

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/15/2014
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E 116TH ST CARMEL, IN 46032
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 9/8, 9/9, 9/10, 9/11, 9/12, and 9/15/2014.</p> <p>Facility Number: 000890 Provider Number: 15G376 AIMS Number: 100244260</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/24/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review, and interview, for 3 of 3 sampled clients (clients #1, #3, and #4) and 1 additional client (client #6) who attended facility</p>	W000125	Due to some of the participants in the facility owned day services program health, medical and/or behavior needs, the laundry facilities and kitchen is locked for	10/15/2014

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

TITLE

(X6) DATE

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

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	<p>owned day services, the facility failed to allow and encourage unimpeded access to the locked kitchen, locked lunches, and locked laundry areas of the day services for clients #1, #3, #4, and #6 who did not require restricted access to the locked kitchen, lunches, and laundry room.</p> <p>Findings include:</p> <p>On 9/9/14 from 9:00am until 10:30am, clients #1, #3, #4, and #6 were observed at the facility owned day services. From 9:00am until 10:30am, the kitchen, client lunches, and the laundry room were locked. From 9:00am until 10:30am, clients #1, #3, #4, and #6 were told by the day services staff to give staff their lunches, staff took the lunches to the kitchen and locked the kitchen door. At 10:05am, an interview with the Workshop Supervisor (WS) was conducted. The WS stated the kitchen, laundry room, and client lunches were "kept locked because [client #6] eats other clients' food, pop, he eats it all. [Client #6] needed locked items." When asked if the facility owned day services had consents for the locked items, WS stated "No, I don't think so." When asked if the facility owned day services had plans to decrease the need for the locked items and to encourage other clients to access the locked kitchen, laundry room,</p>		<p>health and safety reasons. The Workshop Supervisor will obtain consents for all clients as needed regarding the locked items. The Group Home Program Director has obtained Human Rights Committee for Clients #1, 3, 4 and 6 regarding having the laundry facilities and kitchen area locked. The Workshop Supervisor will obtain Human Rights Committee approval for all other consumers currently in the program and ongoing will obtain consents and Human Rights Committee approval for any new participants that are added to the program.</p> <p>Ongoing, the Workshop Supervisor and Program Director will complete assessments for all consumers attending the facility owned day program prior to admission to assess their individual need for the laundry and kitchen facilities to be locked. If there is an assessed need for facilities to be locked, the Workshop Supervisor and Program Director will develop goals for the participant to work toward reducing the need for the facilities to be locked. Ongoing, the Workshop Supervisor and Program Director will work together to obtain Human Rights Committee approval for all consumers in the program at admission regarding the restriction of the laundry and kitchen facilities being locked.</p>	

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	<p>and client lunches, WS stated "No."</p> <p>On 9/9/14 at 12:10pm, client #1's record was reviewed. Client #1's 1/25/14 ISP (Individual Support Plan) and 5/20/13 CFA (Comprehensive Functional Assessment) did not indicate an identified need to lock the kitchen, lunches, and laundry. Client #1's record did not indicate consent for locked items.</p> <p>On 9/9/14 at 1:20pm, client #3's record was reviewed. Client #3's 6/23/14 ISP and undated CFA did not indicate an identified need to lock the kitchen, lunches, and laundry. Client #3's record did not indicate consent for locked items.</p> <p>On 9/9/14 at 11:05am, client #4's record was reviewed. Client #4's 8/24/14 ISP and 8/24/13 CFA did not indicate an identified need to lock the kitchen, lunches, and laundry. Client #4's record did not indicate consent for locked items.</p> <p>On 9/11/14 at 1:05pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the AD (Area Director) was conducted. The QIDP and AD both indicated client #1, #3, #4, and #6's lunches, laundry and the kitchen should not have been locked at day services. The QIDP and AD indicated no consents and no assessments</p>		Responsible Party: Workshop supervisor, Program Director, Area Director				

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W000130	<p>were completed for clients #1, #3, #4, and #6 because none of the clients needed locked lunches, locked kitchen, and locked laundry.</p> <p>9-3-2(a)</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facility failed to encourage and teach personal privacy when opportunities existed.</p> <p>Findings include:</p> <p>1. On 9/8/14 from 4:00pm until 5:30pm, GHS (Group Home Staff) #1 administered clients #2, #3, #4, #5, #6, and #7's medications in the back living room. From 4:00pm until 5:30pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 walked in and out of the back living room, stood, folded clothing from the dryer, and watched television in the medication area when GHS #1 administered clients #2, #3, #4, #5, #6, and #7's medications. During clients #2,</p>	W000130	<p>1. Two screens have been purchased for the back living room where medication administration is completed-one for each entrance to all for privacy during medication administration time. All staff will receive retraining on redirecting consumers during medication administration to teach and encourage personal privacy.</p> <p>The Program Director and/or Home manager will complete medication administration observations a minimum of three times per week for 2 weeks and a minimum of twice per week for the following two weeks to ensure that staff are redirecting consumers during medication administration to teach and encourage personal privacy.</p>	10/15/2014

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	<p>#3, #4, #5, #6, and #7's medication administration times, GHS #1 asked each client if they had a bowel movement and about their medications. No privacy was taught or encouraged by GHS #1.</p> <p>On 9/9/14 from 6:15am until 6:45am, GHS #7 administered clients #1, #2, #4, and #5's medications in the medication area of the back living room. From 6:15am until 6:45am, clients #1, #2, #3, #4, #5, #6, #7, and #8 walked in and out of the back living room, asked questions of GHS #7, and watched television in the medication area when clients #1, #2, #4, and #5's medication were administered. GHS #7 asked each client if they had had a bowel movement, questions regarding their individual medications, and how each client slept during the night. No privacy was taught or encouraged by GHS #7.</p> <p>On 9/11/14 at 1:05pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the AD (Area Director). The QIDP and the AD both indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 should have been redirected during formal and informal opportunities to teach and encourage personal privacy during medication administration.</p>		<p>Ongoing the Program Director and/or Home manager will complete medication administration observations a minimum of once per week to ensure that staff are redirecting consumers during medication administration to teach and encourage personal privacy.</p> <p>2. A formal goal has been developed for Client #1 to redirect and encourage her to go to her room for privacy when she manipulates her breasts. All direct care staff will receive retraining to include asking client #1 to stop or redirecting and encouraging her to go to her room for privacy when she manipulates her breasts.</p> <p>For 4 weeks, the Program Director and/or Home Manager will complete active treatment observations a minimum of twice weekly to observe and provide feedback to staff when redirecting Client #1 or encouraging her to go to her room for privacy when she is manipulating her breasts.</p> <p>Ongoing, the Program Director and/or Home Manager will complete active treatment observations a minimum of weekly to observe and provide feedback to staff when redirecting Client #1 or encouraging her to go to her room for privacy when she is manipulating her breasts.</p>				

