m. DCS #7 got out a skillet, placed the meat in the skillet and began cooking it as clients #2 and #4 sat in the living room. At 5:45 p.m. DCS #7 cut the meat with scissors as client #6 walked around his house and clients #2 and #4 sat in their living room. DCS #7 got tortilla shells from the pantry and stirred the meat with a fork. DCS #6 continued to cut up more meat as client #6 walked around the house, client #5 sat at the table, and clients #2 and #4 sat in their living room. At 5:55 p.m. DCS #6 continued to cook</p>	W0488	<p>The nurse is working with the agency's dietary services provider to do up-dated menu and dining plans for all consumers. The dietary provider will be a part of the February 9 training to address the issues noted in W488. This will include details of when/where/how meals should be conducted. In response to the question posed on 2/2/12 on this issue, on-going compliance with this monitored in several ways: *</p> <p>There is now a Lead DSP in place at Earl Group home who has the reposnsibility to ensure meal/dining are addressed. This person works shifts in the home.</p> <p>* There is now a GH Manager, the Program Manager for Tippecanoe County, who will also be in the home monitoring compliance. * The new QDDP and the agency nurse will also be regularly in the home and monitoring compliance. * During the monthly Earl staff trainings, issues such as meals/dining will be reviewed and documented.</p>	02/01/2012			

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	<p>the meat as client #5 sat at the table, client #1 was in the bathroom, client #3 was in her room, and clients #2 and #4 sat in their living room. DCS #7 came back in and used scissors to cut up more meat. She stirred the meat with a fork as client #6 lay on the floor, client #3 was in her room, client #1 was in the bathroom, and clients #2 and #4 sat in their living room. DCS #7 added water to the meat in the skillet. At 6:00 p.m. DCS #7 washed a knife, added another cup full of water to the meat, got a pan out, opened the lima beans, poured them in the pan and placed them on the stove. At 6:05 p.m. DCS #7 cut up more meat and added water as client #6 walked around his house, client #4 sat on the couch, and client #5 sat at the kitchen table. At 6:15 p.m. DCS #7 cut up red and yellow peppers, she cut up the cooked meat as client #4 sat on the couch, client #5 sat at the table and client #6 walked around his house. At 6:30 p.m. DCS #7 put the peppers in a skillet as client #2 sat at the table. At 6:40 p.m. DCS #7 unloaded the dishwasher, stirred the meat, added seasoning to the meat as client #2 sat at the table. At 6:45 p.m. DCS #7 assisted client #4 in stirring the peppers then assisted her back to the couch. DCS #7 took the lettuce and cheese from refrigerator. At 6:50 DCS #7 went to client #3's room and assisted client #3 in pouring 2 cans of oranges into</p>				

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	<p>a bowl. Clients #2 and #4 sat at the table as DCS #7 cooked the meat, took a bowl out, washed the bowl, poured the lima beans from the pan into the bowl, stirred the meat, took out the plates and cups, placed a serving spoon in the oranges and set them on the table. At 7:00 p.m. DCS #6 placed the plateguard on client #5's plate and placed a rubber mat under his plate for him. DCS #7 placed the corn in the microwave, poured the corn into a serving bowl, stirred the meat, added more water to the meat, opened the bags of rice and placed them in the microwave, placed the tortillas on a plate, heated them up in the microwave, placed the peppers in a bowl, placed bowl of cheese and lettuce on the table, placed corn and lima beans on the table, placed tortillas and sour cream on the table and DCS #6 set the table. At 7:10 p.m. DCS #6 placed meat, lettuce, and cheese in a food processor then she poured the blended mixture onto client #4's plate.</p> <p>On 1-5-12 at 9:14 a.m. a record review for client #2 was conducted. The Comprehensive Functional Assessment (CFA) dated 5-21-11 indicated client #2 was able to assist with meal preparation with assistance.</p> <p>On 1-5-12 at 12:30 p.m. a record review for client #4 was conducted. The CFA</p>			
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	<p>dated 5-21-11 indicated client #4 was able to assist with meal preparation with assistance.</p> <p>On 1-5-11 at 12:18 p.m. a record review for client #3 was conducted. The CFA dated 8-12-11 indicated client #3 was able to assist with meal preparation with assistance.</p> <p>On 1-5-12 at 10:30 a.m. a record review for client #6 was conducted. The CFA dated 8-12-11 indicated client #6 was able to assist with meal preparation with assistance.</p> <p>On 1-5-12 at 12:00 p.m. a record review for client #5 was conducted. The CFA dated 7-18-11 indicated client #5 was able to assist with meal preparation with assistance.</p> <p>On 1-5-12 at 9:15 a.m. a record review for client #1 was conducted. The CFA dated 12-6-11 indicated client #1 was able to assist with meal preparation with assistance.</p> <p>On 1-5-12 at 1:40 p.m. an interview with the Qualified Mental Retardation Professional indicated clients #1, #2, #3, #4, #5, and #6 should all be assisting with meal preparation and the were all capable of assisting with meal preparation.</p>				

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