

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/28/2014
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NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1703 LAUREL DR MARION, IN 46953
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 10/20, 10/21, 10/22, 10/23, 10/24, 10/27, and 10/28/2014.</p> <p>Provider Number: 15G581 AIM Number: 100245560 Facility Number: 001095</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/10/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview, for 2 of 4 sampled clients (clients #2 and #4), the governing body failed to exercise operating direction over the facility to ensure clients #2 and #4 were not charged for services the facility was to provide.</p> <p>Findings include:</p>	W000104	<p>This item outlines that the governing body failed to exercise operating direction over the facility to ensure clients #2 and #4 were not charged for services the facility was to provide: The Director of Group Homes/QDDP will complete training with the home manager and the Business Office on reimbursable expenses. The manager of the</p>	11/27/2014

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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W000149	<p>On 10/22/14 at 11:40am, client #2 and #4's financial records were reviewed with the DGH/QIDP (Director of Group Homes/Qualified Intellectual Disabilities Professional) and the Agency Accountant (AA) which indicated the following:</p> <p>Client #2's financial record included an 7/17/14 "[Name of vision provider]" receipt for \$21.78 for her prescribed eye glasses dispensed from client #2's personal funds account.</p> <p>Client #4's financial record indicated an 8/6/14 "[name of hair salon]" receipt for \$7.00. Upon further review the DGH/QIDP indicated "[name of hair salon]" was a hair salon and client #4 had received a hair cut on 8/6/14.</p> <p>On 10/22/14 at 11:40am, the AA indicated clients #2 and #4 had charges to their personal funds at the facility. The DGH/QIDP stated the facility's rate was "all inclusive" and clients #2 and #4 should be reimbursed for the charges of services the facility was to provide.</p> <p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit</p>		<p>site will complete training of all Direct Care staff at the home. The Staff will flag any receipts that are reimbursable. The Business Office will audit the home's financials on a monthly basis to assure accuracy for all applicable clients. For any expense that is viewed as questionable (meaning the person reviewing the expense cannot determine if the expense is reimbursable or not) the Business Office, Manager and QDDP will collectively determine if the expense is reimbursable. The Business Office will complete an audit of this home to assure no other resident was affected by this same deficient practice. This audit will have occurred no later than 11/27/2014. All above training and process will have occurred and will be in effect no later than 11/27/2014.</p>				

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	<p>mistreatment, neglect or abuse of the client. Based on observation, record review, and interview, for 3 of 8 clients (clients #5, #6, and #8), the facility neglected to ensure implementation of the agency's policy and procedure to prohibit abuse/neglect/mistreatment, to protect clients #5, #6, and #8 from substantiated staff neglect.</p> <p>Findings include:</p> <p>On 10/20/14 at 10:35am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, investigations, and behavioral reports (BRs) from 1/1/14 through 10/20/14 were reviewed and indicated the following:</p> <p>For clients #5 and #8: -A 1/30/14 BDDS report for an incident on 1/29/14 at 4:26pm, indicated staff "reported seeing [clients #5 and #8] on the group home van alone in the [community parking lot]. The reporter indicated that a few minutes later [Group Home Staff (GHS) #3] was observed coming out of [the restaurant] and getting into the van." The report indicated GHS #3 was suspended pending an investigation. The reported indicated "[GHS #3] admitted that after picking up [clients #5 and #8] from the day services he went to [the name of the restaurant]</p>	W000149	<p>This item outlines that the agency failed to ensure implementation of the agency's policy and procedure to prohibit abuse/neglect/mistreatment (ANM) to protect clients from substantiated staff neglect. The plan of correction for these findings is as follows:</p> <p>The QDDP will complete training with all applicable staff on ANM no later than 11/27/2014 on the agency's policy and the regulations on Abuse Neglect and Exploitation including reporting requirements. This training includes Day Services staff in addition to the home staff. Monitoring will occur with a combination of the QDDP, Chief Operations Officer, Corporate Compliance Office and the Chief Executive Officer completing weekly checks initially at programming sites (either SGL or Day Services location). Weekly checks will be completed for at least 4 weeks whereby the frequency can be re-evaluated to determine if that frequency can be reduced or not. The home and day services site manager will monitor his/her respective program at all times while at work. Management oversight will assure timely reporting.</p> <p>All above training and process will</p>	11/27/2014	

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	<p>leaving both [clients #5 and #8] on the van alone while he went into [the restaurant] for approximately 5 min. (minutes). [GHS #3] indicated during the interview that he understood why leaving consumers on the van alone was neglect."</p> <p>For client #6: -An 8/27/14 BDDS report for an incident on 8/27/14 at 1:15pm, indicated client #6 was at the facility owned "Day Services staff waiting for his group home staff to pick him up to go home." The report indicated "when a staff from another agency thought that [client #6] was the individual that she was supposed to be picking up for an appointment and had [client #6] get into her car. They drove away and were gone from the agency for approximately 8 minutes before the staff realized she had the wrong client. She then brought [client #6] back to the agency." The report indicated staff at the day services were retrained on "signing in/signing out" clients from the day services.</p> <p>On 10/20/14 at 10:00am, a review of the facility's 6/15/11 "Abuse, Neglect, and Exploitation" policy indicated, "It is the policy of Carey Services to respect the rights of consumers served and protect them from possible abusive treatment, negligence, or exploitation on the part of</p>		have occurred and will be in effect no later than 11/27/2014.				

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	<p>staff, volunteers, or other consumers. Abusive treatment and/or negligence of responsibilities with respect to the welfare and safety of consumers are incompatible with the purpose of the agency....Definition: Neglect: includes, but is not limited to, failure to provide appropriate supervision, care, training, a safe/clean/sanitary environment, food, medical care, medical supplies and equipment (as indicated in the ISP (Individual Support Plan)."</p> <p>On 10/20/14 at 10:00am, a review of the facility's 10/22/12 "PROCEDURES FOR REPORTING ABUSE AND NEGLECT AND OTHER REPORTABLE OR UNUSUAL INCIDENTS. As required by law, it is the responsibility of each person to report suspected instances of abuse, neglect, and exploitation...responsibilities in reporting such incidents to authorities as well as to agency administrators immediately upon learning of the suspected abuse/neglect/exploitation. Agency staff and volunteers must immediately report incidents to the President/CEO, Human Resources Manager, or designee, who will assign responsibility for investigation and follow-up. The Corporate Compliance Officer will be notified of the allegation and may or may not be asked to assist with the</p>			

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	<p>investigation. A. <u>REPORTABLE INCIDENTS</u>: Carey Services shall meet all the conditions specified in any applicable article of 460 IAC. Carey Services shall report the following circumstances to DDRS/BDDS/DA (Department of Aging) no later than 24 hours after the occurrence of the reportable incident...The following incidents are considered reportable to the appropriate entity as outlined in section B: 1. Any alleged, suspected, or actual abuse, neglect or exploitation of a consumer...."</p> <p>On 10/20/14 at 10:00am, a review of the BDDS 6/11/2002 policy and procedure for "Incident Reporting" indicated "...Reportable incidents to the Bureau of Developmental Disabilities Services are any event or occurrence characterized by risk or uncertainty, resulting in or having the potential to result in significant harm or injury to an individual...Standards: A. Services and supports shall provide necessary safeguards to protect the health, safety, and welfare of individuals. B. Anyone with knowledge of an issue or concern that effects the individual's potential health and safety may submit a BDDS Incident Report form...Reportable Incidents...1) Incident of suspected abuse or neglect of an adult or child who is residing in a community residential</p>			

