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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G702 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 09/22/2015 |
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| NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 7891 E 296TH ST ATLANTA, IN 46031 |
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| W 0000 Bldg. 00 | <p>This visit was for the pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00174958.</p> <p>Complaint #IN00174958: SUBSTANTIATED, Federal and State deficiencies related to the allegations were cited at W149, W154, W157, W189, and W249.</p> <p>Dates of survey: 9/14, 9/15, 9/16, 9/17, 9/21, and 9/22/2015.</p> <p>Facility number: 003179 Provider number: 15G702 AIM number: 200403780</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report was completed by #09182 on 9/28/2015.</p> | W 0000 | | |
| W 0104 Bldg. 00 | <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview, and record review, for 1 of 3 sampled clients</p> | W 0104 | W104 – " The governing body must exercise general policy, budget, and operating | 10/22/2015 |

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

TITLE

(X6) DATE

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

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| | <p>(client A), the governing body failed to include the identification of liquid oxygen use in the facility policy and to ensure the facility implemented its policy and procedure for the care and maintenance of liquid and portable oxygen tanks at the group home for client A.</p> <p>Findings include:</p> <p>On 9/14/15 from 6:05pm until 7:55pm, and on 9/15/15 from 5:55am until 8:05am, client A was observed at the group home with GHS (Group Home Staff) #1 and GHS #2. During both the observation periods, client A's bedroom door and group home exit doors were not marked that liquid oxygen was in use. From 6:05pm until 7:55pm, client A was inside his bedroom and an oxygen concentrator and a tank of liquid portable oxygen was beside him on the floor by the bed. Client A sat on his bed and/or chair wearing his oxygen cannula which administered his oxygen from the oxygen concentrator tank. At 7:30pm, medication administration was observed administered by the GHM (Group Home Manager). At 7:30pm, two liquid oxygen tanks were observed sitting inside a moveable milk crate sitting on the floor in the open and unvented staff office. At 7:30pm, the GHM indicated the liquid</p> | | <p>direction over the facility"</p> <p>The governing body failed to include the identification of liquid oxygen use in the facility policy and to ensure the facility implemented its policy and procedure for the care and maintenance of liquid and portable oxygen tanks at the group home. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·Mandatory staff training will occur on the policy and procedure for use of liquid oxygen and portable oxygen no later than 10/22/2015. ·The home manager will assure compliance during routine group home observations, to occur each day that the manager is at the home. The frequency is generally 5 out of every 7 days. Observations will occur for one month. At the end of one month QDDP will re-evaluate frequency. Confirmation will occur by the Director of Group Homes and Chief Operations Officer during home visits monthly and quarterly respectively. All levels will assure initial compliance before deadline and will assure ongoing compliance thereafter. ·"Oxygen in use" signs have been placed on every exterior door, as well as the office and client A's bedroom door. Client A is the only client with an Oxygen order. The 7.16 Oxygen | | |

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| | <p>oxygen tanks were client A's and stored in the staff office on the floor inside a plastic milk crate. During both observation periods, the extra two liquid oxygen tanks were stored inside the staff office on the floor inside a plastic milk crate. On 9/15/15 at 6:30am, the GHM indicated the staff office was not vented where the liquid oxygen was stored.</p> <p>On 9/16/15 at 12:00noon, client A's record was reviewed. Client A's 10/16/14 ISP (Individual Support Plan) and 6/24/15 "Physician's Order" both indicated client A used "Oxygen 2L (Liters)/min. (minute) 24/7 (twenty-four hours a day seven days per week) Nasal (by Nose cannula)."</p> <p>On 9/15/15 at 12:10pm, the facility's 5/2015 "Health & Safety Policy 7.16. Oxygen Equipment and Supportive Storage, Cleaning, Maintenance, and Safety Procedures" indicated "...III. Oxygen in the Home Safety Precautions...Do not use Aerosol spray near Oxygen unit. Do not store Oxygen in a confined area or unventilated space." The agency's policy and procedure did not include identifying access doors where Oxygen was used and/or stored.</p> <p>On 9/16/15 at 12:00pm, an interview with the QIDP (Qualified Intellectual</p> | | <p>Equipment and Supplies Storage, Cleaning, Maintenance, and Safety Policy has been updated to include: "Oxygen In Use" signs where applicable – including, but not limited to, identifying access doors where oxygen is being stored or used. (See attached Policy)</p> <p>·A vent will be placed in the oxygen storage room to allow ventilation no later than 10/22/2015.</p> | | |

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| W 0149 Bldg. 00 | <p>Disabilities Professional) was conducted. The QIDP indicated she would request additional information from the agency's nursing staff regarding the agency's policy and procedure for the care and maintenance of Oxygen in the group home. No further information was available for review.</p> <p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 4 of 4 allegations reviewed for 4 of 30 incidents reviewed (for clients A, B, C, D, E, F, and Discharged client G), the facility neglected to ensure client F was supervised by the facility staff based on her identified known behavioral needs and neglected to implement client F's ISP (Individual Support Plan) and BSP (Behavior Support Plan).</p> <p>The facility neglected to implement the agency's policy and procedure to immediately report allegations of staff to client abuse, neglect, and/or mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law,</p> | W 0149 | <p>W149 – “The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client”</p> <p>The facility neglected to ensure client F was supervised by the facility staff based on her identified known behavioral needs and neglected to implement client F's ISP and BSP. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·Mandatory staff retraining will occur on client F's ISP and BSP by 10/22/2015. ·The home manager will assure compliance during routine group home observations, generally 5 out of every 7 days. | 10/22/2015 |

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| | <p>to complete thorough investigations, and to complete effective corrective action to protect clients A, B, C, D, E, F, and G from the potential of continued staff abuse/neglect.</p> <p>Findings include:</p> <p>On 9/15/15 at 10:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incidents:</p> <p>1. For client F: -A 6/3/15 BDDS report for an incident on 6/2/15 at 3:15pm, indicated client F "was found by a supported living staff to be unsupervised outside the (facility owned) Day Services building in the parking lot hitting her group home van, screaming that she wanted to go home." The report indicated the Day Services Manager "stated that her staff were dealing with another (client's) behavior, so the supported living program manager and the QDDP (Qualified Developmental Disabilities Professional) went and spoke to [client F] and calmed [client F] down. Due to no one knowing how long that [client F] was outside, an investigation was opened up. It was found through the investigation that [client F] was unsupervised for a period for</p> | | <p>Observations will occur daily for client F for one month. After one month of observations the QDDP and Group Home Manager can reevaluate the frequency. Confirmation will occur by the Director of Group Homes and Chief Operations Officer during home visits monthly and quarterly respectively. All levels will assure initial compliance before deadline and will assure ongoing compliance thereafter.</p> <p>·Mandatory staff retraining will occur at the Day Services Facility no later than 10/22/2015 on client F's ISP and BSP.</p> <p>·Director of Group Homes will ensure that training is completed no later than 10/22/2015.</p> <p>W149 – "The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, abuse of the client"</p> <p>The facility neglected to implement the agency's policy and procedure to immediately report allegations of staff to client abuse, neglect, and/or mistreatment to the administrator and to BDDS in accordance with State Law, to complete thorough investigations, and to complete effective corrective action to protect clients A, B, C, D, E,</p> | | |

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| | <p>approximately 15 minutes. This neglect issue was substantiated. It was also found through the investigation that all of the staff were dealing with another (client's) behavior which gave [client F] an opportunity to go outside." The report indicated "Staff was not suspended during the investigation. It is recommended that all staff be trained to do a head count of clients whenever a group of clients have to evacuate to any part of the building. This will ensure that all clients are present and accounted for."</p> <p>-The 6/2/15 "Investigative Report" indicated the same information from the 6/2/15 BDDS report. The investigative report was documented by the investigator and the investigator paraphrased the staff's comments and statements regarding only the incident for client F. The investigation was not thorough in that it did not include written accounts documented by the witnesses involved.</p> <p>The 6/2/15 Investigative Report indicated a witness statement by WKS (Workshop Staff) #1. WKS #1's statement was paraphrased by the investigator "everyone (the clients) was on break at 3pm. [Client F] was in her group and that she and all of the other clients were in the cafeteria area for their afternoon break."</p> | | <p>F, and G from the potential of continued staff abuse/neglect. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·Mandatory retraining on Policy and Procedures with regard to reporting regulations will occur with all applicable staff by the manager of the home no later than 10/22/2015. ·DDRS Incident Reporting Regulations ·Carey Policy 5.13 on reporting Abuse, Neglect and Exploitation ·Carey Procedure 5.13.1 on reporting Abuse, Neglect and other reportable or unusual incidents ·Carey Policy 5.14 Staff Conduct Towards Consumers ·Carey Policy 1.3 Ethical Codes of Conduct <p>Staff training will stress the importance that all staff knows it is the responsibility of each person to report suspected instances of abuse, neglect and exploitation immediately and that the facility Administrator/Administrator on Duty (AOD) and BDDS must also be notified. The manager will be responsible for assuring that the reporting regulations, policies and procedures are followed.</p> <ul style="list-style-type: none"> ·The policy and procedure of Abuse, Neglect, Mistreatment, | | |

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| | <p>WKS #1 indicated "one of her (WKS #1's) clients needed to be changed before she went home that day, so she asked everyone (the other staff) in the cafeteria at the time, to watch her group so she could go and change her consumer (sic)." WKS #1 indicated once she and the client were returning to the cafeteria everyone "came pouring into the classrooms. She said that the staff had told her that one of her clients [client B] had went off and struck a [staff person] on the arm. [WKS #1] again asked staff to watch her group while she went to assist this second staff." WKS #1 indicated to the investigator "she last saw [client F] at 3pm in the cafeteria."</p> <p>The 6/2/15 Investigative Report indicated a witness statement by WKS #2. WKS #2 paraphrased witness statement by the investigator indicated client B "had an outburst" of physical aggression towards a staff person, WKS #2 "instructed the staff to remove all of the other clients to the classrooms...indicated that [client F] had to left the building (sic) while staff were busy evacuating the clients from the cafeteria, but it was not clear if she let herself out or if someone had opened the door and [client F] walked out."</p> <p>The 6/2/15 Investigation Report indicated "Summary...It is obvious from all of the</p> | | <p>and Exploitation will be a standing agenda item at this home's monthly staff meeting to address what is reportable and the required timing of reporting these incidents. The manager will track all staff who attends these mandatory meetings and keep documentation in the manager's working files. The manager is responsible for addressing any staff person who could not attend the mandatory meeting to assure he/she receives the information covered including this standing agenda item.</p> <p>·The Director of Group Homes and/or Chief Operations Officer will review all submitted documentation, BDDS reports, as well as any documentation from Group Home Observations to identify any issues or concerns as related to the topics of reporting ANME or acts of ANME.</p> <p>·The Director of Group Homes/QDDP will complete training with all investigatory managers no later than 10/22/2015 to ensure the agency's administrative staff identify an allegation of abuse, neglect, and/or mistreatment, to complete monitoring of the agency's plan of correction, to implement policy and procedure to protect clients A, B, C, D, E, and F from the potential of abuse, neglect, and/or mistreatment by immediately reporting and</p> | | |

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| | <p>interviews, that staff were engaged in dealing with another client behavior at that the (sic) same time that [client F] choose to exit the building. The time lines all match and confirm that there was a period of approximately 15 minutes in which she was unattended by staff." The report indicated "Summary of final findings and recommendations: Based upon all of the interviews conducted, the writer of this report must substantiate this neglect issue with [client F]. She was clearly unattended. It is also obvious that all staff were engaged and dealing with a behavior issue at that very same time. The writer does recommend that all staff be trained to do a quick head count of clients whenever a group of clients have to evacuate to any part of the building."</p> <p>2. A 6/19/15 BDDS report for an incident on 6/17/15 at 9:30pm indicated "Writer received a call from group home staff who reported that another group home staff had made an inappropriate comment towards a client."</p> <p>-A 7/9/15 BDDS follow up report for the 6/17/15 incident indicated "the allegation of verbal abuse was unsubstantiated. While the language used was inappropriate it was not found to be verbal abuse. Staff will be retrained on appropriate language to use with</p> | | <p>thoroughly investigating all allegations of abuse, neglect, and/or mistreatment.</p> <p>·The policy for Investigations will be updated to include employee's documented statements (e.g. email would be acceptable). All interviewees will be asked to provide a statement in their own words and if they are unable or unwilling to do so, the reason for this will be documented. We will identify all clients who have been a witness to or otherwise effected by the alleged incident of ANE will, in as much as they are able and appropriate, be included in the investigation/interview process. The policy will be updated accordingly. All clients involved or potentially involved will also be interviewed or represented during the investigatory process. This will occur no later than 10/15/2015.</p> <p>·All investigatory managers will be retrained on this policy and procedure before 10/22/2015.</p> <p>·The Director of Group Homes/ QDDP will review all allegations, interviews and action taken to ensure that the agency administrative staff identify allegations of abuse, neglect, and/or mistreatment, to complete monitoring of the agency's plan of correction, to implement policy and procedure to protect clients</p> | | | | |