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	<p>2. On 9/8/14 from 4:00pm until 6:00pm, and on 9/9/14 from 5:30am until 7:30am, client #1 sat on the sofa without activity, placed her right and left hands inside the collar of her low cut blouse and moved her left and right breasts with her fingers repeatedly without redirection. During both observation periods client #1 manipulated her left and right breasts inside and outside of her blouse and bra. During both observation periods male clients #5 and #6 walked by client #1 and looked at client #1. No privacy was taught or encouraged.</p> <p>On 9/9/14 at 12:10pm, client #1's record was reviewed. Client #1's 1/25/14 ISP (Individual Support Plan) did not indicate a goal/objective for personal privacy. Client #1's 5/20/13 CFA (Comprehensive Functional Assessment) did not indicate an identified need for personal privacy.</p> <p>On 9/11/14 at 1:05pm, an interview was conducted with the QIDP and the AD. The QIDP indicated client #1 did not manipulate her left and right breasts and stated client #1 did have a tissue and/or paper towel inside her bra that she "constantly moves around and feels." No tissue and/or paper towel was observed in use by client #1 during the observation periods. The QIDP stated "If you didn't know [client #1] had a tissue in there, it</p>		Responsible party: Program Director, Home Manager, Area Director				

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W000154	<p>would look like inappropriate behavior." The QIDP indicated other people who walked by client #1 would not know she had a tissue inside her bra she was manipulating instead of her breasts. The AD indicated personal privacy should have been taught and encouraged.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on observation, record review, and interview, for 1 of 1 allegation of neglect (for client #6), the facility failed to complete a thorough investigation of client #6's allegation of staff neglect and mistreatment.</p> <p>Findings include:</p> <p>On 9/9/14 from 5:30am until 7:30am, client #6 was verbally asked by GHS (Group Home Staff) #6 and #7 to "collect the linens" from clients #1, #2, #4, and #6's bedrooms for "the washer." From 5:30am until 5:55am, client #6 was observed to carry sheets, blankets, and towels multiple times through the medication area in the back living room, on client #6's way to the washer located</p>	W000154	<p>The Program Director will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the</p>	10/15/2014			

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	<p>in the room on the other side of the kitchen. At 5:55am, client #6 stood in clients #2 and #4's shared bedroom, client #6 was taking off the wet sheets from client #4's bed, and placing the sheets on a pile on the floor. At 5:55am, client #6 stated he didn't mind collecting the soiled laundry when it was wet with "urine" and stated "but when it has poopie on it, I don't like that." After client #6 removed the soiled linens from client #2 and #4's beds, GHS #6 entered the bedroom and lay folded clean sheets on the end of the bed, and client #6 began to make clients #2 and #4's beds. At 5:55am, GHS #6 stated to client #6 "Remember, don't you change [client #3's] bed."</p> <p>On 9/8/14 at 2:45pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 10/2013 through 09/08/2014 and indicated the following for client #6:</p> <p>A 10/7/13 BDDS report for an incident on 10/6/13 at 8:00pm, indicated on "Monday morning 10/7/13 the house manager at the group home reported to the Program Director (Program Director/Qualified Intellectual Disabilities Professional PD/QIDP) that [client #6] had told her this morning that on Sunday evening 10/6/13 that staff on</p>		<p>Program Director and necessary changes will be made.</p> <p>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</p>				

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	<p>shift told him to clean up the mess made after [client #3] had soiled herself while lying in bed. [Client #6] says that he was told by staff to strip [client #3's] bed of its dirty sheets and put them in the hamper. [Client #6] said the staff scolded him and pounded on the desk as she told him to get a bucket with soap and water and mop the floor. [Client #3] said that she went into the bathroom and cleaned herself up after she had messed in her bed. [Client #3] said that when she went back to her bed, there were no sheets on it so she pulled her comforter out of the hamper and covered up with it."</p> <p>On 9/11/14 at 1:05pm, the facility's 10/8/13 investigation into the 10/6/13 allegation indicated the following: -Client #6 was "not an accurate reporter. [Client #6] often confuses events and reports events from his past as current events." -GHS #9 was "the only staff working at the time of the incident." -Client #3 "said that she had an accident and pooped in her bed, but couldn't help herself. [Client #3] said that she went to the bathroom and cleaned herself up...when she went back to her room her sheets and comforter were in the hamper...she knew there was BM (Bowel Movement) on her comforter, but she</p>			

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	<p>was cold and wanted to cover up...she did not know who took her covers off, but [client #6] might have taken them off (of her bed)...said she cleaned the poop off the floor with toilet paper (in the bathroom)...said she heard yelling and it was loud...said [GHS #9] has a nice voice when asked who was yelling."</p> <p>-Client #8 stated "that [client #6] took the sheets off of [client #3's] bed because staff [GHS #9] told him to because they were dirty with poop...."</p> <p>-Client #7 stated "staff [GHS #9] yelled at [client #6] to clean up [client #3's] mess...said the more she yelled the more confused [client #6] looked and he yelled back...said that [GHS #9] talked on the phone a lot in [GHS #9's] own language...said [GHS #9] pounded on the desk when [client #6] didn't understand how to do the bucket...."</p> <p>-The "Conclusion" indicated "Evidence does not support the allegation [client #6] was forced to complete a staff responsibility. Evidence does support [client #3] had an accident and [client #6] assisted in some manner."</p> <p>-The investigation did not indicate if abuse, neglect, and/or mistreatment was identified by the agency. The investigation did not indicate written witness statements or the questions which were asked during the interviews by the investigator.</p>						