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W000186	<p>setting...a) Physical, sexual, verbal, or mental abuse...ii) sexual-includes all allegations of rape, sexual misconduct, or sexual exploitation...b) Neglect-includes failure to provide appropriate care, food, medical care, or supervision. 2) Exploitation...b) any other type of exploitation, including but not limited to sexual exploitation...14) Inadequate staff support resulting in or having the potential to result in significant harm or injury to an individual or death of an individual. This includes inadequate supervision by staff, even when staffing levels are appropriate...."</p> <p>On 10/28/14 at 10:00am, an interview with the DGH/QIDP (Director of Group Homes/Qualified Intellectual Disabilities Professional) was conducted. The DGH/QIDP indicated client #5, #6, and #8's BDDS reports were the result of substantiated staff neglect.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF 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</p>			
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	<p>24-hour period for each defined residential living unit.</p> <p>Based on observation, record review, and interview, for 3 of 4 sampled clients (clients #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facility failed to provide sufficient staff at the group home to supervise clients and to implement client #2, #3, and #4's Individual Support Plans (ISPs) and Behavior Support Plans (BSPs) and to provide sufficient staff supervision during the morning hours.</p> <p>Findings include:</p> <p>On 10/22/14 from 6:10am until 8:15am, observation and interview were conducted at the group home with clients #1, #2, #3, #4, #5, #6, #7, and #8. From 6:10am until 6:45am, Group Home Staff (GHS) #1 and GHS #2 were supervising clients #1, #2, #3, #4, #5, #6, #7, and #8 at the group home. At 6:45am, GHS #1 indicated he had to leave with client #1 to travel to [name of city] and both left the group home. From 6:45am until 7:08am, GHS #2 was alone with clients #2, #3, #4, #5, #6, #7, and #8. From 6:45am until 7:08am, clients #2, #3, #4, #5, #7, and #8 cooked in the kitchen, poured hot coffee, received medications, and ate their breakfast meal without supervision. From 6:45am until 7:08am, GHS #2 did</p>	W000186	<p>This item outlines that the facility failed to providesufficient staff at the group home to supervise clients and to implement ISPsand BSPs and to provide sufficient staff supervision during the morning hours. The plan of correction for these findings is as follows:</p> <p>The home manager is responsible for staffing and assuringufficient staffing at the site. Retraining will occur with the manager who schedules the staffing onwhat sufficient coverage is including medical appointments. The manger is to assure staffing andretraining will occur no later than 11/27/2014. The QDDP is responsible to monitor the schedule intensely (all schedulesand schedule changes) for at least 2 weeks to determine if the manager iscompetent in scheduling practices and is compliant with the aforementionedtraining. After 2 weeks of compliancethe QDDP will continue to monitor the schedule at least weekly to assuresufficient staffing.</p> <p>Retraining with the home staff will occur no later than11/27/2014 to assure an understanding that one staff cannot leave another ifthe result</p>	11/27/2014			

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	<p>not stay in the same room while clients completed each task, rotated between the kitchen, medication room, living room, bathroom, answered the facility phone, and did not stay within eye sight of clients #2, #3, #4, #5, #7, and #8. At 7:00am, client #6 came out of his bedroom, walked room to room, and sat down next to client #3 in the dining room. At 7:08am, the Residential Manager (RM) entered the facility and indicated GHS #1 should not have left with client #1 until 7:45am. The RM indicated there was not enough staff in the home when GHS #1 left and clients #2, #3, #4, #5, #6, #7, and #8 were alone with GHS #2. The RM stated there were to "be at least two (2) staff to three (3) staff" in the home during this time.</p> <p>Client #2's record was reviewed on 10/23/14 at 11:45am. Client #2's 5/31/14 ISP (Individual Support Plan) indicated objectives to teach client #2 to prepare a menu item and to stay on task. Client #2's 2/2014 Dining plan indicated client #2 was at risk to choke, on a mechanical soft diet, honey thickened liquids, and staff were to "encourage [client #2] to eat slowly and take smaller bites of food and place hands in lap and take a drink every 2 bites in effort to slow rate of intake and clear palate...."</p>		<p>would be insufficient staff coverage.</p> <p>All above training and process will have occurred and will be in effect no later than 11/27/2014.</p>				

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	<p>Client #3's record was reviewed on 10/23/14 at 1:26pm. Client #3's 9/17/13 ISP (Individual Support Plan) and 9/2014 BSP (Behavior Support Plan) indicated "The proactive measure is constant supervision. This will intercept most problem behaviors in this area. When [client #3] is in the common area of the house with other housemates, he needs to be monitored and within arms length of staff at all times. In fact, assigned staff are to be physical between [client #3] and peers when ever others residents are present."</p> <p>Client #4's record was reviewed on 10/23/14 at 12:35pm. Client #4's 10/16/13 ISP (Individual Support Plan) indicated objectives to drink between each bite of food, to work on sign words, to prepare lunch meal with staff, to wear her eye glasses, and to wash her hands before medication administration. Client #4's 6/2013 Dining plan indicated she was a choking risk and "requires verbal prompt with meal set up...to consume small bites of food and to take a drink in between bites. Encourage to eat slowly throughout meal...to lay down spoon after taking bite of food, put hands in lap until the food is thoroughly chewed and swallowed...."</p> <p>On 10/28/14 at 10:00am, an interview</p>			

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W000227	<p>with the DGH/QIDP (Director of Group Homes/Qualified Intellectual Disabilities Professional) was conducted. The DGH/QIDP indicated clients #2, #3, #4, #5, #6, #7, and #8 should be supervised by the facility staff. The DGH/QIDP indicated there should have been two to three (2-3) staff on duty at the group home on 10/21/14 to supervise clients #2, #3, #4, #5, #6, #7, and #8. The DGH/QIDP stated GHS #1 "should not have left" until an additional staff was at the group home. The DGH/QIDP stated client #3 was to have a staff between client #3 and other clients or "within an arms length" for supervision due to client #3's physically aggressive behaviors described in his BSP. The DGH/QIDP indicated clients #2, #3, #4, #5, #6, #7, and #8 needed staff supervision for cooking, handling hot items, dressing, medication administration, eating, and implementation of objectives during formal and informal opportunities. The DGH/QIDP stated clients #2 and #4 "required staff to sit beside" each client while dining to ensure clients #2 and #4 did not choke.</p> <p>9-3-3(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the</p>						

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	<p>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 record review and interview, for 1 of 4 sampled clients (client #2), the facility failed to develop an active treatment program to address client #2's identified incontinence needs.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 10/23/14 at 11:45am. Client #2's 5/31/14 ISP (Individual Support Plan) did not include an objective to address her incontinence of bowel or bladder. Client #2's 10/2013 BSP (Behavior Support Plan) indicated client #2 had a targeted behavior which include Wetting/Soils self by incontinence of bowel and bladder. Client #2's ISP and BSP indicated staff were to encourage her to use the restroom every three hours during the day and every four hours at night. There was no evidence provided of training to address client #2's incontinence.</p> <p>On 10/28/14 at 10:00am, an interview with the DGH/QIDP (Director of Group Homes/Qualified Intellectual Disabilities Professional) was conducted. The DGH/QIDP indicated client #2's identified incontinence need had not been</p>	W000227	<p>This item outlines that the facility failed to develop an active treatment program to address incontinence needs. The plan of correction for these findings is as follows:</p> <p>Nursing staff, upon the direction of the QDDP, will assure that the applicable client has been evaluated of bladder and bowel. Scheduling of such medical appointment will occur no later than 11/27/2014.</p> <p>QDDP will train all applicable staff of this client's history as related to bladder and bowel concerns including but not limited to the effects of some foods on her bladder and bowels as stated in her BSP.</p> <p>QDDP will train all applicable staff that the staff is to complete a behavior report when episodes of incontinence occur to have the documentation to take to the Behavioral consultant and to her physician.</p> <p>QDDP will assure that the ISP includes objective to reduce incidents of incontinence. Included with this will be a tracking sheet to document when</p>	11/27/2014			