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| | <p>consumers."</p> <p>-The 6/19/15 "Investigative Report" for the 6/17/15 incident indicated paraphrased witness statements and "Background of facts...During a phone call with [GHS (Group Home Staff) #1]...it was reported that [GHS #2] told [client F] If you wouldn't have (urinated in) your pants you wouldn't be wet. It was also reported through a written statement from [GHS #3] that [GHS #2] left a client in wet depends and did not change them."</p> <p>The 6/19/15 Investigative Report indicated the investigator paraphrased GHS #1's witness statement indicated GHS #1 "reports that she was not present during the allegations. She stated that [GHS #3] was texting her, during the time the allegations took place, saying that she was uncomfortable and wanted to leave. [GHS #1] reports that [GHS #2] does not fill out the flow sheets, that one staff on each shift fills them out at some point in the shift. She reports that [GHS #3] informed her that [GHS #2] told [client F] If she wouldn't have (urinated on) herself she wouldn't be wet and that [GHS #2] left [client E] in a wet depend (sic)."</p> <p>The 6/19/15 Investigative Report</p> | | <p>from the potential of abuse, neglect, and/or mistreatment by immediately reporting and thoroughly investigating all allegations of abuse, neglect, and/or mistreatment.</p> | |

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| | <p>indicated the investigator paraphrased GHS #2's witness statement GHS #2 "reported that when she did the bed checks [clients E and F] were dry. She also reported that she could not remember who filled out the incontinence flow sheets. [GHS #2] stated that [GHS #3] changed [client E] before she left her shift at 9:30pm. [GHS #2] reported that she did tell [client F] to use the restroom, but [client F] did not want to get out of bed and go. She reports 15 minutes later she went back in and [client F] had wet herself. [GHS #2] states that she told [client F] she wouldn't have been wet if she had gotten out of bed. She reports that she may have said (urinated in) her pants but that she cannot remember."</p> <p>The 6/19/15 Investigative Report indicated the investigator paraphrased GHS #3's witness statement GHS #3 "reports that she was finishing paperwork when [GHS #2] came onto shift and told her that [client E] was wet. She reports that [GHS #2] then went back to [client E's] room. [GHS #3] states that she checked [client E] at 8pm and she was dry. [GHS #3] reports that she did not sign the flow sheet because she did not do meds. (medications)...She also reports that when [GHS #2] did the bed checks she heard her tell [client F] If you wouldn't have (urinated on) yourself you</p> | | | |

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| | <p>wouldn't be wet. [GHS #3] reports leaving at 9:30pm due to being uncomfortable."</p> <p>The 6/19/15 Investigative Report indicated the investigator indicated "...it is apparent that [GHS #2] and [GHS #3] have negative things to say about each other." "Summary of final findings and recommendations...The allegation of neglect was unsubstantiated. The written documentation does not support neglect...The allegation of verbal abuse was unsubstantiated. While the language used was inappropriate it was not found to be verbal abuse. The recommendation will be that [GHS #2] receive a coaching/counseling session on appropriate language to use with consumers." The investigation was not thorough in that no witness statements/no interviews were completed with clients living in the group home; No written narrative witness statements were documented; and the investigation did not address why GHS #3 did not immediately report the allegation to the administrator.</p> <p>3. For client B: -A 7/16/15 BDDS report for an incident on 7/16/15 at 5:24pm indicated "Writer received a call that staff had been verbally abusive towards [client B].</p> | | | |

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| | <p>[Client B] was ending his behavior and walked outside, staff followed [client B] outside and continued (sic) antagonize [client B]. Staff has been suspended."</p> <p>The 7/17/15 "Investigative Report" was not thorough in that it indicated paraphrased witness statements by GHS #4, GHS #5, GHS #8, GHS #9, and GHS #10. The Investigative Report was not thorough in that the investigation did not indicate completed client interviews. The investigation indicated "Background of facts...According to a behavior report written by [GHS #8], consumer [client B] became verbally and physically aggressive upon being denied the right to watch a DVD by [GHS #8]. No reason was provided for denying [client B] this right. Two other [Staff] provided statements of returning to the group home to find [client B] outside and [GHS #8] attempting to grab [client B] and take [client B] inside. Both (staff) report that [GHS #8] was verbally aggressive, grabbing [client B] by the arm, taunting [client B] about wanting to fight, and making verbal threats to them about how [GHS #8] 'would have laid his a-- out had' [client B] actually hit [GHS #8]."</p> <p>The 7/17/15 Investigative Report indicated a paraphrased interview with GHS #5 which indicated GHS #5</p> | | | | | | |

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| | <p>"reported that [GHS #9] called her for help when she arrived [client B] was sitting on the love seat clearly upset. She asked [client B] if he was OK and he started crying and pointed to [GHS #8]. [GHS #5] reported that [GHS #8] then told her about telling [client B] no to watching the movie. When she asked [GHS #8] why he would not let [client B] (watch) it she reports that he became angry and just stormed off. [GHS #5] then went to [client B] who kept trying to say something about [GHS #8] but she could not understand what he was saying." The statement indicated GHS #5 went outside and GHS #10 and GHS #9 "reported what they had witnessed and about (sic) the taunting by [GHS #8] towards [client B] to fight" and GHS #5 called the RM (Residential Manager) "who told her to have [GHS #8] clock out and leave."</p> <p>The RM's paraphrased witness statement indicated the RM "reported and showed a text [from GHS #8] which she received later that evening after [GHS #8] was sent home. The text...stated he was sorry and that he hoped he did not lose his job over the situation."</p> <p>The investigation indicated "the statements concerning [GHS #8's] interaction with [client B] were</p> | | | |

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| | <p>consistent in...All staff including [GHS #8], agreed that [client B's] behaviors began when [GHS #8] told him he could not watch the movie of his Dad's funeral. Three staff report [GHS #8] stated he would retaliate physically towards [client B]...Two staff report...[GHS #8] used threatening/taunting behavior towards [client B] to try to get [client B] to fight with him. Two staff report...[GHS #8] used repeated profanity during the incidents outside...Two staff reported... [GHS #8] repeatedly grabbed [client B] on the arm in an attempt to force him inside. Three staff report...[GHS #8] was yelling loudly and was emotionally upset during the encounter...Summary of final findings...The testimony of all staff is found to be substantially consistent and overwhelmingly conclusive. As such the allegation of verbal abuse is substantiated. Additional (sic) abusive behaviors are substantiated including physical abuse, taunting, and/or threatening behavior, and denying consumer rights...It is the conclusion of this investigator that [GHS #8] represents a significant threat to the consumers he is responsible for and that his employment with Carey Services be terminated without the possibility of rehire." No documented recommendations were indicated for staff retraining for immediately reporting allegations of</p> | | | |

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| | <p>abuse, neglect, and/or mistreatment; protecting clients from the potential of further abuse when GHS #8 was allowed to stay with client B inside the group home; and no witness interviews/statements from clients A, B, C, D, E, and F regarding staff to client interactions.</p> <p>4. For discharged client G: -No BDDS report was available for review for client G's allegation of neglect investigation.</p> <p>-A 10/7/14 "Investigative Report" was not thorough in that it indicated paraphrased witness statements completed by the investigator. The report indicated "Background of facts...[GHS #11] reported [GHS #12] for neglect of a dependent person. (On) 10/7/14 (Tuesday) at 1pm, [GHS #11] reports that on Sunday (10/5/14) she worked ...from 7am to 5pm...stated that she heard night shift staff report that [Discharged client G] was changed at 6:30am...[GHS #12] did not check on [Discharged client G] nor did she change him...[Discharged client G] was not changed from 6:30am to 2:30pm...At 2:30pm...[Discharged client G] was changed...All of [Discharged client G's] bedding was soaked....Summary of final findings....The allegation of neglect</p> | | | |

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| | <p>against [GHS #12] is substantiated...On 10/5/14 [GHS #12] was neglectful in not properly documenting on buddy checks and medical flow sheets. [GHS #12] failed to give proper personal care to [Discharged client G] on 10/5/14." The investigation did not include staff retraining on immediately reporting allegations of abuse, neglect, and/or mistreatment. The investigation was not thorough in that narrative witness statements were not completed and no clients were interviewed.</p> <p>Client F's record was reviewed on 9/17/15 at 4:00pm. Client F's 10/16/14 ISP and 9/2015 BSP both indicated targeted behaviors of "AWOL (Absent Without Leave)/running off, SIB (Self Injurious Behaviors) of head banging, Physical Aggression, Verbal Aggression, and Hallucinations/Delusions." Client F's ISP and BSP both indicated staff were to provide twenty-four hour supervision. Client F's ISP and BSP both indicated staff were to have client F within eye sight supervision at "all times."</p> <p>On 9/15/15 at 10:00am, a review was completed of the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the</p> | | | |

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| | <p>policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...."</p> <p>On 9/15/15 at 10:00am, the facility's records were reviewed. A review of the facility's 6/15/11 policy on "Abuse, Neglect, and Exploitation" 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 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</p> | | | |

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| | <p>safe/clean/sanitary environment, food, medical care, medical supplies and equipment (as indicated in the ISP (Individual Support Plan)." The policy indicated failure to implement clients' program plans could also be considered neglect. The policy indicated the facility staff should immediately report allegations of abuse, neglect, and/or mistreatment to the administrator and to BDDS in accordance with State Law.</p> <p>On 9/15/15 at 10:00am, the facility's 6/2011 "Procedures for Reporting abuse, neglect, and other Reportable or Unusual Incidents" indicated "As required by law, it is the responsibility of each person to report suspected instances of abuse, neglect, and exploitation...Staff and volunteers are provided training and/or tested for competency on an annual basis regarding their responsibilities in reporting such incidents to authorities as well as to agency's administrators immediately upon learning of the suspected abuse/neglect/exploitation." The policy indicated reportable incidents are "1. Any alleged, suspected, or actual abuse, neglect, or exploitation of a consumer."</p> <p>On 9/16/15 at 1:00pm, the facility's Personnel Records were reviewed and an interview with the Human Resource</p> | | | |

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| | <p>Representative (HRR) was conducted. The HRR stated GHS #8's personnel record was "active" because he had not been formally terminated "at this time." The HRR stated GHS #8's "termination was in process for substantiated abuse" of a client.</p> <p>On 9/16/15 at 1:55pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the agency investigated allegations by staff of staff to client abuse, neglect, and/or mistreatment. The QIDP indicated the facility followed the BDDS policy and procedure for allegations of abuse, neglect, and/or mistreatment. The QIDP indicated the facility's investigations were not thorough in that the investigations did not include written narrative witness statements by the staff, did not include witness statements from clients A, B, C, D, E, and F, did not identify the staff neglecting to immediately report allegations to the administrator, and did not document recommendations to complete corrective measures to protect clients from further abuse, neglect, and/or mistreatment. The QIDP indicated no further information was available for review.</p> <p>This federal tag relates to complaint</p> | | | | |

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| W 0153 Bldg. 00 | <p>#IN00174958.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS 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. Based on record review and interview, for 3 of 4 allegations reviewed for 3 of 30 incidents reviewed (for clients B, F, and Discharged client G), the facility failed to implement the agency's policy and procedure to immediately report allegations of staff to client abuse, neglect, and/or mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law.</p> <p>Findings include:</p> <p>On 9/15/15 at 10:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incidents:</p> <p>1. For client F: -A 6/19/15 BDDS report for an incident</p> | W 0153 | <p>W153 – “The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknownsource, are reported immediately to the administrator or to other officials in accordance with State law through established procedures” The facility failed toimplement the agency’s policy and procedure to immediately report allegationsof staff to client abuse, neglect, and/or mistreatment to the administrator andto BDDS in accordance with State Law. The correction for this tag is asfollows:</p> <ul style="list-style-type: none"> ·Mandatory retraining on Policy and Procedures with regard to reporting regulations will occur with all applicable staff by the manager of the home no later than 10/22/2015. ·DDRS Incident | 10/22/2015 |
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| | <p>on 6/17/15 at 9:30pm indicated "Writer received a call from group home staff who reported that another group home staff had made an inappropriate comment towards a client."</p> <p>-A 7/9/15 BDDS follow up report for the 6/17/15 incident indicated "the allegation of verbal abuse was unsubstantiated. While the language used was inappropriate it was not found to be verbal abuse. Staff will be retrained on appropriate language to use with consumers."</p> <p>-The 6/19/15 "Investigative Report" for the 6/17/15 incident indicated paraphrased witness statements and "Background of facts...During a phone call with [GHS (Group Home Staff) #1]...it was reported that [GHS #2] told [client F] If you wouldn't have (urinated in) your pants you wouldn't be wet. It was also reported through a written statement from [GHS #3] that [GHS #2] left a client in wet depends and did not change them."</p> <p>The 6/19/15 Investigative Report indicated the investigator paraphrased GHS #1's witness statement, GHS #1 "reports that she was not present during the allegations. She stated that [GHS #3] was texting her, during the time the</p> | | <p>Reporting Regulations</p> <ul style="list-style-type: none"> ·Carey Policy 5.13 on reporting Abuse, Neglect and Exploitation ·Carey Procedure 5.13.1 on reporting Abuse, Neglect and other reportable or unusual incidents ·Carey Policy 5.14 Staff Conduct Towards Consumers ·Carey Policy 1.3 Ethical Codes of Conduct <p>Staff training will stressthe importance that all staff knows it is the responsibility of each person to report suspected instances of abuse, neglect and exploitation immediately andthat the facility Administrator/Administrator on Duty (AOD) and BDDS must also be notified. The manager will be responsible for assuring that the reporting regulations, policies and procedures are followed.</p> <ul style="list-style-type: none"> ·A post-test will be administered to staff to ensure that staff understands their responsibility. The post-test will occur immediately after the training. (Post-test attached) ·The policy and procedure of Abuse, Neglect, Mistreatment, and Exploitation will be a standing agenda item at this home's monthly staff meeting to address what is reportable and the required timing of reporting these incidents. The manager will track | | | | |