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	<p>On 9/11/14 at 1:30pm, an interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional), the AD (Area Director), and the facility Investigator was conducted. The Investigator stated the questions asked during the interviews with clients and staff "were not available for the surveyor to review." The Investigator stated the facility staff did not document "written statements" and written statements were not a part of the agency's investigative protocol. The Investigator stated "I write the responses down in my notes and then I summarize what was said" during each interview for the investigation report. The Investigator stated "You have to have an element of trust" that the investigation was completed. The Investigator indicated the agency followed the BDDS reporting policy and procedure which included investigations. When asked if the investigation was thorough, the Investigator stated "You have to have an element of trust." The Investigator indicated the investigation did not include questions asked, responses, or witness statements. The Investigator indicated the investigation did not include corrective measures employed after client #6's allegation because it was unsubstantiated.</p>			

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W000218	<p>9-3-2(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #1 and #4), the facility failed to assess client #1's functional ability related to her deafness and to assess client #4's functional ability related to her blindness.</p> <p>Findings include:</p> <p>1. On 9/8/14 from 4:00pm until 6:00pm, and on 9/9/14 from 5:30am until 7:30am, client #1 sat on the sofa without activity, placed her right and left hands inside the collar of her low cut blouse and moved her left and right breasts with her fingers repeatedly without redirection. On 9/8/14 at 5:45pm, GHS (Group Home Staff) #1 stated client #1 read his lips "at times" and indicated he did not know sign language. During both observation periods client #1 manipulated her left and right breasts inside and outside of her blouse and bra. On 9/8/14 at 4:40pm, the QIDP (Qualified Intellectual Disabilities</p>	W000218	<p>1,2 A Functional skill assessment is being scheduled for Client #1 to assess her functional deafness and determine best ways for staff to communicate with her to improve her level of understanding and communication. A Functional Skill assessment is being scheduled for Client #4 to assess her functional blindness and determine best ways for staff to communicate with her to improve her level of understanding and communication. Once the assessments are completed the Home Manager, Program Nurse and Program Director will review results of the findings to determine what formal and informal ways of communication can be implemented by staff to improve Client #1 and 4 level of independence and understanding.</p> <p>Program Director and Program Nurse will receive retraining to include ensuring that all clients with functional disabilities have sensorimotor assessments completed to assess their level of</p>	10/15/2014

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	<p>Professional) arrived at the group home. At 4:40pm, the QIDP prompted client #1 to hold and look at a book while client #1 sat on a sofa without activity. During both observation periods client #1 sat on the sofa in the front living room and was interacted with to wash her hands for meals, medication administration, and to eat meals. No staff used sign language or a communication system for client #1. On 9/9/14 at 5:45am, GHS #7 indicated she did not know sign language to communicate with client #1. GHS #7 indicated client #1 smiles when she understood what was asked of her to complete.</p> <p>On 9/8/14 at 4:40pm, client #1 served herself with the assistance of Group Home Staff (GHS) #1, GHS #5, the Residential Manager (RM), and the QIDP (Qualified Intellectual Disabilities Professional) the evening meal of Mixed Vegetables, Tossed Salad, Salisbury Steak, Bread Slice, and Mashed Potatoes. From 4:45pm until 5:20pm, client #1 handled foods of Salisbury Steak pieces, Mashed Potatoes, Tossed Salad, and Mixed Vegetables with her fingers to push the foods to load her spoons with a bite of food. No staff interacted with client #1 and the RM, GHS #1, and GHS #5 prepared client #1's food custodially.</p>		<p>functioning so staff can be trained on appropriate ways to work with consumers to improve their level of understanding and communication. Ongoing the Program Director and Program Nurse will work to ensure that have sensorimotor assessments completed to assess consumers level of functioning as needed upon admission and ongoing as recommended by the PCP to ensure that effective ways of communication are trained to the staff to improve the consumers level of understanding and communication.</p> <p>Responsible Party: Home manager, Program Director, Program Nurse</p>				

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	<p>On 9/9/14 at 9:00am, client #1 arrived at the facility owned day services with GHS #6 in the facility van. Client #1 was assisted off the van by GHS #6 and client #1 walked away down the sidewalk the opposite way from the doorway for the building. GHS #6 verbally called client #1's name repeatedly and client #1 kept walking. Once clients #3, #4, and #6 were inside the day program, GHS #6 ran after client #1, touched her shoulder, client #1 stopped walking, turned around, smiled, and came into the day program.</p> <p>On 9/9/14 at 12:10pm, client #1's record was reviewed. Client #1's 1/25/14 ISP (Individual Support Plan) did not indicate a goal/objective on how to communicate with client #1. Client #1's 9/20/11 Hearing evaluation indicated client #1 was deaf. Client #1's record did not indicate a sensorimotor assessment for client #1's functional deafness.</p> <p>2. On 9/8/14 from 4:00pm until 6:00pm, and on 9/9/14 from 5:30am until 7:30am, client #4 sat at the dining room table in the group home. Client #4 stared forward while seated. Client #4 flipped pages to a magazine, an empty notebook, and indicated she was blind.</p> <p>On 9/8/14 at 4:40pm, client #4 served herself with the assistance of Group</p>				

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	<p>Home Staff (GHS) #1, GHS #5, the Residential Manager (RM), and the QIDP (Qualified Intellectual Disabilities Professional) the evening meal of Mixed Vegetables, Tossed Salad, Salisbury Steak, Bread Slice, and Mashed Potatoes. From 4:45pm until 5:20pm, client #4 handled foods of Salisbury Steak pieces, Mashed Potatoes, Tossed Salad, and Mixed Vegetables with her fingers to push the foods to load her spoons with a bite of food. During both observation periods during meals client #4 was not verbally described or physically shown the locations of her food was on the plate in front of her or the location of her drinking glasses.</p> <p>On 9/9/14 at 11:05am, client #4's record was reviewed. Client #4's record indicated she was blind. Client #4's 11/29/11 visual assessment indicated she was blind. Client #4's 7/2014 "Physician's Order" indicated client #4's diagnosis included but was not limited to: Blindness. Client #4's 8/24/14 ISP and 8/24/13 CFA (Comprehensive Functional Assessment) indicated client #4 was blind. Review of the record did not indicate a sensorimotor assessment for client #4's functional blindness.</p> <p>On 9/11/14 at 1:05pm, an interview with the QIDP (Qualified Intellectual</p>			