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W000240	<p>addressed or an objective developed. The DGH/QIDP stated client #2 had been incontinent of bowel and bladder for a "long time." The DGH/QIDP indicated a behavior plan was developed in which client #2 was encouraged to go to the bathroom by staff. The DGH/QIDP stated client #2's incontinence increased when client #2 eats "certain foods."</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #4), the facility failed to develop specific guidelines in the ISP (Individual Support Plan) for the use of client #4's small silverware and gait belt.</p> <p>Findings include:</p> <p>On 10/20/14 from 1:50pm until 6:35pm, and on 10/22/14 from 6:10am until 8:15am, client #4 was observed at the group home. During both observation periods client #4 did not use a gait belt to support her walking throughout the group home. On 10/20/14 from 5:50pm until 6:35pm, client #4 was assisted at the</p>	W000240	<p>offers of restroom use are madeand the outcome of such offers/encouragement.</p> <p>QDDP will evaluate other residents to assure no otherresident has the potential to be affect by the same deficient practice.</p> <p>Allabove training and processes will have occurred and will be in effect no laterthan 11/27/2014.</p> <p>This item outlines that the facility failed to developspecific guidelines in the ISP for the use of client #4's small silverware andgait belt. The plan of correction forthese findings is as follows:</p> <p>QDDPwill contact dietician regarding small silverware. Dietician recommendations will be reflectedin the ISP and the ISP will be updated to reflect such recommendationsincluding any applicable adaptive equipment. The Dining Plan will be updated to reflect such recommendations as well. All applicable staff will be re-trained onthe consumer's updated plans</p>	11/27/2014			

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	<p>dining room table by Group Home Staff (GHS) #5, GHS #6, and the Residential Manager (RM). Client #4 did not use small silverware to eat with and did not use a gait belt to assist to walk. On 10/22/14 from 6:45am until 7:30am, client #4 ate her food with a regular spoon, took overflowing bites of thick Oatmeal, was redirected by the staff, and no small silverware was used.</p> <p>On 10/28/14 at 10:00am, an interview with the DGH/QIDP (Director of Group Homes/Qualified Intellectual Disabilities Professional) was conducted. The DGH/QIDP indicated client #4 should have used small silverware to eat with, used a gait belt for walking safety, and no guidelines for their use were in client #4's plans.</p> <p>Client #4's record was reviewed on 10/23/14 at 12:35pm. Client #4's 10/16/13 ISP (Individual Support Plan) indicated client #4 used "Adaptive Equipment List...small silverware...Gait Belt." Client #4's ISP did not indicate guidelines for when staff should encourage client #4 to use her small silverware and her gait belt.</p> <p>9-3-4(a)</p>		<p>no later than 11/27/2014. The manager is responsible for daily monitoring the use of adaptive equipment as ordered and recommended by specialists. Additionally, the dietician will monitor on a quarterly basis. The nurse will complete an observation in the month of November and in the month of December to assure that plans are executed as written. The nurse will continue visits at least on a quarterly basis if the home continues to be in compliance. Frequency of oversight will be increased if any concerns or issues are noted.</p> <p>QDDP and the home manager will assure that an updated PT Evaluation is scheduled no later than 11/27/2014 for the first available appointment. Once the PT Evaluation has occurred and recommendations are approved by the physician, the QDDP and the home manager will train all applicable staff on those orders. If the gait belt is necessary, it will be included. If the gait belt is deemed no longer necessary, the plan and the training will reflect this. The manager is responsible for daily monitoring the use of adaptive equipment as ordered and recommended by specialists. The nurse will complete</p>				

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, for 3 of 4 sampled clients (clients #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facility failed to implement client #2, #3, and #4's Individual Support Plans (ISP) and Behavior Support Plan (BSP) when opportunities existed.</p> <p>Findings include:</p> <p>On 10/22/14 from 6:10am until 8:15am, observation and interview were conducted at the group home with clients #1, #2, #3, #4, #5, #6, #7, and #8. From 6:10am until 6:45am, Group Home Staff</p>	W000249	<p>anobservation in the month of November and in the month of December to assurethat orders are executed as written. Thenurse will continue visits at least on a quarterly basis if the home continuesto be in compliance. Frequency ofoversight will be increased if any concerns or issues are noted.</p> <p>This item outlines that the facility failed to implement ISPs and BSPs whenopportunities existed. The plan ofcorrection is as follows: The home manager is responsible for staffing and assuringufficient staffing at the site. Retraining will occur with the manager who schedules the staffing onwhat sufficient coverage is including medical appointments. The manger is to assure staffing andretraining will occur no later than 11/27/2014. The QDDP is responsible to monitor the schedule intensely (all schedulesand schedule changes) for at least 2 weeks to determine if the manager iscompetent in</p>	11/27/2014	

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	(GHS) #1 and GHS #2 were supervising clients #1, #2, #3, #4, #5, #6, #7, and #8 at the group home. At 6:45am, GHS #1 indicated he had to leave with client #1 to travel to [name of city] and both left the group home. From 6:45am until 7:08am, GHS #2 was alone with clients #2, #3, #4, #5, #6, #7, and #8. From 6:45am until 7:08am, clients #2, #3, #4, #5, #7, and #8 cooked in the kitchen, poured hot coffee, received medications, and ate their breakfast meal without supervision. From 6:45am until 7:08am, GHS #2 did not stay in the same room while clients completed each task, rotated between the kitchen, medication room, living room, bathroom, answered the facility phone, and did not stay within eye sight of clients #2, #3, #4, #5, #7, and #8. From 6:45am until 7:08am, clients #2 and #4 consumed their breakfast bite after bite without pausing or drinking between bites of food. Client #2 received toast cut into bite size pieces without the toast being moistened. Clients #2 and #4 were not asked to pause when eating or to place their hands in their laps between bites. During the observation period client #3 walked without facility staff present from table to table in the dining room where clients #2, #4, #5, and #8 were sitting. At 7:00am, client #6 came out of his bedroom, walked room to room, and sat down next to client #3 in		scheduling practices and is compliant with the aforementioned training. After 2 weeks of compliance the QDDP will continue to monitor the schedule at least weekly to assure sufficient staffing. Retraining with the home staff will occur no later than 11/27/2014 to assure an understanding that one staff cannot leave another if the result would be insufficient staff coverage. Retraining with the home staff will occur no later than 11/27/2014 on all ISPs, BSPs and Risk Plans. All above training and process will have occurred and will be in effect no later than 11/27/2014. QDDP will evaluate all residents to assure no other resident has the potential to be affected by the same deficient practice. <u>Plan of Correction Addendum:</u> Training occurred on 11/21/2014 and 11/26/2014 on Active Treatment and Redirection Training which includes formal and informal active treatment as related to client objectives. Training included definitions of informal and formal opportunities. Redirection was also discussed in this training as a way to provide active treatment as related to client objectives and to use formal and informal opportunities to provide training. See completed training documents provided. <u>Plan of Correction Addendum II:</u> Monitoring for W249 will occur in				

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	<p>the dining room. At 7:08am, the Residential Manager (RM) entered the facility and indicated GHS #1 should not have left with client #1 until 7:45am. Clients #2, #3, #4, #5, #6, and #8 were not asked to wash their hands before eating their breakfast. From 6:10am until 8:15am, client #4 did not wear her prescribed eye glasses or to use sign words.</p> <p>Client #2's record was reviewed on 10/23/14 at 11:45am. Client #2's 5/31/14 ISP (Individual Support Plan) indicated objectives to teach client #2 to prepare a menu item and to stay on task. Client #2's 2/2014 Dining plan indicated client #2 was at risk to choke, on a mechanical soft diet, honey thickened liquids, and staff were to "encourage [client #2] to eat slowly and take smaller bites of food and place hands in lap and take a drink every 2 bites in effort to slow rate of intake and clear palate...."</p> <p>Client #3's record was reviewed on 10/23/14 at 1:26pm. Client #3's 9/17/13 ISP (Individual Support Plan) and 9/2014 BSP (Behavior Support Plan) indicated "The proactive measure is constant supervision. This will intercept most problem behaviors in this area. When [client #3] is in the common area of the house with other housemates, he needs to</p>		<p>two layers. First, the Home Manager will complete at least 5 visits per week. Second, one weekly check will occur by one of the following: the QDDP, Chief Operations Officer, Corporate Compliance Office and/or the Chief Executive Officer at program sites to assure program implementation. Weekly checks will be completed for at least 4 weeks whereby the frequency can be re-evaluated to determine if that frequency can be reduced or not. Observations will be documented.</p>				