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| | <p>allegations took place, saying that she was uncomfortable and wanted to leave. [GHS #1] reports that [GHS #2] does not fill out the flow sheets, that one staff on each shift fills them out at some point in the shift. She reports that [GHS #3] informed her that [GHS #2] told [client F] if she wouldn't have (urinated on) herself she wouldn't be wet and that [GHS #2] left [client E] in a wet depend (sic)."</p> <p>The 6/19/15 Investigative Report indicated the investigator paraphrased GHS #2's witness statement, GHS #2 "reported that when she did the bed checks [clients E and F] were dry...[GHS #2] stated that [GHS #3] changed [client E] before she left her shift at 9:30pm. [GHS #2] reported that she did tell [client F] to use the restroom, but [client F] did not want to get out of bed and go. She reports 15 minutes later she went back in and [client F] had wet herself. [GHS #2] states that she told [client F] she wouldn't have been wet if she had gotten out of bed. She reports that she may have said (urinated in) her pants but that she cannot remember."</p> <p>The 6/19/15 Investigative Report indicated the investigator paraphrased GHS #3's witness statement, GHS #3 "reports that she was finishing paperwork</p> | | <p>all staff who attends these mandatory meetings and keep documentation in the manager's working files. The manager is responsible for addressing any staff person who could not attend the mandatory meeting to assure he/she receives the information covered including this standing agenda item.</p> <p>·The Director of Group Homes and/or Chief Operations Officer will review all submitted documentation, BDDS reports, as well as any documentation from Group Home Observations to identify any issues or concerns as related to the topics of reporting ANME or acts of ANME.</p> <p>·The Director of Group Homes/QDDP will complete training with all investigatory managers no later than 10/22/2015 to ensure the agency's administrative staff identify an allegation of abuse, neglect, and/or mistreatment, to complete monitoring of the agency's plan of correction, to implement policy and procedure to protect clients A, B, C, D, E, and F from the potential of abuse, neglect, and/or mistreatment by immediately reporting and thoroughly investigating all allegations of abuse, neglect, and/or mistreatment.</p> <p>·The policy for Investigations will be updated to include</p> | | |

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| | <p>when [GHS #2] came onto shift and told her that [client E] was wet. She reports that [GHS #2] then went back to [client E's] room. [GHS #3] states that she checked [client E] at 8pm and she was dry...She also reports that when [GHS #2] did the bed checks she heard her tell [client F] If you wouldn't have (urinated on) yourself you wouldn't be wet. [GHS #3] reports leaving at 9:30pm due to being uncomfortable."</p> <p>The 6/19/15 Investigative Report indicated the investigator stated "...it is apparent that [GHS #2] and [GHS #3] have negative things to say about each other." "Summary of final findings and recommendations...The allegation of neglect was unsubstantiated. The written documentation does not support neglect...The allegation of verbal abuse was unsubstantiated. While the language used was inappropriate it was not found to be verbal abuse. The recommendation will be that [GHS #2] receive a coaching/counseling session on appropriate language to use with consumers." The investigation did not address why GHS #3 did not immediately report the allegation to the administrator.</p> <p>2. For client B: -A 7/16/15 BDDS report for an incident on 7/16/15 at 5:24pm indicated "Writer</p> | | <p>employee's documented statements (e.g. email would be acceptable). All interviewees will be asked to provide a statement in their own words and if they are unable or unwilling to do so, the reason for this will be documented. We will identify all clients who have been a witness to or otherwise effected by the alleged incident of ANE will, in as much as they are able and appropriate, be included in the investigation/interview process. The policy will be updated accordingly. All clients involved or potentially involved will also be interviewed or represented during the investigatory process. This will occur no later than 10/15/2015.</p> <p>·All investigatory managers will be retrained on this policy and procedure before 10/22/2015.</p> <p>·The Director of Group Homes/ QDDP will review all allegations, interviews and action taken to ensure that the agency administrative staff identify allegations of abuse, neglect, and/or mistreatment, to complete monitoring of the agency's plan of correction, to implement policy and procedure to protect clients from the potential of abuse, neglect, and/or mistreatment by immediately reporting and thoroughly investigating all allegations of abuse, neglect, and/or mistreatment.</p> | |

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| | <p>received a call that staff had been verbally abusive towards [client B]. [Client B] was ending his behavior and walked outside, staff followed [client B] outside and continued (to) antagonize [client B]. Staff has been suspended."</p> <p>The 7/17/15 "Investigative Report" was not thorough in that it indicated paraphrased witness statements by GHS #4, GHS #5, GHS #8, GHS #9, and GHS #10. The investigation indicated "Background of facts...According to a behavior report written by [GHS #8], consumer [client B] became verbally and physically aggressive upon being denied the right to watch a DVD by [GHS #8]. No reason was provided for denying [client B] this right. Two other [Staff] provided statements of returning to the group home to find [client B] outside and [GHS #8] attempting to grab [client B] and take [client B] inside. Both (staff) report that [GHS #8] was verbally aggressive, grabbing [client B] by the arm, taunting [client B] about wanting to fight, and making verbal threats to them about how [GHS #8] 'would have laid his a-- out' had [client B] actually hit [GHS #8]."</p> <p>The 7/17/15 Investigative Report indicated a paraphrased interview with GHS #5 which indicated GHS #5</p> | | | |

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| | <p>"reported that [GHS #9] called her for help when she arrived [client B] was sitting on the love seat clearly upset. She asked [client B] if he was OK and he started crying and pointed to [GHS #8]. [GHS #5] reported that [GHS #8] then told her about telling [client B] no to watching the movie. When she asked [GHS #8] why he would not let [client B] (watch) it she reports that he became angry and just stormed off. [GHS #5] then went to [client B] who kept trying to say something about [GHS #8] but she could not understand what he was saying." The statement indicated GHS #5 went outside and GHS #10 and GHS #9 "reported what they had witnessed and about (sic) the taunting by [GHS #8] towards [client B] to fight" and GHS #5 called the RM (Residential Manager) "who told her to have [GHS #8] clock out and leave."</p> <p>The investigation indicated "the statements concerning [GHS #8's] interaction with [client B] were consistent in...All staff including [GHS #8], agreed that [client B's] behaviors began when [GHS #8] told him he could not watch the movie of his Dad's funeral. Three staff report [GHS #8] stated he would retaliate physically towards [client B]...Two staff report...[GHS #8] used threatening/taunting behavior towards</p> | | | |

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| | <p>[client B] to try to get [client B] to fight with him. Two staff report...[GHS #8] used repeated profanity during the incidents outside...Two staff reported... [GHS #8] repeatedly grabbed [client B] on the arm in an attempt to force him inside. Three staff report...[GHS #8] was yelling loudly and was emotionally upset during the encounter...Summary of final findings...The testimony of all staff is found to be substantially consistent and overwhelmingly conclusive. As such the allegation of verbal abuse is substantiated. Additional (sic) abusive behaviors are substantiated including physical abuse, taunting, and/or threatening behavior, and denying consumer rights...It is the conclusion of this investigator that [GHS #8] represents a significant threat to the consumers he is responsible for and that his employment with Carey Services be terminated without the possibility of rehire."</p> <p>3. For discharged client G: -No BDDS report was available for review for client G's allegation of neglect investigation. No report was available for review to determine client G's allegation was immediately reported to BDDS.</p> <p>-A 10/7/14 "Investigative Report" indicated paraphrased witness statements</p> | | | |

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| | <p>completed by the investigator. The report indicated "Background of facts...[GHS #11] reported [GHS #12] for neglect of a dependent person. (On) 10/7/14 (Tuesday) at 1pm, [GHS #11] reports that on Sunday (10/5/14) she worked ...from 7am to 5pm...stated that she heard night shift staff report that [Discharged client G] was changed at 6:30am...[GHS #12] did not check on [Discharged client G] nor did she change him...[Discharged client G] was not changed from 6:30am to 2:30pm...At 2:30pm...[Discharged client G] was changed...All of [Discharged client G's] bedding was soaked....Summary of final findings....The allegation of neglect against [GHS #12] is substantiated...On 10/5/14 [GHS #12] was neglectful in not properly documenting on buddy checks and medical flow sheets. [GHS #12] failed to give proper personal care to [Discharged client G] on 10/5/14."</p> <p>On 9/16/15 at 1:55pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the agency investigated allegations by staff of staff to client abuse, neglect, and/or mistreatment. The QIDP indicated the facility followed the BDDS policy and procedure for allegations of abuse, neglect, and/or mistreatment. The QIDP</p> | | | |

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| W 0154 Bldg. 00 | <p>indicated the facility's investigations indicated the staff failed to immediately report allegations to the administrator and to BDDS in accordance with State Law. The QIDP indicated no further information was available for review.</p> <p>9-3-1(b)(5) 9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, for 4 of 4 allegations reviewed for 4 of 30 incidents reviewed (for clients A, B, C, D, E, F, and Discharged client G), the facility failed to implement the agency's policy and procedure to thoroughly investigate allegations of staff to client abuse, neglect, and/or mistreatment for clients A, B, C, D, E, F, and G.</p> <p>Findings include:</p> <p>On 9/15/15 at 10:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incidents:</p> | W 0154 | <p>W154 – “The facility must have evidence that all alleged violations are thoroughly investigated.”</p> <p>The facility failed to implement the agency's policy and procedure to thoroughly investigate allegations of staff to client abuse, neglect, and or mistreatment for clients A, B, C, D, E, F, and G. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> The Director of Group Homes/QDDP will complete training with all investigatory managers no later than 10/22/2015 to ensure the agency's administrative staff identify an allegation of abuse, neglect, and/or mistreatment, to complete monitoring of the | 10/22/2015 | | | |

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| | <p>1. For client F: -An 6/3/15 BDDS report for an incident on 6/2/15 at 3:15pm, indicated client F "was found by a supported living staff to be unsupervised outside the (facility owned) Day Services building in the parking lot hitting her group home van, screaming that she wanted to go home." The report indicated the Day Services Manager "stated that her staff were dealing with another (client's) behavior, so the supported living program manager and the QDDP (Qualified Developmental Disabilities Professional) went and spoke to [client F] and calmed [client F] down. Due to no one knowing how long that [client F] was outside, an investigation was opened up. It was found through the investigation that [client F] was unsupervised for a period for approximately 15 minutes. This neglect issue was substantiated. It was also found through the investigation that all of the staff were dealing with another (client's) behavior which gave [client F] an opportunity to go outside." The report indicated "Staff was not suspended during the investigation. It is recommended that all staff be trained to do a head count of clients whenever a group of clients have to evacuate to any part of the building. This will ensure that all clients are present and accounted for."</p> | | <p>agency's plan of correction, to implement policy and procedure to protect clients A, B, C, D, E, and F from the potential of abuse, neglect, and/or mistreatment by immediately reporting and thoroughly investigating all allegations of abuse, neglect, and/or mistreatment.</p> <p>·The policy for Investigations will be updated to include employee's documented statements (e.g. email would be acceptable). All interviewees will be asked to provide a statement in their own words and if they are unable or unwilling to do so, the reason for this will be documented. We will identify all clients who have been a witness to or otherwise effected by the alleged incident of ANE will, in as much as they are able and appropriate, be included in the investigation/interview process. The policy will be updated accordingly. All clients involved or potentially involved will also be interviewed or represented during the investigatory process. This will occur no later than 10/15/2015.</p> <p>·All investigatory managers will be retrained on this policy and procedure before 10/22/2015.</p> <p>·The Director of Group Homes/ QDDP will review all allegations, interviews and action taken to ensure that the agency</p> | | | | |

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| | <p>-The 6/2/15 "Investigative Report" indicated the same information from the 6/2/15 BDDS report. The investigative report was documented by the investigator and the investigator paraphrased the staff's comments and statements regarding only the incident for client F. The investigation was not thorough in that it did not include written accounts documented by the witnesses involved. The investigation did not include client interviews.</p> <p>The 6/2/15 Investigative Report indicated a witness statement by WKS (Workshop Staff) #1. WKS #1's statement was paraphrased by the investigator "everyone (the clients) was on break at 3pm. [Client F] was in her group and that she and all of the other clients were in the cafeteria area for their afternoon break." WKS #1 indicated "one of her (WKS #1's) clients needed to be changed before she went home that day, so she asked everyone (the other staff) in the cafeteria at the time, to watch her group so she could go and change her consumer (sic)." WKS #1 indicated once she and the client were returning to the cafeteria everyone "came pouring into the classrooms. She said that the staff had told her that one of her clients [client B] had went off and struck a [staff person] on the arm. [WKS #1] again asked staff to watch her group</p> | | <p>administrative staff identify allegations of abuse, neglect, and/or mistreatment, to complete monitoring of the agency's plan of correction, to implement policy and procedure to protect clients from the potential of abuse, neglect, and/or mistreatment by immediately reporting and thoroughly investigating all allegations of abuse, neglect, and/or mistreatment.</p> | | | | |