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W000225	<p>Disabilities Professional) and the AD (Area Director) was conducted. When asked if clients #1 and #4 were assessed to address client #1's functional skills related to her deafness and client #4's functional skills related to her blindness, the QIDP stated "No." The QIDP indicated clients #1 and #4 did not have functional skill assessments completed.</p> <p>9-3-4(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients #1, #3, and #4) and 1 additional client (client #6) who attended facility owned day services, the facility failed to assess clients #1, #3, #4, and #6's vocational abilities related to their individual work history, work skills, and work interests.</p> <p>Findings include:</p> <p>On 9/9/14 from 9:00am until 10:30am, clients #1, #3, #4, and #6 were observed at the facility owned day services. From 9:00am until 10:30am, client #1 sat with her legs crossed on top of her lap on a bench in the lobby of the day services,</p>	W000225	<p>The Workshop Supervisor worked with teams to develop vocational specific goals for all consumers including Clients #1, 3, 4 and 6. The Group home Program Director has updated all consumers ISP to include these vocational goals. The Workshop Supervisor and Program Director will receive retraining to ensure that specific vocational goals are developed at admission for staff to implement at the Workshop setting to increase the consumers level of independence.</p> <p>Clients #1, 3, 4 and 6 Comprehensive Functional Assessments have been updated to include specifics on consumers work history, work skills and work interests. Program Director will receive retraining to include</p>	10/15/2014			

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	<p>asleep with her chin to her chest, eyes closed, and no interaction was observed between client #1 and the facility staff. No activity was offered or encouraged to client #1. From 9:00am until 10:30am, clients #3, #4, and #6 walked throughout the building, drank coffee, and sat at a table in the craft room coloring on paper. At 10:10am, WKS (Workshop Staff) #1 stated to the group of clients "We are starting our day" and prompted the clients to gather around the table and color on paper and "to say a prayer" to start their day. At 9:20am, an interview with the Workshop Supervisor (WS) was conducted. The WS provided a list of activities with clients #3, #4, and #6's names on it with other clients and client #1's name did not appear on the lists. The WS stated the day services was facility owned and "did not have vocational assessments, copies of [client #1, #3, #4, and #6's] ISP (Individual Support Plan) and BSP (Behavior Support Plan)" available for staff to review and/or implement during formal and informal opportunities. The WS indicated client #1 was deaf, mute, and could read lips partially. The WS indicated the staff motion to her. The WS indicated client #4 was blind. The WS indicated client #4 liked to flip pages in the magazines. The WS stated the staff at the facility owned day services</p>		<p>ensuring that Comprehensive Functional Assessments include specifics in the vocational section that assess consumers work history, work skills and work interests. Training will include completing the assessment at admission and a minimum of annually ongoing.</p> <p>All Workshop staff and Workshop supervisor will receive retraining to include ensuring that all consumers are offered formal and/or informal opportunities for active treatment a minimum of every 15 minutes. Program Director and/or Workshop supervisor will complete active treatment observations a minimum of twice weekly to ensure staff are offering all consumers formal and/or informal opportunities for active treatment a minimum of every 15 minutes.</p> <p>Ongoing, Program Director will work with Workshop Supervisor to ensure that specific vocational goals are developed at admission for staff to implement at the Workshop setting to increase the consumers' level of independence. Ongoing, the Program Director will complete Comprehensive Functional Assessments include specifics in the vocational section that assess consumers work history, work skills and work interests are completed at admission and a minimum of annually ongoing.</p>	

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	<p>"do the best they can" to meet client #1 and #4's individual needs.</p> <p>On 9/9/14 at 12:10pm, client #1's record was reviewed. Client #1's record indicated she was deaf and mute. Client #1's 1/25/14 ISP (Individual Support Plan) did not include a vocational goal/objective available for review. Client #1's 5/20/13 CFA (Comprehensive Functional Assessment) did not include her work history and/or work interests.</p> <p>On 9/9/14 at 1:20pm, client #3's record was reviewed. Client #3's 6/23/14 ISP and undated CFA did not include her work history and/or work interests. Client #3's ISP did not include a vocational goal/objective available for review.</p> <p>On 9/9/14 at 11:05am, client #4's record was reviewed. Client #4's record indicated she was blind. Client #4's 8/24/14 ISP and 8/24/13 CFA did not include her work history and/or work interests. Client #4's ISP did not include a vocational goal/objective available for review.</p> <p>On 9/11/14 at 1:05pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the AD (Area Director) was conducted. The</p>		Responsible Party: Home Manager, Program Director, Workshop Supervisor				

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W000248	<p>QIDP and AD both indicated clients #1, #3, #4, and #6 should have been prompted, offered activities, and offered work opportunities to complete tasks during day services. The QIDP indicated clients #1, #3, #4, and #6's vocational assessments did not include a work history, work skills, and/or their work interests. The QIDP indicated no vocational goals/objectives were available for review.</p> <p>9-3-4(a)</p> <p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients #1, #3, and #4) and 1 additional client (client #6) who attended facility owned day services, the facility failed to ensure the facility owned day services had access to clients #1, #3, #4, and #6's ISPs (Individual Support Plans).</p> <p>Findings include:</p> <p>On 9/9/14 from 9:00am until 10:30am, clients #1, #3, #4, and #6 were observed at the facility owned day services. From</p>	W000248	<p>Copies of Client #1, 3, 4, and 6 Individual Support Plans, Risk Plans and Behavior Plans have been given to the Workshop Supervisor.</p> <p>Program Director will receive retraining to include ensuring that copies of all necessary paperwork for each consumer is given to the Workshop Supervisor at admission and a minimum of annually ongoing. Ongoing the Program Director will ensure that updated copies of consumers ISP, RMAP and BSP are given to the Workshop Supervisor at</p>	10/15/2014			