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	<p>be monitored and within arms length of staff at all times. In fact, assigned staff are to be physical between [client #3] and peers when ever others residents are present."</p> <p>Client #4's record was reviewed on 10/23/14 at 12:35pm. Client #4's 10/16/13 ISP (Individual Support Plan) indicated objectives to drink between each bite of food, to work on sign words, to wear her eye glasses, and to wash her hands before medication administration. Client #4's 6/2013 Dining plan indicated she was a choking risk and "requires verbal prompt with meal set up...to consume small bites of food and to take a drink in between bites. Encourage to eat slowly throughout meal...to lay down spoon after taking bite of food, put hands in lap until the food is thoroughly chewed and swallowed...."</p> <p>On 10/28/14 at 10:00am, an interview with the DGH/QIDP (Director of Group Homes/Qualified Intellectual Disabilities Professional) was conducted. The DGH/QIDP indicated clients #2, #3, #4, #5, #6, #7, and #8 should be supervised by the facility staff. The DGH/QIDP stated GHS #1 "should not have left" until an additional staff was at the group home. The DGH/QIDP stated client #3 was to have a staff between client #3 and</p>			

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W000259	<p>other clients or "within an arms length" for supervision due to client #3's physically aggressive behaviors described in his BSP. The DGH/QIDP indicated clients #2, #3, #4, #5, #6, #7, and #8 needed staff supervision for cooking, handling hot items, dressing, medication administration, eating, and implementation of objectives during formal and informal opportunities. The DGH/QIDP stated clients #2 and #4 "required staff to sit beside" each client while dining to ensure clients #2 and #4 did not choke.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview, for 1 of 4 sampled clients (client #3), the facility failed to ensure client #3's CFA (Comprehensive Functional Assessment) was reviewed at least annually.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 10/23/14 at 1:26pm. Client #3's 9/11/2013 CFA (Comprehensive</p>	W000259	<p>This item outlines that the facility failed to ensure that Client #3's CFA (Comprehensive Functional Assessment) was reviewed at least annually. The plan of correction is as follows:</p> <p>The CFA was updated on 11/11/2014. The home manager will be responsible for a monthly audit sheet. Included on this tracking sheet will be the last CFA date. To assure continued compliance the home manager</p>	11/27/2014

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W000260	<p>Functional Assessment) was not reviewed annually.</p> <p>On 10/28/14 at 10:00am, an interview with the DGH/QIDP (Director of Group Homes/Qualified Intellectual Disabilities Professional) was conducted. The DGH/QIDP indicated client #3's documented CFA (Comprehensive Functional Assessment) was not reviewed annually.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview, for 1 of 4 sampled clients (client #3), the facility failed to annually complete client #3's ISP (Individual Support Plan).</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 10/23/14 at 1:26pm. Client #3's 9/17/2013 ISP (Individual Support Plan) indicated the facility failed to annually complete client #3's ISP.</p> <p>On 10/28/14 at 10:00am, an interview</p>	W000260	<p>will submit this monthly to the QDDP and to the COO. Internally, the QDDP will report a plan of correction for any item that is out of compliance and the annual timeframe to the COO.</p> <p>All above training and process will have occurred and will be in effect no later than 11/27/2014. QDDP will evaluate all residents to assure no other resident has the potential to be affected by the same deficient practice.</p> <p>This item outlines that the facility failed to ensure that Client #3's ISP was reviewed at least annually. The plan of correction is as follows:</p> <p>The ISP was updated on 11/11/2014. The home manager will be responsible for a monthly audit sheet. Included on this tracking sheet will be the last ISP date. To assure continued compliance the home manager will submit this monthly to the QDDP and to the COO. Internally, the QDDP will report a plan of correction for any item</p>	11/27/2014			

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W000289	<p>with the DGH/QIDP (Director of Group Homes/Qualified Intellectual Disabilities Professional) was conducted. The DGH/QIDP indicated client #3's documented ISP was not reviewed annually. The DGH/QIDP indicated no additional information was available for review.</p> <p>9-3-4(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on record review and interview, for 1 of 1 sampled client (client #3) who had restrictive techniques employed, the facility failed to clearly define the specific techniques utilized in client #3's Behavior Support Plans (BSPs).</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 10/23/14 at 1:26pm. Client #3's 9/17/13 ISP (Individual Support Plan) and 9/2014 BSP (Behavior Support Plan) both indicated staff were to use "CPI (Crisis Prevention Intervention) approved techniques." Client #3's BSP indicated</p>	W000289	<p>that is out of compliance and the annual timeframe to the COO.</p> <p>All above training and process will have occurred and will be in effect no later than 11/27/2014. QDDP will evaluate all residents to assure no other resident has the potential to be affected by the same deficient practice.</p> <p><b>W289 MANAGEMENT OF INAPPROPRIATE CLIENT BEHAVIOR</b> This item outlines that the facility failed to clearly define the specific techniques utilized in client #3's BSP. The plan of correction is as follows: The BSP will be updated by 11/27/2014. The update will include which CPI restraints to use and the hierarchy. Additionally the CPI policy will be included in this update. Other residents are affected by this deficient practice and this will require all BSPs to be updated. The behavior consultant will update all BSPs no later than 12/31/2014. Due to the number of BSPs and the unique needs of each client this deadline is</p>	11/27/2014			

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	<p>"...CPI team control position see below...Staff should employ the CPI team control position or the APT Emergency Floor Position see Carey Services policy #4.4.1 for detailed descriptions of these procedures. CPI and APT are taught by an in house staff trainer...." No definition of what CPI and APT techniques were approved was included in the plan. Client #3's BSP did not specifically define which CPI and APT physical restraints were to be used when client #3 would require a CPI restraint, and failed to indicate the hierarchy from least restrictive to most intrusive techniques employed.</p> <p>On 10/28/14 at 10:00am, an interview with the DGH/QIDP (Director of Group Homes/Qualified Intellectual Disabilities Professional) was conducted. The DGH/QIDP indicated the facility staff had employed CPI physical restraints on client #3 to manage aggressive behaviors. The DGH/QIDP indicated client #3 had physical restraints employed by the facility staff. The DGH/QIDP indicated there was no documented evidence which described written interventions from least restrictive to most intrusive techniques staff were to employ for client #3's behaviors. The DGH/QIDP indicated client #3's BSPs did not state and/or define the specific techniques used for</p>		<p>appropriate. After each of the BSPs are updated and approved by applicable HRC and Guardian/Advocates/Etc. the staff will be trained on each BSP. <u>Plan of Correction Addendum:</u></p> <p>BSPs will be updated by 11/27/2014. The update will include which CPI restraints to use and the hierarchy. Additionally the CPI policy will be included in this update.</p> <p>There were two client BSPs identified with CPI. For one client, the CPI was removed and for Client #3, CPI hierarchy was added on 11/21/2014. Training was completed on 11/21/2014. No other client was affected by deficient practice. See completed training documents provided.</p>				