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| | <p>while she went to assist this second staff." WKS #1 indicated to the investigator "she last saw [client F] at 3pm in the cafeteria."</p> <p>The 6/2/15 Investigative Report indicated a witness statement by WKS #2. WKS #2 paraphrased witness statement by the investigator indicated client B "had an outburst" of physical aggression towards a staff person, WKS #2 "instructed the staff to remove all of the other clients to the classrooms...indicated that [client F] had to left the building (sic) while staff were busy evacuating the clients from the cafeteria, but it was not clear if she let herself out or if someone had opened the door and [client F] walked out."</p> <p>The 6/2/15 Investigation Report indicated "Summary...It is obvious from all of the interviews, that staff were engaged in dealing with another client behavior at that the (sic) same time that [client F] choose to exit the building. The time lines all match and confirm that there was a period of approximately 15 minutes in which she was unattended by staff." The report indicated "Summary of final findings and recommendations: Based upon all of the interviews conducted, the writer of this report must substantiate this neglect issue with [client F]. She was clearly unattended. It is also obvious that</p> | | | |

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| | <p>all staff were engaged and dealing with a behavior issue at that very same time. The writer does recommend that all staff be trained to do a quick head count of clients whenever a group of clients have to evacuate to any part of the building."</p> <p>2. A 6/19/15 BDDS report for an incident on 6/17/15 at 9:30pm indicated "Writer received a call from group home staff who reported that another group home staff had made an inappropriate comment towards a client."</p> <p>-A 7/9/15 BDDS follow up report for the 6/17/15 incident indicated "the allegation of verbal abuse was unsubstantiated. While the language used was inappropriate it was not found to be verbal abuse."</p> <p>-The 6/19/15 "Investigative Report" for the 6/17/15 incident indicated paraphrased witness statements and "Background of facts...During a phone call with [GHS (Group Home Staff) #1]...it was reported that [GHS #2] told [client F] If you wouldn't have (urinated in) your pants you wouldn't be wet. It was also reported through a written statement from [GHS #3] that [GHS #2] left a client in wet depends and did not change them."</p> | | | | |

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| | <p>The 6/19/15 Investigative Report was not thorough in that the investigation indicated the investigator paraphrased GHS #1, GHS #2, and GHS #3's witness statements and no narrative descriptions were documented. The investigation did not include client interviews regarding the incident. The investigation did not include investigation as to why GHS #3 did not immediately report the incident while on duty.</p> <p>The 6/19/15 Investigative Report indicated the investigator indicated "...it is apparent that [GHS #2] and [GHS #3] have negative things to say about each other." "Summary of final findings and recommendations...The allegation of neglect was unsubstantiated. The written documentation does not support neglect...The allegation of verbal abuse was unsubstantiated. While the language used was inappropriate it was not found to be verbal abuse. The recommendation will be that [GHS #3] receive a coaching/counseling session on appropriate language to use with consumers." The investigation was not thorough in that no witness statements/no interviews were completed with clients living in the group home; No written narrative witness statements were documented; and the investigation did not address why GHS #3 did not</p> | | | |

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| | <p>immediately report the allegation to the administrator.</p> <p>3. For client B: -A 7/16/15 BDDS report for an incident on 7/16/15 at 5:24pm indicated "Writer received a call that staff had been verbally abusive towards [client B]. [Client B] was ending his behavior and walked outside, staff followed [client B] outside and continued (to) antagonize [client B]. Staff has been suspended."</p> <p>The 7/17/15 "Investigative Report" was not thorough in that it indicated paraphrased witness statements by GHS #4, GHS #5, GHS #8, GHS #9, and GHS #10. The Investigative Report was not thorough in that the investigation did not indicate completed client interviews. The investigation indicated "Background of facts...According to a behavior report written by [GHS #8], consumer [client B] became verbally and physically aggressive upon being denied the right to watch a DVD by [GHS #8]. No reason was provided for denying [client B] this right. Two other [Staff] provided statements of returning to the group home to find [client B] outside and [GHS #8] attempting to grab [client B] and take [client B] inside. Both (staff) report that [GHS #8] was verbally aggressive, grabbing [client B] by the arm, taunting</p> | | | |

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| | <p>[client B] about wanting to fight, and making verbal threats to them about how [GHS #8] 'would have laid his a-- out' had [client B] actually hit [GHS #8]."</p> <p>The 7/17/15 Investigative Report indicated a paraphrased interview with GHS #5 which indicated GHS #5 "reported that [GHS #9] called her for help when she arrived [client B] was sitting on the love seat clearly upset. She asked [client B] if he was OK and he started crying and pointed to [GHS #8]. [GHS #5] reported that [GHS #8] then told her about telling [client B] no to watching the movie. When she asked [GHS #8] why he would not let [client B] (watch) it she reports that he became angry and just stormed off. [GHS #5] then went to [client B] who kept trying to say something about [GHS #8] but she could not understand what he was saying." The statement indicated GHS #5 went outside and GHS #10 and GHS #9 "reported what they had witnessed and about (sic) the taunting by [GHS #8] towards [client B] to fight" and GHS #5 called the RM (Residential Manager) "who told her to have [GHS #8] clock out and leave."</p> <p>The investigation indicated "the statements concerning [GHS #8's] interaction with [client B] were</p> | | | |

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| | <p>consistent in...All staff including [GHS #8], agreed that [client B's] behaviors began when [GHS #8] told him he could not watch the movie of his Dad's funeral. Three staff report [GHS #8] stated he would retaliate physically towards [client B]...Two staff report...[GHS #8] used threatening/taunting behavior towards [client B] to try to get [client B] to fight with him. Two staff report...[GHS #8] used repeated profanity during the incidents outside...Two staff reported... [GHS #8] repeatedly grabbed [client B] on the arm in an attempt to force him inside. Three staff report...[GHS #8] was yelling loudly and was emotionally upset during the encounter...Summary of final findings...The testimony of all staff is found to be substantially consistent and overwhelmingly conclusive. As such the allegation of verbal abuse is substantiated. Additional (sic) abusive behaviors are substantiated including physical abuse, taunting, and/or threatening behavior, and denying consumer rights...It is the conclusion of this investigator that [GHS #8] represents a significant threat to the consumers he is responsible for and that his employment with Carey Services be terminated without the possibility of rehire." The investigation was not thorough in that no documented recommendations were indicated for staff retraining for</p> | | | |

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| | <p>immediately reporting allegations of abuse, neglect, and/or mistreatment; protecting clients from the potential of further abuse when GHS #8 was allowed to stay with client B inside the group home; and no witness interviews/statements from clients A, B, C, D, E, and F regarding staff to client interactions.</p> <p>4. For discharged client G: -No BDDS report was available for review for client G's allegation of neglect investigation.</p> <p>-A 10/7/14 "Investigative Report" was not thorough in that it indicated paraphrased witness statements completed by the investigator. The report indicated "Background of facts...[GHS #11] reported [GHS #12] for neglect of a dependent person. (On) 10/7/14 (Tuesday) at 1pm, [GHS #11] reports that on Sunday (10/5/14) she worked ...from 7am to 5pm...stated that she heard night shift staff report that [Discharged client G] was changed at 6:30am...[GHS #12] did not check on [Discharged client G] nor did she change him...[Discharged client G] was not changed from 6:30am to 2:30pm...At 2:30pm...[Discharged client G] was changed...All of [Discharged client G's] bedding was soaked....Summary of final</p> | | | |

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| | <p>findings....The allegation of neglect against [GHS #12] is substantiated...On 10/5/14 [GHS #12] was neglectful in not properly documenting on buddy checks and medical flow sheets. [GHS #12] failed to give proper personal care to [Discharged client G] on 10/5/14." The investigation did not include staff retraining on immediately reporting allegations of abuse, neglect, and/or mistreatment. The investigation was not thorough in that narrative witness statements were not completed and no clients were interviewed.</p> <p>On 9/16/15 at 1:00pm, the facility's Personnel Records were reviewed and an interview with the Human Resource Representative (HRR) was conducted. The HRR stated GHS #8's personnel record was "active" because he had not been formally terminated "at this time." The HRR stated GHS #8's "termination was in process for substantiated abuse" of a client.</p> <p>On 9/16/15 at 1:55pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the agency investigated allegations by staff of staff to client abuse, neglect, and/or mistreatment. The QIDP indicated the facility's investigations were not thorough</p> | | | |

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| W 0157 Bldg. 00 | <p>in that the investigations did not include written narrative witness statements by the staff, did not include witness statements from clients A, B, C, D, E, and F, and did not identify the staff neglecting to immediately report allegations to the administrator. The QIDP indicated no further information was available for review.</p> <p>This federal tag relates to complaint #IN00174958.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, for 4 of 4 allegations reviewed for 4 of 30 incidents reviewed (for clients A, B, C, D, E, F, and Discharged client G), the facility failed to complete effective corrective action to protect clients A, B, C, D, E, F, and G from the potential of continued staff abuse/neglect.</p> <p>Findings include:</p> <p>On 9/15/15 at 10:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following</p> | W 0157 | <p>W157 – “If the alleged violation is verified, appropriate corrective actions must be taken.”</p> <p>The facility failed to complete effective corrective action to protect clients A, B, C, D, E, F, and G from the potential of continued staff abuse/neglect. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·Mandatory retraining on Policy with regard to reporting regulations will occur with all applicable staff by the manager of the home no later than 10/22/2015. | 10/22/2015 |

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| | <p>incidents:</p> <p>1. For client F: -An 6/3/15 BDDS report for an incident on 6/2/15 at 3:15pm, indicated client F "was found by a supported living staff to be unsupervised outside the (facility owned) Day Services building in the parking lot hitting her group home van, screaming that she wanted to go home." The report indicated the Day Services Manager "stated that her staff were dealing with another (client's) behavior, so the supported living program manager and the QDDP (Qualified Developmental Disabilities Professional) went and spoke to [client F] and calmed [client F] down. Due to no one knowing how long that [client F] was outside, an investigation was opened up. It was found through the investigation that [client F] was unsupervised for a period for approximately 15 minutes. This neglect issue was substantiated. It was also found through the investigation that all of the staff were dealing with another (client's) behavior which gave [client F] an opportunity to go outside." The report indicated "Staff was not suspended during the investigation. It is recommended that all staff be trained to do a head count of clients whenever a group of clients have to evacuate to any part of the building. This will ensure that</p> | | <ul style="list-style-type: none"> ·DDRS Incident Reporting Regulations ·Carey Policy 5.13 on reporting Abuse, Neglect and Exploitation ·Carey Procedure 5.13.1 on reporting Abuse, Neglect and other reportable or unusual incidents ·Carey Policy 5.14 Staff Conduct Towards Consumers ·Carey Policy 1.3 Ethical Codes of Conduct <p>Staff training will stress the importance that all staff knows it is the responsibility of each person to report suspected instances of abuse, neglect and exploitation immediately and that the facility Administrator/Administrator on Duty (AOD) and BDDS must also be notified. The manager will be responsible for assuring that the reporting regulations, policies and procedures are followed.</p> <ul style="list-style-type: none"> ·A post-test will be administered to staff to ensure that staff understands their responsibility. The post-test will occur immediately after the training. (Post-test attached) ·The group home manager will complete this training no later than 10/22/2015 and the manager will be responsible for assuring that the reporting regulations, policies and procedures are followed. ·The manager is overseen by QDDP/Director of Group Homes and/or the Chief Operations | | | | |

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| | <p>all clients are present and accounted for."</p> <p>The 6/2/15 Investigative Report indicated a witness statement by WKS (Workshop Staff) #1. WKS #1's statement was paraphrased by the investigator "everyone (the clients) was on break at 3pm. [Client F] was in her group and that she and all of the other clients were in the cafeteria area for their afternoon break." WKS #1 indicated "one of her (WKS #1's) clients needed to be changed before she went home that day, so she asked everyone (the other staff) in the cafeteria at the time, to watch her group so she could go and change her consumer (sic)." WKS #1 indicated once she and the client were returning to the cafeteria everyone "came pouring into the classrooms. She said that the staff had told her that one of her clients [client B] had went off and struck a [staff person] on the arm. [WKS #1] again asked staff to watch her group while she went to assist this second staff." WKS #1 indicated to the investigator "she last saw [client F] at 3pm in the cafeteria."</p> <p>The 6/2/15 Investigation Report indicated "Summary...It is obvious from all of the interviews, that staff were engaged in dealing with another client behavior at that the (sic) same time that [client F] choose to exit the building. The time</p> | | <p>Officer who will review all reportable incidents to assure compliance per the aforementioned training. The Corporate Compliance Officer will investigate all events that occur that require investigation.</p> | | | | |

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| | <p>lines all match and confirm that there was a period of approximately 15 minutes in which she was unattended by staff." The report indicated "Summary of final findings and recommendations: Based upon all of the interviews conducted, the writer of this report must substantiate this neglect issue with [client F]. She was clearly unattended. It is also obvious that all staff were engaged and dealing with a behavior issue at that very same time. The writer does recommend that all staff be trained to do a quick head count of clients whenever a group of clients have to evacuate to any part of the building." No information was available for review to determine if the corrective action was completed.</p> <p>2. A 6/19/15 BDDS report for an incident on 6/17/15 at 9:30pm indicated "Writer received a call from group home staff who reported that another group home staff had made an inappropriate comment towards a client."</p> <p>-A 7/9/15 BDDS follow up report for the 6/17/15 incident indicated "the allegation of verbal abuse was unsubstantiated. While the language used was inappropriate it was not found to be verbal abuse. Staff will be retrained on appropriate language to use with consumers."</p> | | | |