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	<p>9:00am until 10:30am, client #1 sat with her legs crossed on top of her lap on a bench in the lobby of the day services, asleep with her chin to her chest, eyes closed, and no interaction was observed between client #1 and the facility staff. No activity was offered or encouraged to client #1. From 9:00am until 10:30am, clients #3, #4, and #6 walked throughout the building, drank coffee, and sat at a table in the craft room coloring on paper. At 10:10am, WKS (Workshop Staff) #1 stated to the group of clients "We are starting our day" and prompted the clients to gather around the table and color on paper and "to say a prayer" to start their day. At 9:20am, an interview with the Workshop Supervisor (WS) was conducted. The WS provided a list of activities with clients #3, #4, and #6's names on it with other clients and client #1's name did not appear on the lists. The WS stated the day services was facility owned and "did not have vocational assessments, copies of [client #1, #3, #4, and #6's] ISP (Individual Support Plan) and BSP (Behavior Support Plan)" available for staff to review and/or implement during formal and informal opportunities. The WS indicated client #1 was deaf, mute, and could read lips partially. The WS indicated the staff motion to her. The WS indicated client #4 was blind. The</p>		<p>admission and ongoing a minimum of annually once updated. Responsible Party: Program Director, Workshop Supervisor</p>				

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W000249	<p>WS indicated client #4 liked to flip pages in the magazines. The WS stated the staff at the facility owned day services "do the best they can" to meet client #1 and #4's individual needs.</p> <p>On 9/9/14 at 12:10pm, client #1's record was reviewed. Client #1's 1/25/14 ISP (Individual Support Plan) was not available at the workshop.</p> <p>On 9/9/14 at 1:20pm, client #3's record was reviewed. Client #3's 6/23/14 ISP was not available at the workshop.</p> <p>On 9/9/14 at 11:05am, client #4's record was reviewed. Client #4's 8/24/14 ISP was not available at the workshop.</p> <p>On 9/11/14 at 1:05pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the AD (Area Director) was conducted. The QIDP stated she "thought" the workshop had copies of clients #1, #3, #4, and #6's ISP from the agency.</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</p>						

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	<p>treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, for 3 of 4 sampled clients (clients #1, #3, and #4) and 1 additional client (client #6), the facility failed to implement ISP (Individual Support Plans) when opportunities existed.</p> <p>Findings include:</p> <p>1. On 9/8/14 from 4:00pm until 6:00pm, and on 9/9/14 from 5:30am until 7:30am, client #1 sat on the sofa without activity, placed her right and left hands inside the collar of her low cut blouse and moved her left and right breasts with her fingers repeatedly without redirection. During both observation periods client #1 manipulated her left and right breasts inside and outside of her blouse and bra. On 9/8/14 at 4:40pm, the QIDP (Qualified Intellectual Disabilities Professional) arrived at the group home. At 4:40pm, the QIDP prompted client #1 to hold and look at a book while client #1 sat on a sofa without activity. During both observation periods client #1 sat on the sofa in the front living room and was interacted with to wash her hands for meals, medication administration, and to eat meals. No staff used sign language or</p>	W000249	<p>1. A formal goal has been developed for Client #1 to redirect and encourage her to go to her room for privacy when she manipulates her breasts. All direct care staff will receive retraining to include prompting and engaging all clients, including Client #1 in an activity and interaction a minimum of every 15 minutes.</p> <p>For 4 weeks, the Program Director and/or Home Manager will complete active treatment observations a minimum of twice weekly to observe and provide feedback to staff to ensure they are prompting and engaging all clients, including Client #1 in an activity and interaction a minimum of every 15 minutes.</p> <p>Ongoing, the Program Director and/or Home Manager will complete active treatment observations a minimum of weekly to observe and provide feedback to staff to ensure they are prompting and engaging all clients, including Client #1 in an activity and interaction a minimum of every 15 minutes.</p> <p>2. All Workshop staff and Workshop supervisor will receive</p>	10/15/2014			

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	<p>a communication system for client #1.</p> <p>On 9/9/14 at 12:10pm, client #1's record was reviewed. Client #1's 1/25/14 ISP (Individual Support Plan) indicated goals/objectives to thoroughly wash her hair, take a shower, purchase an item while in the community, complete an activity of her choice, and to participate in monthly exit drills.</p> <p>On 9/11/14 at 1:05pm, an interview was conducted with the QIDP and the AD. The QIDP indicated client #1 did not manipulate her left and right breasts and stated client #1 did have a tissue and/or paper towel inside her bra that she "constantly moves around and feels." No tissue and/or paper towel was observed in use by client #1 during the observation periods. The QIDP stated "if you didn't know [client #1] had a tissue in there, it would look like inappropriate behavior." The QIDP indicated other people who walked by client #1 would not know she had a tissue inside her bra she was manipulating instead of her breasts. The QIDP indicated client #1 should have been prompted and encouraged for activity and interaction every fifteen minutes.</p> <p>2. On 9/9/14 from 9:00am until 10:30am, clients #1, #3, #4, and #6 were</p>		<p>retraining to include ensuring that all consumers are offered formal and/or informal opportunities for active treatment a minimum of every 15 minutes.</p> <p>Ongoing, the Program Director and/or Workshop supervisor will complete active treatment observations a minimum of twice weekly to ensure staff are offering all consumers formal and/or informal opportunities for active treatment a minimum of every 15 minutes.</p> <p>Responsible Party: Home Manager, Program Director, Workshop Supervisor</p>				

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	<p>observed at the facility owned day services. From 9:00am until 10:30am, client #1 sat on a bench in the lobby of the day services, asleep with her chin to her chest, eyes closed, and no interaction was observed between client #1 and the facility staff. No activity was offered or encouraged to client #1. From 9:00am until 10:30am, clients #3, #4, and #6 walked throughout the building, drank coffee, and sat at a table in the craft room coloring on paper. At 10:10am, WKS (Workshop Staff) #1 stated to the group of clients "We are starting our day" and prompted the clients to gather around the table and color on paper and "to say a prayer" to start their day. At 9:20am, an interview with the Workshop Supervisor (WS) was conducted. The WS provided a list of activities with clients #3, #4, and #6's names on it with other clients and client #1's name did not appear on the lists. The WS stated the day services was facility owned and "did not have vocational assessments, copies of [client #1, #3, #4, and #6's] ISP (Individual Support Plan) and BSP (Behavior Support Plan)" available for staff to review and/or implement during formal and informal opportunities. The WS indicated client #1 was deaf, mute, and could read lips partially. The WS indicated the staff motion to her. The WS indicated client #4 was blind. The</p>			