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W000317	<p>client #3.</p> <p>9-3-5(a)</p> <p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. Based on record review and interview, for 1 of 4 sampled clients (client #2) who received psychotropic medications, the facility failed to evaluate client #2's status for an annual decrease or contraindication of psychotropic medication.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 10/23/14 at 11:45am. Client #2's 5/31/14 ISP (Individual Support Plan) and 10/2013 BSP (Behavior Support Plan) indicated targeted behaviors of verbal aggression, physical aggression, physical non compliance, tantrums, and wetting/soils self. Client #2's 10/1/14 "Physician's Order" indicated client #2 received Depakote 500mg (milligrams) daily for behaviors (Schizophrenia) started 5/6/12, Risperidone 3mg give 1 tab by mouth every night at bedtime for Schizophrenia started 5/6/13, and</p>	W000317	<p><b>W317 DRUG USAGE</b></p> <p>This item outlines that the facility failed to evaluate client #2's status for an annual decrease or contraindication of psychotropic medication. The plan of correction is as follows:</p> <p>The QDDP will discuss client #2's psychotropic medication with the applicable prescriber to determine reduction or contraindication no later than 11/27/2014.</p> <p>The QDDP will assure that all consumers have a plan to reduce psychotropic medications at least annually or contraindication of such no later than 11/27/2014.</p> <p>The nurse will monitor medication changes on the medication administration record.</p>	11/27/2014			

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W000331	<p>Paroxetine 30mg, give 1 tab by mouth every night at bedtime for depression started 5/6/13. Client #2's 10/2/14, 7/9/14, 4/24/14, and 10/17/13 "Psychotropic Medications Review(s)" did not indicate a decrease or contraindication of client #2's psychotropic medications. Client #2's record did not indicate the last psychotropic medication change or contraindication. No behavior data was provided for review.</p> <p>Interview with the DGH/QIDP (Director of Group Homes/Qualified Intellectual Disabilities Professional) was conducted on 10/28/14 at 10:00am. The DGH/QIDP indicated client #2's psychiatric medication had not been changed in over a year and no contraindication for client #2's psychiatric medication had been documented. The DGH/QIDP indicated client #2 had no documented evidence that a medication change had been considered or a medication reduction.</p> <p>9-3-5(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and</p>	W000331	<b>W331 NURSING SERVICES</b> This	11/27/2014			

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	<p>interview, for 2 of 4 sampled clients (clients #1 and #3), the facility's nursing services failed to develop a plan which included the oversight of client #1's wound care by the outside agency and to develop a plan for the use of client #1's Unna Boots use, and for client #3's Oxygen use at night and CPAP (Continuous Positive Airway Pressure) breathing machine.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Client #1's record was reviewed on 10/23/14 at 11:05am. Client #1's 9/6/14 "Physician's Order" indicated the use of the outside wound clinic for client #1's open left leg wound, dressing changes by the wound clinic, and antibiotic ordered. Client #1's 8/25/14 BDDS (Bureau of Developmental Disabilities Services) report for an incident on 8/23/14 at 4:00pm, indicated client #1 was on Leave of Absence from the facility, went to an Emergency Room at the hospital for an injury to his left lower leg, and was admitted to the hospital. Client #1's diagnoses included but were not limited to: Diabetes, Cerebral Palsy, Peripheral Neuropathy, Osteoarthritis, Sleep Apnea, and history of skin ulcers (open areas to the skin). Client #1's record indicated repeated medical interventions by the wound clinic to treat his recurring open</li> </ol>		<p>item outlines that the facility failed to develop a plan which included the oversight of client #1's wound care by the outside agency and to develop a plan of the use of Client #1's Unna Boots use, and for client #3's Oxygen use at night and CPAP breathing machine. The plan of correction is as follows: The nurse will be trained by QDDP no later than 11/27/2014 on nursing expectations at the SGL including how to complete nursing assessments. The nurse will assure thorough completion of nursing assessments and will update plans to include the use of CPAP machines and Oxygen use no later than 11/27/2014. All above training and process will have occurred and will be in effect no later than 11/27/2014. QDDP will evaluate all residents to assure no other resident has the potential to be affected by the same deficient practice.</p> <p><u>Plan of Correction Addendum:</u></p> <p>The agency's Registered Nurse will train the identified LPN on nursing assessments on 12/16/2014.</p>				

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	<p>areas in 2013. Client #1's record did not indicate specific wound clinic information such as: the size, shape, and effectiveness of treatment for client #1's wound. Client #1's 7/2013 "Impaired Skin Integrity Protocol" indicated the five stages of client #1's wound, the signs and symptoms, preventative measures, and "treatment: Measure wound weekly, Monitor for signs and symptoms of infection, fever, redness, swelling, warmth, drainage, dressing change." Client #1's 9/19/14 "physician's order" indicated the use of "Unna Boots" to be worn by client #1 to treat his left leg open areas and no plan was available for review. Client #1's 8/31/14 and 9/30/14 Nursing Assessments did not include an assessment of client #1's left leg wound with the size, shape, color, drainage, stage of ulcer, dressing change, or the effectiveness of treatments.</p> <p>On 10/28/14 at 10:00am, an interview with the DGH/QIDP (Director of Group Homes/Qualified Intellectual Disabilities Professional) was conducted. The DGH/QIDP indicated the agency had experienced a change of personnel in the nursing department. The DGH/QIDP indicated client #1's treatment plans from the wound care clinic did not document the size, shape, color, symptoms, or drainage of client #1's wound. The</p>			

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W000336	<p>DGH/QIDP indicated the wound clinic provided treatment to client #1's leg wound twice a week. The DGH/QIDP indicated client #1's Impaired Skin Integrity Protocol was for the staff to use. The DGH/QIDP indicated no plan had been developed which included the use of the Unna Boots.</p> <p>2. Client #3's record was reviewed on 10/23/14 at 1:26pm. Client #3's 9/17/13 ISP (Individual Support Plan) and 9/2014 BSP (Behavior Support Plan) indicated the use of a CPAP machine for breathing at night and the use of Oxygen at night. Client #3's record did not include a plan for the use of the CPAP machine or the Oxygen at night use. Client #3's diagnosis included but was not limited to: Sleep Apnea.</p> <p>On 10/28/14 at 10:00am, an interview with the DGH/QIDP was conducted. The DGH/QIDP indicated client #3's plans did not include the use of the CPAP machine or Oxygen at night. The DGH/QIDP indicated the agency nurse was responsible for client #3's nursing services.</p> <p>9-3-6(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES</p>						

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	<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. Based on record review and interview, for 1 of 4 sampled clients (client #2), the facility failed to complete nursing quarterlies for client #2.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 10/23/14 at 11:45am. Client #2's record included nursing quarterly assessments completed on 6/30/14, 1/31/14, 10/31/13, and 7/23/13. Client #2's record indicated no nursing assessments were available for review before 6/2014 and after 1/31/14.</p> <p>On 10/28/14 at 10:00am, an interview with the Director of Group Homes/Qualified Intellectual Disabilities Professional) was conducted. The DGH/QIDP indicated the facility had experienced a change in nursing personnel at the facility and it was possible the quarterly documents were completed but not available. The DGH/QIDP indicated no additional documentation was available for review.</p> <p>9-3-6(a)</p>	W000336	<p><b>W336 NURSING SERVICES</b> This item outlines that the facility failed to complete Nursing quarterlies for client #2. The plan of correction is as follows: The nurse will be trained by QDDP no later than 11/27/2014 on nursing expectations at the SGL including how to complete nursing quarterlies. The nurse will assure updated nursing quarterly for client #2 and any other client at this home. This documentation will be in place no later than 11/27/2014. Oversight will be the home manager's completion of a monthly checklist to track applicable dates to assure compliance. The audit sheet will be submitted to the QDDP and to the COO to assure ongoing compliance.</p> <p><u>Plan of Correction Addendum:</u></p> <p>The agency's Registered Nurse will train the identified LPN on nursing assessments on 12/16/2014.</p>	11/27/2014			