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| | <p>-The 6/19/15 "Investigative Report" for the 6/17/15 incident indicated paraphrased witness statements and "Background of facts...During a phone call with [GHS (Group Home Staff) #1]...it was reported that [GHS #2] told [client F] If you wouldn't have (urinated in) your pants you wouldn't be wet. It was also reported through a written statement from [GHS #3] that [GHS #2] left a client in wet depends and did not change them."</p> <p>The 6/19/15 Investigative Report indicated the investigator paraphrased GHS #1's witness statement indicated GHS #1 "reports that she was not present during the allegations. She stated that [GHS #3] was texting her, during the time the allegations took place, saying that she was uncomfortable and wanted to leave. [GHS #1] reports that [GHS #2] does not fill out the flow sheets, that one staff on each shift fills them out at some point in the shift. She reports that [GHS #3] informed her that [GHS #2] told [client F] If she wouldn't have (urinated on) herself she wouldn't be wet and that [GHS #2] left [client E] in a wet depend (sic)."</p> <p>The 6/19/15 Investigative Report indicated the investigator paraphrased</p> | | | |

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| | <p>GHS #2's witness statement GHS #2 "reported that when she did the bed checks [clients E and F] were dry. She also reported that she could not remember who filled out the incontinence flow sheets. [GHS #2] stated that [GHS #3] changed [client E] before she left her shift at 9:30pm. [GHS #2] reported that she did tell [client F] to use the restroom, but [client F] did not want to get out of bed and go. She reports 15 minutes later she went back in and [client F] had wet herself. [GHS #2] states that she told [client F] she wouldn't have been wet if she had gotten out of bed. She reports that she may have said (urinated in) her pants but that she cannot remember."</p> <p>The 6/19/15 Investigative Report indicated the investigator paraphrased GHS #3's witness statement GHS #3 "reports that she was finishing paperwork when [GHS #2] came onto shift and told her that [client E] was wet. She reports that [GHS #2] then went back to [client E's] room. [GHS #3] states that she checked [client E] at 8pm and she was dry. [GHS #3] reports that she did not sign the flow sheet because she did not do meds. (medications)...She also reports that when [GHS #2] did the bed checks she heard her tell [client F] If you wouldn't have (urinated in) yourself you wouldn't be wet. [GHS #3] reports</p> | | | |

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| | <p>leaving at 9:30pm due to being uncomfortable."</p> <p>The 6/19/15 Investigative Report indicated the investigator indicated "...it is apparent that [GHS #2] and [GHS #3] have negative things to say about each other." "Summary of final findings and recommendations...The allegation of neglect was unsubstantiated. The written documentation does not support neglect...The allegation of verbal abuse was unsubstantiated. While the language used was inappropriate it was not found to be verbal abuse. The recommendation will be that [GHS #2] receive a coaching/counseling session on appropriate language to use with consumers." No information was available for review to determine if corrective action was completed for staff to client interaction and for immediately reporting allegations of abuse, neglect, and/or mistreatment.</p> <p>3. For client B: -A 7/16/15 BDDS report for an incident on 7/16/15 at 5:24pm indicated "Writer received a call that staff had been verbally abusive towards [client B]. [Client B] was ending his behavior and walked outside, staff followed [client B] outside and continued (sic) antagonize [client B]. Staff has been suspended."</p> | | | |

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| | <p>The 7/17/15 "Investigative Report" was not thorough in that it indicated paraphrased witness statements by GHS #4, GHS #5, GHS #8, GHS #9, and GHS #10. The investigation indicated "Background of facts...According to a behavior report written by [GHS #8], consumer [client B] became verbally and physically aggressive upon being denied the right to watch a DVD by [GHS #8]. No reason was provided for denying [client B] this right. Two other [Staff] provided statements of returning to the group home to find [client B] outside and [GHS #8] attempting to grab [client B] and take [client B] inside. Both (staff) report that [GHS #8] was verbally aggressive, grabbing [client B] by the arm, taunting [client B] about wanting to fight, and making verbal threats to them about how [GHS #8] 'would have laid his a-- out had' [client B] actually hit [GHS #8]." No corrective action was available for review.</p> <p>The 7/17/15 Investigative Report indicated a paraphrased interview with GHS #5 which indicated GHS #5 "reported that [GHS #9] called her for help when she arrived [client B] was sitting on the love seat clearly upset. She asked [client B] if he was OK and he started crying and pointed to [GHS #8]."</p> | | | | | | |

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| | <p>[GHS #5] reported that [GHS #8] then told her about telling [client B] no to watching the movie. When she asked [GHS #8] why he would not let [client B] (watch) it she reports that he became angry and just stormed off. [GHS #5] then went to [client B] who kept trying to say something about [GHS #8] but she could not understand what he was saying." The statement indicated GHS #5 went outside and GHS #10 and GHS #9 "reported what they had witnessed and about (sic) the taunting by [GHS #8] towards [client B] to fight" and GHS #5 called the RM (Residential Manager) "who told her to have [GHS #8] clock out and leave."</p> <p>The investigation indicated "the statements concerning [GHS #8's] interaction with [client B] were consistent in...All staff including [GHS #8], agreed that [client B's] behaviors began when [GHS #8] told him he could not watch the movie of his Dad's funeral. Three staff report [GHS #8] stated he would retaliate physically towards [client B]...Two staff report...[GHS #8] used threatening/taunting behavior towards [client B] to try to get [client B] to fight with him. Two staff report...[GHS #8] used repeated profanity during the incidents outside...Two staff reported... [GHS #8] repeatedly grabbed [client B]</p> | | | |

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| | <p>on the arm in an attempt to force him inside. Three staff report...[GHS #8] was yelling loudly and was emotionally upset during the encounter...Summary of final findings...The testimony of all staff is found to be substantially consistent and overwhelmingly conclusive. As such the allegation of verbal abuse is substantiated. Additional (sic) abusive behaviors are substantiated including physical abuse, taunting, and/or threatening behavior, and denying consumer rights...It is the conclusion of this investigator that [GHS #8] represents a significant threat to the consumers he is responsible for and that his employment with Carey Services be terminated without the possibility of rehire." No documented recommendations and/or completed corrective action were indicated for staff retraining for immediately reporting allegations of abuse, neglect, and/or mistreatment and/or protecting clients A, B, C, D, E, and F from the potential of further abuse when GHS #8 was allowed to stay with client B inside the group home.</p> <p>4. For discharged client G: -No BDDS report was available for review for client G's allegation of neglect investigation.</p> <p>-A 10/7/14 "Investigative Report" was</p> | | | |

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| | <p>not thorough in that it indicated paraphrased witness statements completed by the investigator. The report indicated "Background of facts...[GHS #11] reported [GHS #12] for neglect of a dependent person. (On) 10/7/14 (Tuesday) at 1pm, [GHS #11] reports that on Sunday (10/5/14) she worked ...from 7am to 5pm...stated that she heard night shift staff report that [Discharged client G] was changed at 6:30am...[GHS #12] did not check on [Discharged client G] nor did she change him...[Discharged client G] was not changed from 6:30am to 2:30pm...At 2:30pm...[Discharged client G] was changed...All of [Discharged client G's] bedding was soaked....Summary of final findings....The allegation of neglect against [GHS #12] is substantiated...On 10/5/14 [GHS #12] was neglectful in not properly documenting on buddy checks and medical flow sheets. [GHS #12] failed to give proper personal care to [Discharged client G] on 10/5/14." The investigation did not include completed corrective action staff retraining on immediately reporting allegations of abuse, neglect, and/or mistreatment.</p> <p>On 9/16/15 at 1:00pm, the facility's Personnel Records were reviewed and an interview with the Human Resource Representative (HRR) was conducted.</p> | | | |

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| W 0159 Bldg. 00 | <p>The HRR stated GHS #8's personnel record was "active" because he had not been formally terminated "at this time." The HRR stated GHS #8's "termination was in process for substantiated abuse" of a client.</p> <p>On 9/16/15 at 1:55pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the facility's investigations did not identify the staff failing to immediately report allegations to the administrator, and did not document recommendations to complete corrective measures to protect clients from further abuse, neglect, and/or mistreatment. The QIDP indicated no further information was available for review.</p> <p>This federal tag relates to complaint #IN00174958.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review, and interview, for 1 of 6 clients (client F), the</p> | W 0159 | W159 – "Each client's active treatment program must be integrated, coordinated and | 10/22/2015 |

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| | <p>QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate, and monitor client F's behavioral assessment and to develop an active treatment program for client F.</p> <p>Findings include:</p> <p>During observations on 9/14/15 from 6:05pm until 7:55pm, and on 9/15/15 from 5:55am until 8:05am, clients A, B, C, D, E, and F were observed in the group home with two (2) facility staff on duty. During both observation periods clients A, B, C, D, E, and F accessed each area of the group home. During both observation periods in the kitchen the pantry closet door was open to expose in eye sight a three (3) foot long barbeque grill fork which hung on the wall inside the closet. During both observation periods an open bag of double blade edged razors were located inside the shared bathroom accessible within an arm's reach on the shelf. During both observation periods a pair of scissors, a metal thermometer with a pointed end, a potato peeler, and a Phillips screw driver were left unsecured in the group home. On 9/14/15 at 6:30pm, the RM (Residential Manager) entered the home and indicated it was because the surveyor was present. The RM stated "Sharps were kept secured because" of client F's</p> | | <p>monitored by a qualified mental retardation professional".</p> <p>The QIDP failed to integrate, coordinate, and monitor client F's behavioral assessment and to develop an active treatment program for client F.</p> <ul style="list-style-type: none"> ·An assessment will be completed to indicate the identified need for the locked/secured items for client F by 10/15/2015. ·QIDP will consult with Behavior Specialist and other applicable team members to discuss whether or not sharps need to continue to be locked for client F. BSP will be updated by 10/22/2015. ·Staff retraining of ISP and BSP will be completed within one week of the updated BSP. ·The QIDP will ensure compliance by monitoring progress of update to BSP. The QIDP will also ensure that an updated BSP is complete and review BSP by 10/22/2015. ·By 10/22/2015 all other individuals affected by this restriction will be updated as well. ·Retraining of ISP's for these individuals will be completed within one week of the completion of Client F's BSP and ISP update. | |

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| | <p>history of threats with knives.</p> <p>On 9/15/15 at 9:20am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client F needed the locked restriction for sharps and knives and HRC (Human Rights Committee) had approved the restriction. The QIDP indicated client F did not have a documented assessment which indicated the identified need for the locked/secured items and referred to client F's BSP (Behavior Support Plan). The QIDP indicated she was unsure if client F was in need of the locked sharps restriction. The QIDP indicated the last time client F had threats with a knife was 2003 and no current assessment was available for review.</p> <p>Client F's record was reviewed on 9/17/15 at 4:00pm. Client F's 10/16/14 ISP (Individual Support Plan) and 9/20/14 BSP (Behavior Support Plan) did not include an objective to decrease the need for locked/secured knives/sharps. Client F's BSP indicated targeted behaviors of SIB (Self Injurious Behavior) of head banging and Physical Aggression. Client F's record did not include a behavior of sharp object misuse. Client F's BSP indicated "History & Background</p> | | | |
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| W 0186 Bldg. 00 | <p>Information...moved to the [name of group home] 10/2002. Aggression...She does have a history of cutting self superficially however this has not occurred in past 24 months...Antecedents...Staff must keep all scissors and knives locked up to ensure [client F's] safety, as she has in the past gone to the drawer to retrieve a knife when upset...."</p> <p>9-3-3(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 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review, and interview, for 3 of 3 sampled clients (clients A, B, and C) and 3 additional clients (clients D, E, and F), the facility failed to ensure sufficient staff were available on duty at the group home to supervise and to implement clients A, B, C, D, E, and F's ISPs (Individual Support Plan), BSPs (Behavior Support Plan), and Risk Plans.</p> | W 0186 | <p>W186 – "The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans".</p> <p>The facility failed to ensure sufficient staff were available on duty at the group home to supervise and to implement clients A, B, C, D, E, and F's ISP's, BSP's, and Risk</p> | 10/22/2015 |