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	<p>WS indicated client #4 liked to flip pages in the magazines. The WS stated the staff at the facility owned day services "do the best they can" to meet client #1 and #4's individual needs.</p> <p>On 9/9/14 at 12:10pm, client #1's record was reviewed. Client #1's record indicated she was deaf and mute. Client #1's 1/25/14 ISP (Individual Support Plan) indicated goals/objectives to thoroughly wash her hair, to brush her teeth twice daily, to take a shower, to purchase an item while in community, to complete an activity of her choice, to wash her hands before medication administration, to gather and bring her dirty laundry to the laundry area, and to participate in monthly evacuation drills.</p> <p>On 9/9/14 at 1:20pm, client #3's record was reviewed. Client #3's 6/23/14 ISP indicated goals/objectives to thoroughly brush her teeth, to participate in choice activities 5 minutes, to wash her upper body, to punch out her multivitamin, to select a quarter from other coins, and to adjust the water temperature.</p> <p>On 9/9/14 at 11:05am, client #4's record was reviewed. Client #4's record indicated she was blind. Client #4's 8/24/14 ISP indicated goals/objectives to use hand sanitizer during medication</p>				

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W000317	<p>administration to wash her hands, to complete a physical activity of choice for 10 minutes, to identify coins, and to make her own bed.</p> <p>On 9/11/14 at 1:05pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the AD (Area Director) was conducted. The QIDP indicated staff should have implemented formal and informal objectives/programs when opportunities existed.</p> <p>9-3-4(a)</p> <p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. Based on record review and interview, for 1 of 1 sampled client (client #3) who received psychotropic medications, the facility failed to evaluate client #3's status for an annual decrease or contraindication of psychotropic medication.</p> <p>Findings include: Client #3's record was reviewed on 9/9/14 at 1:20pm. Client #3's 6/23/14</p>	W000317	<p>Documentation was found to indicate the Client #3 Thioridazine was lowered from 175 mg to 100 mg in January of 2014. Documentation was also present to show that Client #3 psychiatrist reviewed the lower dosage of the Thioridazine in April 2014 and July 2014 and stated that Client #3 was doing well on the lowered dose. Client #3 Behavior Support Plan dated June of 2014 also reflects the lowered dosage of Thioridazine from 175 mg to 100</p>	10/15/2014

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	<p>ISP (Individual Support Plan) and client #3's 11/14/12 BSP (Behavior Support Plan) indicated the targeted behaviors of temper tantrums and verbal assault. Client #3's plans indicated the use of Thioridazine (anti psychotic) 175mg (milligrams) daily for "Schizophrenia, self talk, verbal assaults, (and) temper outbursts." Client #3's 7/11/14, 4/4/14, 1/27/14, 11/8/13, and 8/2/13 "Psych (Psychiatric) Medication Reviews" did not indicate a change in client #3's psychiatric medications or a contraindication. Client #3's 7/2014 "Physician's Order" indicated client #3's Thioridazine was started on 2/17/2010. Client #3's record did not indicate the last psychotropic medication change or contraindication. No data of targeted behaviors was provided for review.</p> <p>Interview with the Area Director (AD) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 9/11/14 at 1:05pm. The AD and QIDP indicated client #3's psychiatric medication had not been changed in over a year and no contraindication for client #3's psychiatric medication had been documented. The AD indicated she would look for additional documented written evidence for client #3.</p> <p>9-3-5(a)</p>		<p>mg.</p> <p>Program Director and Program Nurse will receive retraining to include ensuring that all consumers, including client #3 psychiatric medications are reviewed on a quarterly basis and a discussion is had with the psychiatrist a minimum of annual to determine if any reductions in medications can be made or if a consumer is at a therapeutic appropriate dose.</p> <p>Ongoing the Program Director and Program Nurse will ensure that all clients taking psychotropic medication have a discussion with the psychiatrist a minimum of annually to determine if any reductions in medications can be made or if a consumer is at a therapeutic appropriate dose. The Program Nurse will ensure that documentation of this discussion is available for review and documentation clearly indicates if a reduction in medication is recommended or if the psychiatrist feels the medication is at an appropriate therapeutic level to meet the client's needs for stability.</p> <p>Responsible Party: Program Director, Program Nurse</p>				

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review, and interview for 4 of 8 clients (clients #2, #4, #6, and #7), the facility failed to administer medications without error and as prescribed by the clients' physician.</p> <p>Findings include:</p> <p>On 9/8/14 at 2:45pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 1/1/14 through 9/8/2014 were reviewed and indicated the following for client #2, #4, #6, and #7's medication errors:</p> <p>For client #2: -A 4/7/14 BDDS report for an incident on 4/7/14 at 6:30am, indicated staff passed client #2's "evening meds (medications) for [client #2] instead of the morning meds...."</p> <p>-A 3/6/14 BDDS report for an incident on 3/5/14 at 5:30am, indicated on 3/6/14 "staff noticed that there were meds that had been punched out of the packets and put in a med cup, sitting out of direct sight but locked inside the med cabinet.</p>	W000368	<p>The staff working in this home will be retrained on medication administration policy and procedures to include ensuring that all clients are given their medications as directed by the physician and as indicated by the MAR. For 4 weeks, the Home Manager and/or Program Director will complete Medication observations a minimum of twice weekly to ensure staff are administering medications as prescribed. After the four weeks and ongoing, the Home Manager and/or the QIDP will complete a weekly medication administration observation to ensure the staff administer medications as prescribed. The HM and/or PD will be responsible for ensuring any necessary follow-up is completed for any errors made in the administration of medications.</p> <p><i>Addendum:</i> <i>For 4 weeks, the Home Manager, Program Director and/or Program Nurse will complete Medication observations a minimum of four times weekly to ensure staff are administering medications as prescribed. For the second four weeks the Home Manager, Program Director and/or Program</i></p>	10/15/2014