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W000352	<p>483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. Based on record review and interview, for 2 of 4 sampled clients (clients #3 and #4), the facility failed to obtain a dental assessment and dental examination annually for clients #3 and #4.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 10/23/14 at 1:26pm. Client #3's record indicated dental assessments on 5/2/13 and 11/7/12. Client #3's record did not indicate a current dental assessment.</p> <p>Client #4's record was reviewed on 10/23/14 at 12:35pm. Client #4's record did not indicate a current dental assessment available for review for client #4.</p> <p>An interview with the Director of Group Homes/Qualified Intellectual Disabilities Professional (DGH/QIDP) was conducted on 10/28/14 at 10:00am. The DGH/QIDP indicated clients #3 and #4 had no current dental examinations completed within the past twelve months.</p> <p>9-3-6(a)</p>	W000352	<p><b>W352 COMPREHENSIVEDENTAL DIAGNOSTIC SERVICE</b> This item outlines that the facility failed to obtain adental assessment and dental examination annually for clients #3 and #4. The plan of correction is as follows:</p> <p>QDDP and the home manager will determine all applicableresidents that this deficient practice affects. All clients will be scheduled for a dental exam no later than 11/27/2014for the first available appointment.</p> <p>Oversight will be the home manager's completion of a monthlychecklist to track applicable dates to assure compliance. The audit sheet will be submitted to the QDDPand to the COO to assure ongoing compliance.</p> <p>All above training and process will have occurred and willbe in effect no later than 11/27/2014. QDDP will evaluate all residents to assure no other resident has</p>	11/27/2014			

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W000368	<p>483.460(k)(1) <b>DRUG ADMINISTRATION</b> The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review, and interview for 7 of 8 clients (clients #1, #2, #3, #4, #5, #6, and #7), the facility failed to administer medications without error and as prescribed by the clients' physician.</p> <p>Findings include:</p> <p>On 10/20/14 at 10:35am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 12/1/13 through 10/20/14 were reviewed and indicated the following medication errors for client #1, #2, #3, #4, #5, #6, and #7:</p> <p>1. For client #1: -An 10/4/14 BDDS report for an incident on 10/4/14 at 7:00am, indicated client #1 received his "Hydrocodone/APAP (for pain) at 7am, instead of the schedule time of 7pm."</p> <p>On 10/23/14 at 11:05am, client #1's record was reviewed. Client #1's 9/9/14 "Physician's Order" indicated "Hydroco/APAP 10-325mg (milligrams)</p>	W000368	<p>thepotential to be affect by the same deficient practice.</p> <p><b>W368 DRUGADMINISTRATION</b> This item outlines that the facility failed to administer medications without error and as prescribed by the clients' physician. The plan of correction is as follows: QDDP and the Nurse will provide retraining to all home staffno later than 11/27/2014 on how to pass medications. QDDP to retrain on Buddy Check processes (a process wherebyone staff double checks the medication pass of a colleague to assure nomedication errors occurred). Monitoring will occur with a combination of the QDDP, ChiefOperations Officer, Corporate Compliance Office and the Chief Executive Officercompleting weekly checks initially at programming sites (either SGL or DayServices location). Weekly checks willbe completed for at least 4 weeks whereby the frequency can be re-evaluated todetermine if that frequency can be reduced or not. All above training and process will have occurred and willbe in effect no later than 11/27/2014. QDDP will evaluate all residents to assure no other resident has thepotential to be affect by the same deficient</p>	11/27/2014	

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	<p>(for pain) give 1 tab by mouth three times daily."</p> <p>2. For client #2: -A 6/28/14 BDDS report for an incident on 6/26/14 at 9:00pm, indicated client #2 "had not received 9pm dose of Depakote (for Schizophrenia) on 6/26/14."  On 10/23/14 at 11:45am, client #2's record was reviewed. Client #2's 10/1/14 "Physician's Order" indicated "Depakote 500mg, give 1 tab by mouth every night at bedtime" for Schizophrenia.</p> <p>3. For client #3: -A 6/13/14 BDDS report for an incident on 6/12/14 at 7:00am, indicated Group Home Staff #1 "failed to pass" client #3's Lorazepam 0.5mg (for Schizophrenia) tablet at 7:00am on 6/13/14.  -A 12/17/13 BDDS report for an incident on 12/16/13 at 5:00pm, indicated client #3 received "double doses of the following medications: Sinemet 200mg (for Parkinson's Disease), Trileptal 600mg (for behaviors), and Lorazepam 0.5mg (for Schizophrenia)."  On 10/23/14 at 1:26pm, client #3's record was reviewed. Client #3's 9/30/14 "Physician's Order" indicated "Lorazepam 0.5mg, give 1 tab by mouth</p>		<p>practice. <u>Plan of Correction Addendum:</u>  Manager is monitoring the home medication passes five times weekly or more and will complete a Med Pass Observation form for each occurrence. Additionally, the LPN will complete one Med Pass Observation per week. This will occur for 4 weeks and will be re-evaluated to determine if frequency is appropriate.</p>				

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	<p>twice daily for Schizophrenia and Trileptal 600mg, give 1 tablet by mouth 3 times daily with food."</p> <p>4. For client #4: -A 6/13/14 BDDS report for an incident on 6/12/14 at 7:00am, indicated client #4 "did not receive controlled substance Clonazepam 0.5mg (for behaviors) on the morning of 6/12/14" by Group Home Staff #1.</p> <p>-A 5/2/14 BDDS report for an incident on 5/1/14 at 9:00pm, indicated "staff passed once a day Levaquin (antibiotic for bacterial infection) and prednisone (an anti inflammatory medication) and followed procedure with documentation. A second staff (Group Home Staff #9) did not follow procedure and later repassed above (same) medications."</p> <p>On 10/23/14 at 12:35pm, client #4's record was reviewed. Client #4's 10/2014 "Physician's Order" indicated "Clonazepam (Klonopin) (for behaviors) 0.5mg, give 1 tab by mouth twice daily."</p> <p>5. For client #5: -A 5/2/14 BDDS report for an incident on 5/1/14 at 9:00pm, indicated client #5's "evening dose of Keppra (for seizures) was omitted on 5/1/14" by GHS #9.</p>						

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	<p>On 10/24/14 at 9am, client #5's 10/1/14 "Physician's Order" indicated "Keppra 750mg (for seizures), give 1 tablet by mouth 2 times daily."</p> <p>6. For client #6: -A 6/9/14 BDDS report for an incident on 6/5/14 at 9:00pm, indicated client #6 was at Special Olympics from 6/5/14 through 6/8/14 and client #6 "did not receive evening (9:00pm) dose of Amitiza" medication for constipation. The 6/12/14 "Investigation" indicated Group Home Staff #1 packed client #6's medications for Special Olympics.</p> <p>-A 5/27/14 BDDS report for an incident on 5/25/14 at 9:00pm, indicated client #6 did not receive his 9:00pm dose of Amitiza for constipation medication.</p> <p>-A 4/26/14 BDDS report for an incident on 4/24/14 at 7:00pm, indicated client #6 "did not receive dose of Cipro for sinus infection" on 4/24/14 at 7:00pm.</p> <p>-A 4/23/14 BDDS report for an incident on 4/21/14 at 7:00pm, indicated client #6 "did not receive dose of Cipro for sinus infection."</p> <p>-A 4/21/14 BDDS report for an incident on 4/20/14 at 4:00pm, indicated "staff did not pass [client #6's] 4:00pm dose of</p>			

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	<p>Amitiza on 4/20/14."</p> <p>-A 3/20/14 BDDS report for an incident on 3/19/14 at 9:00pm, indicated client #6 was given the "wrong dose" of "Amitiza 24 mcg" for constipation. The report indicated client #6 was "given a 4:00pm dose as directed, [client #6] was not to receive another dose until 7:00am on the 20th (3/20/14). [Group Home Staff (GHS) #7] gave a dose again at 9:00pm on the 19th although it was not on the MAR (Medication Administration Record)."</p> <p>-A 3/7/14 BDDS report for an incident on 2/26/14 at 9:08pm, indicated "On 2/26/14 [GHS #7] gave [client #6] a second dose of SMZ/TMP D (Sulfamethoxazole and trimethoprim a combination antibiotic used to treat infections) tab 800-160. This had already been properly given and [GHS #7] gave the dose when it should not have been given."</p> <p>On 10/24/14 at 9:30am, client #6's 10/1/14 "Physician's Order" indicated "Amitiza 24mcg (for constipation), give 1 capsule by mouth twice daily."</p> <p>7. For client #7: -A 12/18/13 BDDS report for an incident on 12/16/13 at 5:00pm, indicated client #7 "received double doses of Propranolol</p>			