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| | <p>Findings include:</p> <p>1. During observations on 9/14/15 from 6:05pm until 7:55pm, and on 9/15/15 from 5:55am until 8:05am, clients A, B, C, D, E, and F were observed in the group home with two (2) facility staff on duty. During both observation periods clients A, B, C, D, E, and F accessed each area of the group home. On 9/15/15 at 12:20pm, the RM (Residential Manager) indicated and the following were observed: clients C, D, and E were in wheelchairs, client A wore continuous oxygen and staff checked his oxygen tank, and clients B and F were to be supervised by the staff. On 9/14/15 at 7:55pm, on 9/15/15 at 8:05am, and on 9/15/15 at 12:20pm, the facility's as worked schedule was requested from the RM and was not provided for review.</p> <p>On 9/15/15 at 12:20pm, an interview was conducted with the RM and the QIDP (Qualified Intellectual Disabilities Professional). The RM stated the facility was "short of staff currently." The QIDP indicated there had been multiple staff changes at the group home and the facility did not have enough staff to supervise clients A, B, C, D, E, and F according to their identified needs.</p> <p>On 9/22/15 at 10:55am, an interview was</p> | | <p>Plans. The planof correction for these findings is as follows:</p> <ul style="list-style-type: none"> ·The home manager is responsible for staffing and assuring sufficient staffing at the site. Retraining will occur with the manager who schedules the staffing on what sufficient coverage is including medical appointments. The manager is to assure staffing and retraining will occur no later than 10/22/2015. The QDDP is responsible to monitor the schedule intensely (all schedules and schedule changes) for at least 2 months to determine if the manager is competent in scheduling practices and is compliant with the aforementioned training. After 2 months of compliance the QDDP will continue to monitor the schedule at least weekly to assure sufficient staffing. ·The Human Resources Department will ensure that the home has adequate staffing by 10/22/2015. ·The Chief Operations Officer will monitor the staffing levels at weekly meetings. ·All above training and process will have occurred and will be in effect no later than 10/22/2015. | | |

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| | <p>conducted with the RM and QIDP. Both indicated the facility did not have enough staff on duty and available to work at the group home to supervise clients A, B, C, D, E, and F. The RM stated "there should be three to four staff on day shift, three to four staff on evening (shift), and one (staff) for the overnight" shift of personnel on duty at the group home. The RM indicated clients B and F had identified behaviors of physical aggression, verbal aggression, and AWOL (Absent Without Leave) and indicated there should be staff available to supervise the clients. The RM stated clients C, D, and E "required" two staff to transfer "even with a hooyer lift" and there "should be at least one to two other staff" to supervise the other clients when these clients were assisted by staff.</p> <p>On 9/16/15 at 12:00noon, client A's record was reviewed. Client A's 10/16/14 ISP (Individual Support Plan) and 1/2015 BSP (Behavior Support Plan) included targeted behaviors of non compliance, socially inappropriate behaviors, and lying. Client A's plans indicated his diagnosis included, but was not limited to, COPD (Chronic Obstructive Pulmonary Disease) requiring twenty-four hour oxygen by nasal cannula at two liters per minute. Client A's plans and 8/31/15 "Physician's</p> | | | |

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| | <p>Order" indicated he required twenty-four hour staff supervision.</p> <p>On 9/16/15 at 11:10am, client B's record was reviewed. Client B's 10/16/14 ISP (Individual Support Plan) and 5/2015 BSP (Behavior Support Plan) included targeted behaviors of inappropriate social interaction/personal space and boundaries, Aggression, Non compliance, and Wetting. Client B's plans and 8/31/15 "Physician's Order" indicated he required twenty-four hour staff supervision.</p> <p>On 9/16/15 at 10:30am, client C's record was reviewed. Client C's 5/26/15 ISP and risk plans indicated she was dependent on facility staff to transfer her to/from her wheelchair, bed, and complete her daily routine. Client C's plans and 8/31/15 "Physician's Order" indicated she required twenty-four hour staff supervision.</p> <p>2. During observations on 9/14/15 from 6:05pm until 7:55pm, and on 9/15/15 from 5:55am until 8:05am, client C was observed in the group home, sat in a wheelchair leaned over the sides of the wheelchair, and fed herself a pureed diet with a spoon from a divided plate. During both observation periods, facility staff prepared client C's pureed food and</p> | | | |

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| | <p>a nose glass of thin liquids and gave to client C then left client C at the dining room table. During both observation periods, staff did not stay in eye sight and/or physically in the dining room area where they were able to see client C consuming her foods and drink. Client C consumed her food leaned over in her wheelchair and during each bite of food and/or drink of fluid client C's tongue thrust outward from her mouth. On 9/15/15 at 6:55am, client C sat alone at the table, took a drink of fluid from an adaptive glass, and began to cough. No staff was present at the dining room table.</p> <p>Client C's record was reviewed on 9/16/15 at 10:30am and no nursing skin protocols were available for review for client C's seating and positioning. Client C's 5/26/15 ISP (Individual Support Plan), 8/31/15 "Physician's Order," and 5/2015 Risk Plans indicated client C received a pureed diet. Client C's 3/24/15 "Aspiration Risk Assessment" indicated client C had "Food or liquid falling from the mouth...Rapid spooning/eating...Tongue thrusting out of mouth...takes large bites of food....Reduced chewing ability...no teeth...Leans right or left...Recommendations: Encourage and assist client to sit up straight when eating to promote good posture and to reduce</p> | | | |

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| W 0189 Bldg. 00 | <p>risk for coughing/choking when eating. Hand over hand (staff) assist client as needed to locate food items on plate and to take a drink due to decrease (sic) vision. Discourage client from eating quickly." Client C's 6/2015 "Dining" plan indicated "Dining...Positioning: Up in chair." Client C's 4/9/15 "Nutritional Assessment" indicated the RD (Registered Dietician) "observed [client C] at group home on 3/24/15 for supper. She is self feeding with use of nose cup and divided plate. Client leaning to one side throughout meal and needed cushions in wheelchair to keep sitting up straight...Client did...shovel food into mouth...She needed assistance from staff to offer drinks throughout meal...."</p> <p>On 9/16/15 at 12:20pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated staff should be present to supervise client C during eating meals.</p> <p>9-3-3(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and</p> | | | |

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| | <p>competently. Based on record review and interview, for 1 additional client (client F), the facility failed to provide sufficient training and/or retraining to ensure staff provided staff supervision and implementation of client F's BSP (Behavior Support Plan) and ISP (Individual Support Plan).</p> <p>Findings include:</p> <p>On 9/15/15 at 10:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incident for client F:</p> <p>-A 6/3/15 BDDS report for an incident on 6/2/15 at 3:15pm, indicated client F "was found by a supported living staff to be unsupervised outside the (facility owned) Day Services building in the parking lot hitting her group home van, screaming that she wanted to go home." The report indicated the Day Services Manager "stated that her staff were dealing with another (client's) behavior, so the supported living program manager and the QDDP (Qualified Developmental Disabilities Professional) went and spoke to [client F] and calmed [client F] down. Due to no one knowing how long that [client F] was outside, an investigation</p> | W 0189 | <p><u>W189</u> – "The facility must provide each employeewith initial and continuing training that enables the employee to perform hisor her duties effectively, efficiently, and competently".</p> <p>The facility failed toprovide sufficient training and/or retraining to ensure staff provided staffsupervision and implementation of client F’s BSP and ISP.</p> <p>·Mandatory staff retraining will occur by the Group Home Manager and QIDP on client F’s ISP and BSP Retraining of ISP for this individual will be completed within one week of the completion of Client F’s BSP and ISP update.</p> <p>·The home manager will assure compliance during routine group home observations, to occur monthly for six consecutive months. After six months reevaluation by the QIDP can occur. Confirmation will occur by the Director of Group Homes and Chief Operations Officer during home visits monthly and quarterly respectively. All levels will assure initial compliance before deadline and will assure ongoing compliance thereafter.</p> <p>·Mandatory staff retraining will occur at the Day Services Facility no later than 10/22/2015 on client</p> | 10/22/2015 | | | |

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| | <p>was opened up. It was found through the investigation that [client F] was unsupervised for a period for approximately 15 minutes. This neglect issue was substantiated. It was also found through the investigation that all of the staff were dealing with another (client's) behavior which gave [client F] an opportunity to go outside." The report indicated "Staff was not suspended during the investigation. It is recommended that all staff be trained to do a head count of clients whenever a group of clients have to evacuate to any part of the building. This will ensure that all clients are present and accounted for."</p> <p>-The 6/2/15 "Investigative Report" indicated the same information from the 6/2/15 BDDS report. The investigative report was documented by the investigator and the investigator paraphrased the staff's comments and statements regarding only the incident for client F.</p> <p>The 6/2/15 Investigative Report indicated a witness statement by WKS (Workshop Staff) #1. WKS #1's statement was paraphrased by the investigator "everyone (the clients) was on break at 3pm. [Client F] was in her group and that she and all of the other clients were in the cafeteria area for their afternoon break."</p> | | <p>F's ISP and BSP.</p> <p>·Director of Group Homes will ensure that training is completed no later than 10/22/2015. Retraining of ISP and BSP for this individual will be completed within one week of the completion of Client F's BSP and ISP update.</p> | | | | |

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| | <p>WKS #1 indicated "one of her (WKS #1's) clients needed to be changed before she went home that day, so she asked everyone (the other staff) in the cafeteria at the time, to watch her group so she could go and change her consumer (sic)." WKS #1 indicated once she and the client were returning to the cafeteria everyone "came pouring into the classrooms. She said that the staff had told her that one of her clients [client B] had went off and struck a [staff person] on the arm. [WKS #1] again asked staff to watch her group while she went to assist this second staff." WKS #1 indicated to the investigator "she last saw [client F] at 3pm in the cafeteria."</p> <p>The 6/2/15 Investigative Report indicated a witness statement by WKS #2. WKS #2 paraphrased witness statement by the investigator indicated client B "had an outburst" of physical aggression towards a staff person, WKS #2 "instructed the staff to remove all of the other clients to the classrooms...indicated that [client F] had to left the building (sic) while staff were busy evacuating the clients from the cafeteria, but it was not clear if she let herself out or if someone had opened the door and [client F] walked out."</p> <p>The 6/2/15 Investigation Report indicated "Summary...It is obvious from all of the</p> | | | |

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| | <p>interviews, that staff were engaged in dealing with another client behavior at that the (sic) same time that [client F] choose to exit the building. The time lines all match and confirm that there was a period of approximately 15 minutes in which she was unattended by staff." The report indicated "Summary of final findings and recommendations: Based upon all of the interviews conducted, the writer of this report must substantiate this neglect issue with [client F]. She was clearly unattended. It is also obvious that all staff were engaged and dealing with a behavior issue at that very same time. The writer does recommend that all staff be trained to do a quick head count of clients whenever a group of clients have to evacuate to any part of the building."</p> <p>Client F's record was reviewed on 9/17/15 at 4:00pm. Client F's 10/16/14 ISP and 9/2015 BSP both indicated targeted behaviors of "AWOL (Absent Without Leave)/running off, SIB (Self Injurious Behaviors) of head banging, Physical Aggression, Verbal Aggression, and Hallucinations/Delusions. Client F's ISP and BSP both indicated staff were to provide twenty-four hour supervision. Client F's ISP and BSP both indicated staff were to have client F within eye sight supervision at "all times."</p> | | | |

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| W 0216 Bldg. 00 | <p>On 9/16/15 at 1:55pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated staff should have implemented client F's ISP and BSP when opportunities existed. The QIDP indicated staff did not supervise client F when client F exited the facility owned day services without staff supervision.</p> <p>This federal tag relates to complaint #IN00174958.</p> <p>9-3-3(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include physical development and health.</p> <p>Based on observation, record review, and interview for 1 of 3 sampled clients (client C), the facility failed to complete a mobility assessment for client C.</p> <p>Findings include:</p> <p>During observations on 9/14/15 from 6:05pm until 7:55pm, and on 9/15/15 from 5:55am until 8:05am, client C was observed in the group home and sat in a wheelchair and leaned over the sides of the wheelchair. Client C was observed to eat, drink, and sat in the living room in</p> | W 0216 | <p>W216 – “The comprehensive functional assessment must include physical development and health”.</p> <p>The facility failed to complete a mobility assessment for client C. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·A monthly chart audit will be used to track all assessments for all clients. Mobility will be added to this by 10/06/2015. ·Group Home Manager will complete the monthly chart audit each month and turn in to the Director of Group Homes no later | 10/22/2015 | | | |

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| | <p>her wheelchair leaning over the sides of the chair.</p> <p>Client C's record was reviewed on 9/16/15 at 10:30am and no nursing skin protocols were available for review for client C's seating and positioning. Client C's 5/26/15 ISP (Individual Support Plan) and 5/2015 Risk Plans did not identify client C's problems with positioning and wheelchair use. Client C's 6/2015 "Dining" plan indicated "Dining...Positioning: Up in chair." Client C's 4/14/15 "Occupational" Therapy (OT) evaluation indicated "assist varies...recommend (the use) of Hoyer Lift" for transfers and did not indicate a positioning and mobility assessment. Client C's record did not indicate assessments by experts in positioning or adaptive equipment use (Wheelchairs). Client C's 6/2015 "Fall Risk" plan indicated she had "unsteady gait or balance...Wheelchair during waking hours."</p> <p>On 9/16/15 at 12:20pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated she would contact the agency nurse for details regarding client C related to her mobility and positioning assessments. The QIDP indicated the nurse was not available for</p> | | <p>than the 15th. October's monthly chart audit with the mobility assessment added on is to be completed no later than 10/15/2015.</p> <ul style="list-style-type: none"> ·Group Home Director will review chart audits monthly and ensure that all consumers have the assessments completed that they need. ·Client C will have a PT Evaluation scheduled by 10/15/2015. ·Group Home Manager will obtain referral from PCP and schedule appointment for PT Evaluation by 10/15/2015. ·The LPN will update the skin protocol for Client C to ensure proper seating positions until the new PT Evaluation can be completed. This will occur no later than 10/16/2015. ·Upon receiving PT Evaluation Risk Plans will be updated and staff training will occur 1 week from receiving updated PT Evaluation. ·A flow sheet will be used to follow updated Risk Plans as well as new PT Evaluation once it is completed. ·The Group Home Director will ensure this is completed no later than 10/22/2015. ·The home manager will assure compliance during routine group home observations, | | | | |