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	<p>The staff was able to identify the meds as belonging to [client #2] which had not been signed off in the MAR (Medication Administration Record) for 3/5/14 morning med pass." The report indicated client #2 indicated she did not receive her morning medications on 3/5/14. The report indicated the medications of "Fish Oil 1000mg (for nutrition), Multivitamin (for nutrition), Triamt HCTZ 37.5 25mg (for water retention/swelling), Metoprolol (for Hypertension), and Ammonium Lactate 12% (for dry skin)."</p> <p>-A 3/3/14 BDDS report for an incident on 3/1/14 at 7:00am, indicated staff notified the Program Director "that over the weekend on 3/1/14 and 3/2/14 [client #2] received the medication Triamet HCTZ Maxzide 25mg (milligrams) each morning (for water retention/swelling)...The med (medication) is only supposed to be given every Monday, Wednesday, and Friday mornings. Nurse notified and told staff to not give it to [client #2] on Monday morning but to resume med passing on Wednesday."</p> <p>Client #2's record was reviewed on 9/9/14 at 11:05am. Client #2's 9/2014 MAR (Medication Administration Record) and 7/2014 "Physician's Order" both indicated the morning medications</p>		<p><i>Nurse will complete Medication observations a minimum of three times weekly to ensure staff are administering medications as prescribed.</i></p> <p><i>Ongoing, the Home Manager, Program Director and/or Program Nurse will complete medication administration observation twice weekly to ensure the staff administer medications as prescribed. The HM and/or PD will be responsible for ensuring any necessary follow-up is completed for any errors made in the administration of medications.</i></p> <p>Responsible Staff: Home Manager, Program Director, Program Nurse</p>				

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	<p>of "Fish Oil 1000mg (for nutrition), Multivitamin (for nutrition), Triamt HCTZ 37.5 25mg (for water retention/swelling) on Monday, Wednesday, and Friday, Metoprolol (for Hypertension), and Ammonium Lactate 12% (for dry skin)."</p> <p>For client #4: -A 4/7/14 BDDS report for an incident on 4/7/14 at 6:30am, indicated staff "passed the evening med (medications) for [client #4] instead of the morning meds...Nurse said to keep [client #4] home from day program and to monitor her for side effects."</p> <p>On 9/9/14 at 11:05am, client #4's 9/2014 MAR and 7/2014 "Physician's Order" were reviewed. Both documents indicated "evening medications" of Ranitidine 150mg 1 tablet by mouth at bedtime, Zocor 40mg 1 tablet at bedtime for Hyperlipidemia, Levetiracetam 500mg 1 tablet every 12 hours for seizures, and Oyster Calcium 500mg with Vitamin D for nutrition 1 table three times a day.</p> <p>For client #6: -A 5/12/14 BDDS report for an incident on 5/9/14 at 8:00am, indicated client #6 did not receive his morning medications "because staff did not follow medication</p>			

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	<p>administration protocol."</p> <p>-Client #6's 5/10/14 "Investigative Summary" indicated the staff did not administer client #6's morning medication because "the morning medications were still in the bubble pack."</p> <p>On 9/11/14 at 11:00am, client #6's 9/2014 MAR (Medication Administration Record) and 7/2014 "Physician's Order" both indicated morning medications of "Denta 5000 plus cream, use after brushing" in the morning for Periodontal Gingivitis, Risperdone 4mg (milligrams) twice daily for behaviors, Geodon 40mg twice daily for behaviors, Benztropine 2mg twice daily for behaviors, and Calcium Carbonate 600mg with Vitamin D twice daily for nutrition "at 7:00am and 5:00pm."</p> <p>For client #7: -An 8/6/14 BDDS report for an incident on 8/6/14 at 8:00am, indicated client #7 "had not received her medication, Metformin for the past few days...The medication did not arrive with the regular cycle fill at the beginning of the month. The pharmacy was notified and the medication was to be sent...When the medication did not arrive, the nurse notified and called the pharmacy again...The medication still did not</p>			

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	<p>arrive. [Client #7] takes 1000mg of Metformin at 7:00am, and 1000mg at 5:00pm, daily for her Diabetes."</p> <p>-A 4/3/14 BDDS report for an incident on 4/3/14 at 7:00am, indicated "staff reported" that client #7 took her afternoon dose of Metformin 100mg (for) Diabetes/Blood Sugar medication along with her morning dose" of 1000mg of Metformin medication. The report indicated client #7 skipped her evening dose on 4/3/14 of Metformin at the nurse's recommendation.</p> <p>Client #7's record was reviewed on 9/11/14 at 11:30am. Client #7's 9/2014 MAR and 7/2014 "Physician's Order" both indicated "Metformin 500mg, take 2 tablets (or 1000mg) 2 times a day for Diabetes."</p> <p>On 9/11/14 at 1:05pm, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders.</p> <p>On 9/11/14 at 1:05pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the AD (Area Director) was conducted. The QIDP and the AD both indicated staff</p>			

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W000382	<p>should administer medications according to physician's orders. The AD indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders.</p> <p>9-3-6(a)</p> <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 4 of 4 sampled clients (clients #1, #2, #3, and #4), and for 4 additional clients (clients #5, #6, #7, and #8), the facility failed to ensure client medications were kept locked when not being readied for administration.</p> <p>Findings include:</p> <p>On 9/8/14 from 3:45pm until 6:00pm, observation and interview were completed at the group home. From 3:45pm until 5:30pm, the upper part of the medication cabinet in the back living room where client #1, #2, #3, #4, #5, #6, #7, and #8's routine medications were stored was unlocked and unsecured. From 4:00pm until 5:30pm, GHS (Group Home Staff) #1 administered client #2,</p>	W000382	<p>All staff will receive retraining on ensuring that the medication cabinet is locked during medication administration when exiting the medication area for any reason.</p> <p>Home Manager and/or Program Director will complete medication administration observations at least twice per week for four weeks to ensure that all staff are locking the medication cabinet during medication administration when staff are out of the area for any reason.</p> <p>Ongoing, the Home Manager and/or Program Director will complete medication administration observations at least once per week to ensure that all staff are locking the medication cabinet during medication administration when</p>	10/15/2014			