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W000369	<p>20mg" for high blood pressure.</p> <p>On 10/28/14 at 10:00am, an interview with the DGH/QIDP (Director of Group Homes/Qualified Intellectual Disabilities Professional) was conducted. The DGH/QIDP indicated staff should administer medications according to physician's orders. The DGH/QIDP indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders for clients #1, #2, #3, #4, #5, #6, and #7.</p> <p>9-3-6(a)</p> <p>483.460(k)(2) <b>DRUG ADMINISTRATION</b> 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 2 of 6 medications administered during the evening medication administration (clients #2 and #3), the facility failed to ensure client #2 and #3's medications were given without error.</p> <p>Findings include:</p>	W000369	<p><b>W369 DRUGADMINISTRATION</b> This item outlines that the facility failed to ensure client#2 and #3's medications were given without error. The plan of correction is as follows: QDDP and the Nurse will provide retraining to all home staffno later than 11/27/2014 on how to pass medications. QDDP to retrain on Buddy Check processes (a process wherebyone staff double checks the medication passes of a</p>	11/27/2014

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	<p>On 10/20/14 at 4:10pm, GHS (Group Home Staff) #4 asked client #2 to come to the medication room for medication administration. GHS #4 compared client #2's "Gaviscon Chew, give 1 tab (tablet) to chew by mouth 3 times daily with meals" for heartburn to client #2's 10/2014 MAR (Medication Administration Record). GHS #4 handed client #2 the Gaviscon medication in a medication cup, and client #2 consumed the medication by chewing it in client #2's mouth. No food or a meal was provided. At 6:29pm, client #2 consumed her first bite of food at the evening meal.</p> <p>On 10/20/14 at 4:15pm, GHS #4 asked client #3 to come to the medication room for medication administration. GHS #4 compared client #3's "Oxcarbazepin (for behaviors) 600mg (milligrams), give 1 tablet by mouth 3 times daily with food" to client #3's 10/2014 MAR. GHS #4 handed client #3 the Oxcarbazepine medication in a medication cup and client #3 consumed the medication with water. No food or a meal was provided. At 6:30pm, client #3 consumed his first bite of food at the evening meal. At 6:30pm, GHS #4 indicated clients #2 and #3 did not receive food or a meal with their evening medications.</p>		<p>colleague to assure nomedication errors occurred). Monitoring will occur with a combination of the QDDP, ChiefOperations Officer, Corporate Compliance Office and the Chief Executive Officercompleting weekly checks initially at programming sites (either SGL or DayServices location). Weekly checks willbe completed for at least 4 weeks whereby the frequency can be re-evaluated todetermine if that frequency can be reduced or not. All above training and process will have occurred and willbe in effect no later than 11/27/2014. QDDP will evaluate all residents to assure no other resident has thepotential to be affect by the same deficient practice. <u>Plan of Correction Addendum:</u></p> <p>Manager ismonitoring the home medication passes five times weekly or more and willcomplete a Med Pass Observation form for each occurrence. Additionally, the LPN will complete one Med PassObservation per week. This will occurfor 4 weeks and will be re-evaluated to determine if frequency is appropriate.</p>				

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	<p>On 10/23/14 at 11:45am, client #2's 10/1/14 Physician's Order and 10/2014 MAR (Medication Administration Record) both indicated "Gaviscon Chew, give 1 tab (tablet) to chew by mouth 3 times daily with meals."</p> <p>On 10/23/14 at 1:26pm, client #3's 10/1/14 Physician's Order and 10/2014 MAR both indicated "Oxcarbazepin (for behaviors) 600mg, give 1 tablet by mouth 3 times daily with food."</p> <p>On 10/28/14 at 10:00am, an interview with the Director of Group Homes/Qualified Intellectual Disabilities Professional (DGH/QIDP) was conducted. The DGH/QIDP indicated client #2 and #3's medications should have been administered according to their Physician's orders. The DGH/QIDP indicated the facility staff should administer medications according to Core A/Core B medication administration training. The DGH/QIDP indicated client #2 and #3's medications were given in error when food was not provided at the time of the medication administration or if the client did not eat within one half hour of consuming the medication.</p> <p>On 10/22/14 at 1:00pm, a record review of the facility's 2004 "Core A/Core B Medication Training" indicated "Lesson 3</p>				

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W000381	<p>Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders.</p> <p>9-3-6(a)</p> <p>483.460(l)(1) <b>DRUG STORAGE AND RECORDKEEPING</b> The facility must store drugs under proper conditions of security. Based on observation, record review, and interview, the facility failed to store medication securely for 4 of 4 sample clients (#1, #2, #3, and #4) and four additional clients (clients #5, #6, #7, and #8) who resided in the home.</p> <p>Findings include:</p> <p>On 10/21/14 from 6:10am until 8:15am, observations were conducted and clients #1, #2, #3, #4, #5, #6, #7, and #8 walked and/or accessed each room throughout the group home independently. During the observation period the medication cart was unlocked. At 8:00am, the Surveyor identified to the Residential Manager (RM) that the medication cart was unlocked. The RM indicated the medication cart should be secure when medications were not administered.</p> <p>An interview was conducted on 10/28/14</p>	W000381	<p><b>W381 DRUG STORAGE AND RECORDKEEPING</b> This item outlines that the facility failed to store medication securely. The plan of correction is as follows:</p> <p>QDDP and the Nurse will provide retraining to all home staff no later than 11/27/2014 on how to secure and store medications.</p> <p>Insufficient staffing was addressed in previous standard tag and was a contributing factor to this tag as well. See W186 POC.</p> <p>Monitoring will occur with a combination of the QDDP, Chief Operations Officer, Corporate Compliance Office and the Chief Executive Officer completing weekly checks initially at programming sites (either SGL or Day Services)</p>	11/27/2014

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W000382	<p>at 10:00am, with the DGH/QIDP (Director of Group Homes/Qualified Intellectual Disabilities Professional). The DGH/QIDP indicated the medication cart should be kept locked when medications were not administered. The DGH/QIDP indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 had access to the medication cart. The DGH/QIDP indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>On 10/22/14 at 1:00pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be kept secured when not being administered.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) <b>DRUG STORAGE AND RECORDKEEPING</b> The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 4 of 4 sample clients (#1, #2, #3, and #4) and four additional clients (clients #5, #6, #7, and #8) who resided in the home, the facility failed to keep</p>	W000382	<p>location). Weekly checks will be completed for at least 4 weeks whereby the frequency can be re-evaluated to determine if that frequency can be reduced or not.</p> <p>All above training and process will have occurred and will be in effect no later than 11/27/2014. QDDP will evaluate all residents to assure no other resident has the potential to be affected by the same deficient practice.</p> <p><b>W382 DRUG STORAGE AND RECORDKEEPING</b> This item outlines that the facility failed to keep medication locked when not being administered. The plan of</p>	11/27/2014			