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| W 0249 Bldg. 00 | <p>interview. The QIDP indicated client C had no professional assessments for positioning or adaptive equipment (Wheel Chairs) available for review. The QIDP indicated no mobility assessment was available for review.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, for 1 of 3 sampled clients (client C) and 1 additional client (client F), the facility failed to provide sufficient training and/or retraining to ensure staff provided staff supervision for clients C and F and implementation of client F's BSP (Behavior Support Plan) and ISP (Individual Support Plan).</p> <p>Findings include:</p> <p>1. On 9/15/15 at 10:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were</p> | W 0249 | <p>generally 5 out of every 7 days. Observations will occur daily for client F for one month. After one month of observations the QDDP and Group Home Manager can reevaluate the frequency. Confirmation will occur by the Director of Group Homes and Nurse during home visits monthly. All levels will assure initial compliance before deadline and will assure ongoing compliance thereafter.</p> <p>W249 – "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>The facility failed to provide sufficient training and/or retraining to ensure staff provided supervision for clients C</p> | 10/22/2015 | |

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| | <p>reviewed and included the following incident for client F:</p> <p>-An 6/3/15 BDDS report for an incident on 6/2/15 at 3:15pm, indicated client F "was found by a supported living staff to be unsupervised outside the (facility owned) Day Services building in the parking lot hitting her group home van, screaming that she wanted to go home." The report indicated the Day Services Manager "stated that her staff were dealing with another (client's) behavior, so the supported living program manager and the QDDP (Qualified Developmental Disabilities Professional) went and spoke to [client F] and calmed [client F] down. Due to no one knowing how long that [client F] was outside, an investigation was opened up. It was found through the investigation that [client F] was unsupervised for a period for approximately 15 minutes. This neglect issue was substantiated. It was also found through the investigation that all of the staff were dealing with another (client's) behavior which gave [client F] an opportunity to go outside." The report indicated "Staff was not suspended during the investigation. It is recommended that all staff be trained to do a head count of clients whenever a group of clients have to evacuate to any part of the building. This will ensure that</p> | | <p>and F and implementation of client F's BSP and ISP. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·Mandatory staff retraining will occur on client F's ISP and BSP within one week of updated ISP and BSP. Staff training on client C's dining plan will occur by 10/22/2015 as well. ·The home manager will assure compliance during routine group home observations, generally 5 out of every 7 days. After one month the QIDP and Group Home manager can re-evaluate the need of observations if compliance has been met. If compliance has not been met observations will continue for another month and reevaluation will occur once again. Confirmation will occur by the Director of Group Homes and Chief Operations Officer during home visits monthly and quarterly respectively. All levels will assure initial compliance before deadline and will assure ongoing compliance thereafter. ·Mandatory staff retraining will occur at the Day Services Facility no later than 10/22/2015 on client F's ISP and BSP. ·Director of Group Homes will ensure that training is completed no later than 10/22/2015. ·The home manager is | | | | |

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| | <p>all clients are present and accounted for."</p> <p>-The 6/2/15 "Investigative Report" indicated the same information from the 6/2/15 BDDS report. The investigative report was documented by the investigator and the investigator paraphrased the staff's comments and statements regarding only the incident for client F.</p> <p>The 6/2/15 Investigative Report indicated a witness statement by WKS (Workshop Staff) #1. WKS #1's statement was paraphrased by the investigator "everyone (the clients) was on break at 3pm. [Client F] was in her group and that she and all of the other clients were in the cafeteria area for their afternoon break." WKS #1 indicated "one of her (WKS #1's) clients needed to be changed before she went home that day, so she asked everyone (the other staff) in the cafeteria at the time, to watch her group so she could go and change her consumer (sic)." WKS #1 indicated once she and the client were returning to the cafeteria everyone "came pouring into the classrooms. She said that the staff had told her that one of her clients [client B] had went off and struck a [staff person] on the arm. [WKS #1] again asked staff to watch her group while she went to assist this second staff." WKS #1 indicated to the</p> | | <p>responsible for staffing and assuring sufficient staffing at the site. Retraining will occur with the manager who schedules the staffing on what sufficient coverage is including medical appointments. The manger is to assure staffing and retraining will occur no later than 10/22/2015. The QDDP is responsible to monitor the schedule intensely (all schedules and schedule changes) for at least 2 months to determine if the manager is competent in scheduling practices and is compliant with the aforementioned training. After 2 months of compliance the QDDP will continue to monitor the schedule at least weekly to assure sufficient staffing.</p> <ul style="list-style-type: none"> ·The Human Resources Department will ensure that the home has adequate staffing by 10/22/2015. ·The Chief Operations Officer will monitor the staffing levels at weekly meetings. ·All above training and process will have occurred and will be in effect no later than 10/22/2015. | | | | |

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| | <p>investigator "she last saw [client F] at 3pm in the cafeteria."</p> <p>The 6/2/15 Investigative Report indicated a witness statement by WKS #2. WKS #2 paraphrased witness statement by the investigator indicated client B "had an outburst" of physical aggression towards a staff person, WKS #2 "instructed the staff to remove all of the other clients to the classrooms...indicated that [client F] had to left the building (sic) while staff were busy evacuating the clients from the cafeteria, but it was not clear if she let herself out or if someone had opened the door and [client F] walked out."</p> <p>The 6/2/15 Investigation Report indicated "Summary...It is obvious from all of the interviews, that staff were engaged in dealing with another client behavior at that the (sic) same time that [client F] choose to exit the building. The time lines all match and confirm that there was a period of approximately 15 minutes in which she was unattended by staff." The report indicated "Summary of final findings and recommendations: Based upon all of the interviews conducted, the writer of this report must substantiate this neglect issue with [client F]. She was clearly unattended. It is also obvious that all staff were engaged and dealing with a behavior issue at that very same time.</p> | | | |

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| | <p>The writer does recommend that all staff be trained to do a quick head count of clients whenever a group of clients have to evacuate to any part of the building."</p> <p>Client F's record was reviewed on 9/17/15 at 4:00pm. Client F's 10/16/14 ISP and 9/2015 BSP both indicated targeted behaviors of "AWOL (Absent Without Leave)/running off, SIB (Self Injurious Behaviors) of head banging, Physical Aggression, Verbal Aggression, and Hallucinations/Delusions." Client F's ISP and BSP both indicated staff were to provide twenty-four hour supervision. Client F's ISP and BSP both indicated staff were to have client F within eye sight supervision at "all times."</p> <p>On 9/16/15 at 1:55pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated staff should have implemented client F's ISP and BSP when opportunities existed. The QIDP indicated staff did not supervise client F when client F exited the facility owned day services without staff supervision.</p> <p>2. During observations on 9/14/15 from 6:05pm until 7:55pm, and on 9/15/15 from 5:55am until 8:05am, client C was observed in the group home, sat in a wheelchair leaned over the sides of the</p> | | | |

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| | <p>wheelchair, and fed herself a pureed diet with a spoon from a divided plate.</p> <p>During both observation periods, facility staff prepared client C's pureed food and a noney glass of thin liquids and gave to client C then left client C at the dining room table. During both observation periods, staff did not stay in eye sight and/or physically in the dining room area where they were able to see client C consuming her foods and drink. Client C consumed her food leaned over in her wheelchair and during each bite of food and/or drink of fluid client C's tongue thrust outward from her mouth. On 9/15/15 at 6:55am, client C sat alone at the table, took a drink of fluid from an adaptive glass, and began to cough. No staff was present at the dining room table.</p> <p>Client C's record was reviewed on 9/16/15 at 10:30am and no nursing skin protocols were available for review for client C's seating and positioning. Client C's 5/26/15 ISP (Individual Support Plan), 8/31/15 "Physician's Order," and 5/2015 Risk Plans indicated client C received a pureed diet. Client C's 3/24/15 "Aspiration Risk Assessment" indicated client C had "Food or liquid falling from the mouth...Rapid spooning/eating...Tongue thrusting out of mouth...takes large bites of food....Reduced chewing ability...no</p> | | | | | | |

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| | <p>teeth...Leans right or left...Recommendations: Encourage and assist client to sit up straight when eating to promote good posture and to reduce risk for coughing/choking when eating. Hand over hand (staff) assist client as needed to locate food items on plate and to take a drink due to decrease (sic) vision. Discourage client from eating quickly." Client C's 6/2015 "Dining" plan indicated "Dining...Positioning: Up in chair." Client C's 4/9/15 "Nutritional Assessment" indicated the RD (Registered Dietician) "observed [client C] at group home on 3/24/15 for supper. She is self feeding with use of nose cup and divided plate. Client leaning to one side throughout meal and needed cushions in wheelchair to keep sitting up straight...Client did...shovel food into mouth...She needed assistance from staff to offer drinks throughout meal...."</p> <p>On 9/16/15 at 12:20pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated staff should be present to supervise client C during eating meals.</p> <p>This federal tag relates to complaint #IN00174958.</p> <p>9-3-4(a)</p> | | | |

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| W 0382 Bldg. 00 | <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 6 of 6 clients (clients A, B, C, D, E, and F) who resided in the home, the facility failed to keep medication secure when administered for clients A, B, C, D, E, and F.</p> <p>Findings include:</p> <p>During observations on 9/15/15 from 5:55am until 8:05am, clients A, B, C, D, E, and F were observed in the group home with two (2) facility staff on duty. At 7:10am, the RM (Residential Manager) and client F mixed client F's Poly Glycol (Miralax) medication into an 8 ounce glass of juice, the RM carried the medication mixture to the dining room table, set the mixture down, and positioned client F in front of the mixture with clients A, B, and C watching, and the RM walked away from client F and the mixture. From 7:10am until 7:20am, the RM and GHS (Group Home Staff) #5 walked through the dining room and clients A, B, C, D, and F sat at the dining room table. No staff stayed within eye sight of client F's medication mixture.</p> | W 0382 | <p>W382 – “The facility must keep all drugs and biologicals locked except when being prepared for administration”. The facility failed to keep medication secure when administered for clients A, B, C, D, E, and F. The plan of correction for this tag is as follows: ·Applicable staff will be retrained by the LPN or RN on how to secure medications when not being administered, as well as while they are administering medications no later than 10/22/2015.</p> <p>·The home manager will assure compliance during routine medication observations. The manager will explicitly monitor the security of the medications at 75% of applicable medication passes x1 week. The manager, if observations confirm compliance, can reduce the frequency of confirmation to 50% of applicable medication passes x1 week. If observations confirm non-compliance, must increase to 100% of applicable med passes. Ongoing monitoring will occur each day that the manager is at the home for a period of one month. The frequency is generally</p> | 10/22/2015 | | | |

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| | <p>On 9/15/15 at 7:55am, an interview with the RM was conducted. The RM indicated medications were not secure when the medication mixture was left at the dining room table.</p> <p>On 9/15/15 at 9:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated medications should be kept locked and secured when not being administered. The QIDP indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>On 9/15/15 at 9:30am, 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> | | 5 days out of every 7. Confirmation will occur by the Director of Group Homes and Chief Operations Officer during home visits monthly and quarterly respectively. All levels will assure ongoing compliance. | | | | |
| W 0436 Bldg. 00 | 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 | | | | | | |

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| | <p>communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 2 of 3 sampled clients (clients A and B) with adaptive equipment, the facility failed to have available client B's picture book used to communicate and failed to teach and encourage client A to wear his prescribed eye glasses when opportunities existed.</p> <p>Findings include:</p> <p>1. During observations on 9/14/15 from 6:05pm until 7:55pm, and on 9/15/15 from 5:55am until 8:05am, client B was observed in the group home. During both observation periods, client B did not have his communication book with him and/or available for use. During both observation periods, client B used motions and vocalizations to communicate his wants and needs. During both observation periods facility staff requested the RM (Residential Manager) to come into the room, asked client B to repeat his communication a second and/or third time, and the RM would attempt to decide to what client B was referring. On 9/15/15 at 8:05am, the RM stated client B used gestures to communicate and client B knew "some sign." The RM indicated the facility staff</p> | W 0436 | <p>W436 – “The facility must furnish, maintain ingood repair, and teach clients to use and to make informed choices about these of dentures, eyeglasses, hearing and other communication aids, braces, andother devices identified by the interdisciplinary team as needed by theclient”. The facility failed to haveavailable client B’s picture book used to communicate and failed to teach andencourage client A to wear his prescribed eye glasses when opportunitiesexisted. The plan of correction for this tag are as follows:</p> <ul style="list-style-type: none"> ·Prescribed glasses: All clients that use prescribed glasses are potentially affected by this deficient practice. Staff to be trained by the group home manager on using formal and informal opportunities to use glasses no later than 10/22/2015. ·The home manager will assure compliance during routine group home observations, to occur each day that the manager is at the home. The frequency is generally 5 days out of every 7. After one month the QIDP and Group Home manager can re-evaluate the need of observations if compliance has been met. If compliance has not been met observations will | 10/22/2015 | |

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| | <p>did not know sign language. The RM stated the facility staff "do their best to figure out" what client B was communicating. During both observation periods, client B was not prompted or encouraged to use pictures or a communicate book to express his wants/needs. During the observation periods client B was non verbal.</p> <p>On 9/16/15 at 11:10am, client B's record was reviewed. Client B's 10/16/14 ISP (Individual Support Plan) and 5/2015 BSP (Behavior Support Plan) included targeted behaviors of inappropriate social interaction/personal space and boundaries, Aggression, and Non compliance. Client B's ISP indicated client B "speaks few words, difficult to understand. Knows some sign (language) and has communication book." Client B's plans and 8/31/15 "Physician's Order" indicated he was non verbal. Client B's 9/18/14 and 8/28/14 "Speech Therapy" assessments indicated a recommendation for client B to use a communication book to express his wants/needs.</p> <p>2. During observations on 9/14/15 from 6:05pm until 7:55pm, and on 9/15/15 from 5:55am until 8:05am, client A was observed in the group home and did not wear his prescribed eye glasses. During both observation periods, client A</p> | | <p>continue for another month and reevaluation will occur once again. Confirmation will occur by Director of Group Homes and Chief Operations officer during home visits monthly and quarterly respectively. All levels will assure ongoing compliance.</p> <p>·Communication book: All staff will be retrained on utilizing client B's picture book to communicate effectively with the client by the group home manager no later than 10/22/2015.</p> <p>·A goal for client B will be added to his ISP to ensure that staff are working with him on using his communication book no later than 10/22/2015.</p> <p>·The home manager will assure compliance during routine group home observations, to occur each day that the manager is at the home. The frequency is generally 5 days out of every 7. After one month the QIDP and Group Home manager can re-evaluate the need of observations if compliance has been met. If compliance has not been met observations will continue for another month and reevaluation will occur once again. Confirmation will occur by Director of Group Homes and Chief Operations officer during home visits monthly and quarterly respectively. All levels will assure ongoing compliance.</p> | | | | |

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| | <p>completed watching television, medication administration, shaving, completing a word find puzzle, and dining without wearing his prescribed eye glasses. On 9/15/15 at 8:05am, client A was preparing to leave for the day services program and put on his prescribed eye glasses. At 8:05am, client A stated "I have to wear them if I want to see." During both observation periods, client A was not prompted and/or encouraged to wear his prescribed eye glasses.</p> <p>On 9/16/15 at 12:00noon, client A's record was reviewed. Client A's 10/16/14 ISP (Individual Support Plan) and 1/2015 BSP (Behavior Support Plan) included targeted behaviors of non compliance, socially inappropriate behaviors, and lying. Client A's 8/24/15 Visual Evaluation indicated client A wore prescribed eye glasses.</p> <p>On 9/15/15 at 12:20pm, an interview was conducted with the RM and the QIDP (Qualified Intellectual Disabilities Professional). The RM and the QIDP indicated client B was non verbal and the facility staff were to use pictures and/or client B's communication book to communicate. The RM and QIDP indicated client A wore prescribed eye glasses and should have been taught</p> | | <p>The home manager will purchase items to be posted in the home to promote and educate the staff on sign language. Additionally, the manager will purchase resources on sign language for the staff to use with the consumer and will connect with local resources to have a sign language class provided for staff at this group home. The purchase of materials will occur no later than 10/22/2015, however the class will be scheduled for the first available time slot – the scheduling will occur prior to 10/22/2015.</p> <p>The home manager will assure compliance during routine group home observations, to occur each day that the manager is at the home. The frequency is generally 5 days out of every 7. Confirmation will occur by Director of Group Homes and Chief Operations officer during home visits monthly and quarterly respectively. All levels will assure ongoing compliance.</p> | | | | |

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| W 0449 Bldg. 00 | <p>and/or encouraged to wear his prescribed eye glasses.</p> <p>On 9/22/15 at 10:55am, an interview was conducted with the RM and QIDP. Both indicated no further information was available for review. The RM indicated the facility staff should have encouraged client A to wear his eye glasses and should have encouraged client B to use his communication book to express client B's needs.</p> <p>9-3-7(a)</p> <p>483.470(i)(2)(iv) EVACUATION DRILLS</p> <p>The facility must investigate all problems with evacuation drills and take corrective action.</p> <p>Based on record review and interview for 6 of 6 clients (clients A, B, C, D, E, and F) who lived in the group home and for 4 of 12 drills reviewed, the facility failed to initiate and document effective corrective action to prevent further incidents of lengthy evacuation drill times on the night shift.</p> <p>Findings include:</p> <p>On 9/15/15 at 11:05am, record reviews were completed of the facility's evacuation drills for the period from</p> | W 0449 | <p>W449 – "The facility must investigate all problems with evacuation drills and take corrective action".</p> <p>The facility failed to initiate and document effective corrective action to prevent further incidents of lengthy evacuation drill times on the night shift. The plan of correction for this tag are as follows:</p> <ul style="list-style-type: none"> The group home manager will assure that there are sufficient staff present on third shift to ensure that evacuation drills can be done in a timely manner. This will occur as soon as staff training | 10/22/2015 | | | |

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| | <p>9/2014 through 9/15/15 which included the participation of clients A, B, D, E, and F; and for client C from 4/15 through 9/15/15. The drills did not indicate a reason for each lengthy duration of the drill and did not include corrective measures to ensure prompt evacuation. The evacuation drills indicated the following:</p> <p>On 6/29/15 at 12:00am, duration 8 minutes. On 3/19/15 at 2:15am, duration 6 minutes. On 12/19/14 at 12:35am, duration 15 minutes. On 9/25/14 at 1:35am, duration 15 minutes.</p> <p>On 9/15/15 at 11:05am, an interview with the Qualified Intellectual Disabilities Professional (QIDP) and GHM (Group Home Manager) was conducted. The GHM and the QIDP indicated there were no further documented drills for review. The GHM and the QIDP indicated the evacuation drills had lengthy evacuation times because the clients were dependent on staff to complete each drill. The GHM and the QIDP indicated clients A, B, C, D, E, and F needed staff's verbal prompts, physical assistance, and physical guidance to exit during each drill. The GHM indicated clients C, D,</p> | | <p>is completed.</p> <ul style="list-style-type: none"> For every fire drill longer than 5 minutes, the group home manager will complete an investigation as to why the drill took longer than 5 minutes. Documentation will be submitted to the Group Home Director and Chief Operations Officer for review. The Group Home Director and Chief Operations Officer will assure that an appropriate investigation as to why the drill lasted over 5 minutes is complete and what corrective action needs to be taken. The home manager is responsible for staffing and assuring sufficient staffing at the site. Retraining will occur with the manager who schedules the staffing on what sufficient coverage is including medical appointments. The manger is to assure staffing and retraining will occur no later than 10/22/2015. The QDDP is responsible to monitor the schedule intensely (all schedules and schedule changes) for at least 2 months to determine if the manager is competent in scheduling practices and is compliant with the aforementioned training. After 2 months of compliance the QDDP will continue to monitor the schedule at least weekly to assure sufficient staffing. The Human Resources Department will ensure that the home has adequate staffing by 10/22/2015. | | |

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| W 0454 Bldg. 00 | <p>and E need staff to physically assist them for transfers to their wheelchairs and to exit during each drill. The QIDP indicated none of the drills included documentation for the reasons why each drill was lengthy in duration and did not include corrective measures to ensure prompt evacuation for clients A, B, C, D, E, and F.</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation, interview, and record review, for 3 of 3 sampled clients (clients A, B, and C), and 3 additional clients (clients D, E, and F), the facility failed to teach and encourage sanitary methods for client A's nebulizer machine and for clients A, B, C, D, E, and F during dining.</p> <p>Findings include:</p> <p>During observations on 9/14/15 from 6:05pm until 7:55pm, and on 9/15/15 from 5:55am until 8:05am, clients A, B, C, D, E, and F were observed in the group home with two (2) facility staff on duty. During both observation periods,</p> | W 0454 | <p>The Chief Operations Officer will monitor the staffing levels at weekly meetings.</p> <p>W454 – "The facility must provide a sanitary environment to avoid sources of transmission of infections".</p> <p>The facility failed to teach and encourage sanitary methods for client A's nebulizer machine and for clients A, B, C, D, E, and F during dining. The plan of correction for this tag is as follows:</p> <p>Mandatory staff retraining will be done on protocol for sanitary method to cleanse and store the nebulizer equipment by the LPN or RN no later than 10/22/2015. Additionally staff will be trained on sanitary methods in the kitchen and will include the expectation that taking flip-flops off and</p> | 10/22/2015 |

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| | client A's nebulizer machine had the medication reservoir attached to the oxygen tubing and was stored in the living room with a dish towel draped over the top of the machine and supplies on a table at the end of the sofa. The tubing and reservoir on the machine had a liquid mist on the inside of the tubing and nebulizer reservoir. On 9/15/15 at 6:40am, client A with the RM (Residential Manager) assembled his breathing medication, poured the medication into the existing reservoir on the nebulizer machine in the living room, and client A turned on the machine. No cleaning of the nebulizer machine was observed completed before the medication was dispensed into the machine. At 6:50am, client A turned off the nebulizer machine, indicated his treatment was complete, and GHS (Group Home Staff) #5 moved the tubing on top of the nebulizer machine then replaced the same dish towel to cover the machine. At 6:50am, GHS #5 indicated client A's nebulizer machine was stored in the living room, under the dish towel, and was considered clean. From 7:30am until 7:55am, GHS #6 walked into the group home from the outside and was wearing flip flop open toe sandals on her feet. Clients A, B, C, and F were seated at the dining room table eating breakfast without staff present. At 7:30am, GHS | | flipping shoes on the dining room chairs, then using hands to wipe off feet, flipping socks at the dining room table, and then serving clients breakfast without washing hands is not proper infection control. ·Infection Control Policy will be reviewed. ·Proper Hand Washing will be reviewed. ·Universal Precautions will be reviewed. ·The home manager will assure compliance during routine group home observations, to occur each day that the manager is at the home. The frequency is generally 5 out of 7 days. After one month the QIDP and Group Home manager can re-evaluate the need of observations if compliance has been met. If compliance has not been met observations will continue for another month and reevaluation will occur once again. Confirmation will occur by the Director of Group Homes and Chief Operations Officer during home visits monthly and quarterly respectively. All levels will assure ongoing compliance. | | | | |

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| NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 7891 E 296TH ST ATLANTA, IN 46031 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| | <p>#6 after walking into the group home, sat down at the end of the dining room table where the clients were eating, flipped her shoes up on the dining room chair at the end of the table. GHS #6 removed her sandals and used her right and left hands to make a brushing motion on the bottoms of her feet which flipped bits of dirt into the air around the dining room table. GHS #6 took a pair of rolled up socks from GHS #6's purse, unrolled the socks, and flipped the socks with her hands in a motion to untangle the socks. Lint and dust was seen in the air above the dining room table where clients A, B, C, and F were eating. Facility staff assisted clients D and E to join clients A, B, C, F at the dining room table to eat breakfast. After GHS #6 put on the untangled socks and then her personal tennis shoes at the dining room table, GHS #6 walked to the kitchen assembled client E's breakfast, poured client B a second bowl of cereal, poured drinks for clients C and D, and no handwashing was observed. At 7:50am, GHS #6 walked to the kitchen, retrieved empty bowls/containers, and indicated she was fixing clients Jello to take in their lunches. GHS #6 dipped fruit mixed with Jello into containers without washing her hands.</p> <p>On 9/15/15 at 12:20pm, an interview was</p> | | | |

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| | <p>conducted with the RM and the QIDP (Qualified Intellectual Disabilities Professional). The RM indicated clients and staff should wash their hands before handling food and medications. The RM and QIDP both indicated the staff should follow the agency's infection control policy and procedure. The RM and QIDP both indicated the facility staff and clients should also follow Universal Precautions for infection control in the group home.</p> <p>On 9/22/15 at 10:55am, an interview was conducted with the RM and QIDP. The RM and QIDP both indicated client A's nebulizer should be cleaned after each use. The RM and QIDP both indicated clients and staff should wash their hands before handling food and medications.</p> <p>On 9/15/15 at 12:10pm, a review of the facility's 11/20/13 "Infection Control" policy and procedure was reviewed and indicated "...Handwashing: Hand washing and rinseless hand sanitizers are know to be the most effective ways to reduce the spread of infection. Therefore, Carey Services will provide training and require all staff to practice the use of proper hand washing while working." The policy and procedure indicated the facility follow Universal Precautions and hand washing to limit</p> | | | |

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| | <p>the spread of infection. The policy and procedure indicated staff and clients should wash their hands before starting their day and before handling food.</p> <p>On 9/15/15 at 12:10pm, the facility's 5/2015 "Oxygen Equipment and Supplies Storage, Cleaning, Maintenance, and Safety Procedures" indicated the equipment should be cleaned "Nasal Cannula should be detached and discarded every 14 days or more frequently if the prongs become encrusted with nasal secretions. When not in use, nasal cannula should be stored in a breathable bag" and did not indicate how often the nebulizer reservoir was cleaned.</p> <p>9-3-7(a)</p> | | | |