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	<p>medication locked when not being administered.</p> <p>Findings include:</p> <p>On 10/21/14 from 6:10am until 8:15am, observations were conducted and clients #1, #2, #3, #4, #5, #6, #7, and #8 walked and/or accessed each room throughout the group home independently. During the observation period the medication administration cart was unlocked and the keys hung from the unsecured lock to the medication cart. At 6:45am, GHS (Group Home Staff) #2 opened the unsecured medication cart, removed client #8's Polyglycol (for constipation) medication, measured out 17 grams of medication, and mixed the medication powder with client #8's Orange Juice. GHS #2 set client #8's medication on top of the medication cart, left the medication unsecured, and left the medication cart unsecured in the open medication room. GHS #2 carried the mixture to the dining room table, set the mixture down in front of client #8, and left the room. No staff was present continuously in the dining room with client #8 and her medication mixture. At 8:00am, the Surveyor showed the Residential Manager (RM) client #8's unsecured medication on top of the medication cart, the unsecured medication at the dining room table, and</p>		<p>correction is as follows:</p> <p>QDDP and the Nurse will provide retraining to all home staffno later than 11/27/2014 on how to secure and store medications.</p> <p>Insufficient staffing was addressed in previous standard tagand was a contributing factor to this tag as well. See W186 POC.</p> <p>Monitoring will occur with a combination of the QDDP, ChiefOperations Officer, Corporate Compliance Office and the Chief Executive Officercompleting weekly checks initially at programming sites (either SGL or DayServices location). Weekly checks willbe completed for at least 4 weeks whereby the frequency can be re-evaluated todetermine if that frequency can be reduced or not.</p> <p>All above training and process will have occurred and willbe in effect no later than 11/27/2014. QDDP will evaluate all residents to assure no other resident has thepotential to be affect by the same deficient practice.</p>				

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	<p>the RM indicated she was not aware client #8's medication was in client #8's Orange Juice. The RM indicated medications should be secure when not being administered. The RM indicated staff should be present when client #8 took her medication.</p> <p>An interview was conducted on 10/28/14 at 10:00am, with the DGH/QIDP (Director of Group Homes/Qualified Intellectual Disabilities Professional). The DGH/QIDP indicated the medications should be kept secured when not administered. The DGH/QIDP indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 had access to the medication room and cart. The DGH/QIDP indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>On 10/22/14 at 1:00pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated "Core Lesson 3: Principles of Administering Medication" indicated medications should be secured and staff should watch clients consume their medications.</p> <p>9-3-6(a)</p>						

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W000383	<p>483.460(I)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation, record review, and interview, the facility failed to secure the medication cabinet keys for 4 of 4 sample clients (#1, #2, #3, and #4) and four additional clients (clients #5, #6, #7, and #8) who resided in the home.</p> <p>Findings include:</p> <p>On 10/21/14 from 6:10am until 8:15am, observations were conducted and clients #1, #2, #3, #4, #5, #6, #7, and #8 walked and/or accessed each room throughout the group home independently. During the observation period the medication administration cart keys hung from the unlocked lock to the medication cart. At 8:00am, the Surveyor showed the Residential Manager (RM) the keys which hung from the unlocked lock on the medication cart unlocked medication cart. The RM indicated the medication cart keys should be secure and the staff should know where the keys were kept.</p> <p>An interview was conducted on 10/28/14 at 10:00am, with the DGH/QIDP (Director of Group Homes/Qualified Intellectual Disabilities Professional). The DGH/QIDP indicated the medication</p>	W000383	<p><b>W383 DRUG STORAGE AND RECORDKEEPING</b> This item outlines that the facility failed to secure medication cabinet keys. The plan of correction is as follows:</p> <p>QDDP and the Nurse will provide retraining to all home staff no later than 11/27/2014 on how to secure and store medications and keys.</p> <p>Insufficient staffing was addressed in previous standard tag and was a contributing factor to this tag as well. See W186 POC.</p> <p>Monitoring will occur with a combination of the QDDP, Chief Operations Officer, Corporate Compliance Office and the Chief Executive Officer completing weekly checks initially at programming sites (either SGL or Day Services location). Weekly checks will be completed for at least 4 weeks whereby the frequency can be re-evaluated to determine if that frequency can be reduced or not.</p> <p>All above training and process will have occurred and will be in effect</p>	11/27/2014			

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W000436	<p>keys should be kept secured when medications were not administered and the keys were not secured when left in the unlocked medication cart. The DGH/QIDP indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 had access to the medication cart and the keys to the medication cart. The DGH/QIDP indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>On 10/22/14 at 1:00pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medication cart keys should be kept secure.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT 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. Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #2 and #3) with adaptive equipment, the facility failed to teach and</p>	W000436	<p>no later than 11/27/2014. QDDP will evaluate all residents to assure no other resident has thepotential to be affect by the same deficient practice.</p> <p><b>W436 SPACE ANDEQUIPMENT</b> This item outlines that the facility failed to teach andencourage clients #2 and #3 to wear their</p>	11/27/2014			

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	<p>encourage clients #2 and #3 to wear their prescribed eye glasses.</p> <p>Findings include:</p> <p>On 10/20/14 from 1:50pm until 6:35pm, and on 10/22/14 from 6:10am until 8:15am, observations were conducted and clients #2 and #3 did not wear their prescribed eye glasses. During both observation periods clients #2 and #3 completed dining, walked throughout the group home, completed medication administration, colored pictures, and watched television. Clients #2 and #3 were not encouraged to wear their prescribed eyeglasses.</p> <p>Client #2's record was reviewed on 10/23/14 at 11:45am. Client #2's 2/17/14 visual examination indicated client #2 wore prescribed eye glasses to see. Client #2's 5/29/13 and 10/16/13 ISP did not indicate an objective to teach and wear her prescribed eye glasses.</p> <p>Client #3's record was reviewed on 10/23/14 at 1:26pm. Client #3's 9/17/13 ISP indicated an objective to wear his prescribed eye glasses daily for one and one half hours.</p> <p>On 10/28/14 at 10:00am, an interview with the DGH/QIDP (Director of Group</p>		<p>prescribed eye glasses. The plan of correction is as follows:</p> <p>QDDP will train all staff on following their plans to encourage client to use and wear eye glasses as prescribed. Training will occur no later than 11/27/2014.</p> <p>QDDP to update and assure that all applicable residents' ISPs have an objective to teach and wear prescribed eye glasses. ISP and training to staff will highlight the use of formal and informal opportunities to teach and encourage all applicable clients to wear their prescribed eye glasses.</p> <p>All above training and process will have occurred and will be in effect no later than 11/27/2014. QDDP will evaluate all residents to assure no other resident has the potential to be affected by the same deficient practice.</p>				

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W000440	<p>Homes/Qualified Intellectual Disabilities Professional) was conducted. The DGH/QIDP indicated clients #2 and #3 wore prescribed eye glasses to see. The DGH/QIDP indicated staff should use formal and informal opportunities to teach and encourage clients #2 and #3 to wear their prescribed eye glasses.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facility failed to conduct quarterly evacuation drills for the 3:00 PM to 9:59 PM shift of personnel.</p> <p>Findings include:</p> <p>On 10/20/14 at 10:51 AM, a review of the facility's evacuation drills from 10/2013 through 10/20/2014 was conducted. The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, #4, #5, #6, #7, and #8 after 5/27/14 at 3:30 PM and on 10/20/14 at 10:51 AM for 3:00 PM to 9:59 PM shift of personnel.</p>	W000440	<p><b>W440 EVACUATIONDRILLS</b> This item outlines that the facility failed to conductevacuations drills. The plan ofcorrection is as follows: QDDP will train all staff and managers on the Drill Calendar. The QDDP will generate a Drill Calendar forthe year. The Drill Calendar will beposted in each home. The manager will betrained to assure he/she is knowledgeable on how to complete each drill and howto read the Drill Calendar. The managerwill submit the completed drills to the QDDP monthly. The QDDP will submit these drills to theSafety Committee as well for record keep and assistance in tracking. The QDDP will complete monthly quality assurance checks toassure that all monthly drills are present and ready for review by</p>	11/27/2014			

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	<p>On 10/28/14 at 10:00 AM, an interview with the Director of Group Homes/Qualified Intellectual Disabilities Professional) was conducted. The DGH/QIDP indicated no there were no additional evacuation drills available for review. The DGH/QIDP indicated the group home was missing a drill for the evening shift of personnel.</p> <p>9-3-7(a)</p>		<p>ISDH and/orLSC officials. All above training and processes will have occurred and willbe in effect no later than 11/27/2014. QDDP will evaluate all residents to assure no other resident has thepotential to be affect by the same deficient practice.</p>		