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	<p>#3, #4, #5, #6, and #7's evening medications. From 3:45pm until 5:30pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 walked through the medication area and/or had access to the unlocked and unsecured medication cabinet. At 5:30pm, GHS #1 indicated the medication cabinet doors were unlocked and unsecured from 3:45pm until he locked the doors at 5:30pm. GHS #1 indicated the upper door on the cabinet should be locked and secured. GHS #1 indicated he left the sight of the cabinet which was unlocked and unsecured throughout the time from 3:45pm until 5:30pm.</p> <p>On 9/11/14 at 1:05pm, an interview with the Area Director (AD) was conducted. The AD indicated all medications should be kept locked in the medication cabinet. The AD indicated the facility followed the Living in the Community Core A/Core B medication administration training. No nurse was available for interview.</p> <p>On 9/11/14 at 1:10pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated "Core Lesson 3: Principles of Administering Medication" indicated medications should be secured.</p>		<p>staff are out of the area for any reason.</p> <p>Responsible Party: Home Manager, Program Director</p>				

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W000454	<p>9-3-6(a)</p> <p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation, record review, and interview for 1 additional client (client #7), the facility failed to ensure sanitary methods were used during medication administration when client #7 consumed her Metformin (for Diabetes) medication after dropping the tablet on the floor.</p> <p>Findings include:</p> <p>On 9/8/14 at 5:22pm, client #7 was asked by GHS (Group Home Staff) #1 to select her Metformin medication tablet card for administration. Client #7 and GHS #1 popped her medication tablet from the medication card into a medication cup. Client #7 took the tablet out of the medication cup with her fingers and dropped it on the floor. Client #7 and GHS #1 looked downward at the floor, client #7 located the medication tablet, picked the tablet up with her fingers, and consumed the tablet from the floor without redirection from GHS #1. GHS #1 signed client #7 consumed her Metformin medication.</p>	W000454	<p>All direct care staff will receive retraining on infection control and universal precautions including encouraging clients to not consume their medications after they have been dropped on the floor. Retraining will include if a medication has been dropped on the floor staff should replace the medication and discard the dropped medication. Home Manager and/or Program Director will complete medication administration observations at least twice per week for four weeks to ensure that all staff are encouraging clients to not consume their medications after they have been dropped on the floor.</p> <p>Ongoing, the Home Manager and/or Program Director will complete medication administration observations at least once per week to ensure that all staff are encouraging clients to not consume their medications after they have been dropped on the floor.</p> <p>Responsible Party: Home Manager, Program Director</p>	10/15/2014			

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W000484	<p>On 9/11/14 at 1:05pm, an interview with the Area Director (AD) was conducted. The AD indicated the staff should have taught and encouraged client #7 to not take her medication tablets after dropping the medication on the floor. The AD indicated GHS #1 should have replaced the medication tablet and discarded the dropped medication. The AD indicated staff were trained during Core A/Core B medication training to follow Universal Precautions.</p> <p>On 9/11/14 at 1:10pm, the undated Core A/Core B Medication Administration training manual page 3 indicated "Universal precautions" included washing hands before medication administration, before eating, and after using the restroom.</p> <p>9-3-7(a)</p> <p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facility failed to</p>	W000484	All direct care staff will receive retraining to include ensuring that all consumers have a full set of silverware available to them and that they use a bread plate or	10/15/2014

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	<p>ensure clients had a full set of silverware and bread plate (or barrier between the bread and table) during dinner.</p> <p>Findings include:</p> <p>On 9/8/14 at 4:40pm, staff set the dining table with client #7. At 4:40pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 served themselves with the assistance of Group Home Staff (GHS) #1, GHS #5, the Residential Manager (RM), and the QIDP (Qualified Intellectual Disabilities Professional) the evening meal of Mixed Vegetables, Tossed Salad, Salisbury Steak, Bread Slice, and Mashed Potatoes. From 4:45pm until 5:20pm, GHS #1 walked from client to client cutting their steak with a knife from the kitchen. Clients #1, #2, #4, #5, #6, #7, and #8 did not have a knife offered to them (client #3 had a pureed diet texture). From 4:45pm until 5:20pm, clients #1, #2, #4, #5, #6, #7, and #8 lay their slice of bread on the dining room table without a plate and/or a barrier between the table and their slice of bread. No teaching or redirection was encouraged.</p> <p>On 9/11/14 at 1:05pm, an interview with AD (Area Director) and the QIDP was conducted. The QIDP and AD both indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 should have been provided a</p>		<p>barrier between their food and the table. Retraining will include ensuring that consumers are assisted with cutting food items based on their functioning levels and that staff are not just automatically doing it for them. Retraining will also include ensuring that consumers are encourage and/or redirected to not place their food directly on the table and to use a plate or other barrier as needed.</p> <p>Direct care staff, HM and PD will receive retraining to include ensuring that all tables, chairs, eating utensils and dishes are designed to meet the developmental needs of each consumer. If there are issues with furniture, eating utensils and chairs not meeting clients developmental needs, staff will report the need to the HM and PD so that the issue can be resolved in a timely manner so that all consumers needs are being met.</p> <p>For 4 weeks the HM and/or PD will complete walkthroughs of the home and mealtime observations a minimum of twice weekly to ensure that all furniture, dishes, eating utensils are meeting consumers developmental needs. Ongoing, the HM and/or PD will complete walkthroughs of the home and mealtime observations a minimum of weekly to ensure that all furniture, dishes, eating utensils are</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G376		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/15/2014	
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W000488	<p>full set of silverware and a bread plate or barrier between the table and the bread during each meal.</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facility staff failed to teach and encourage clients to use condiments and dining utensils consistent with their developmental level.</p> <p>Findings include:</p> <p>On 9/8/14 at 4:40pm, staff set the dining table with client #7. At 4:40pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 served themselves with the assistance of Group Home Staff (GHS) #1, GHS #5, the Residential Manager (RM), and the QIDP (Qualified Intellectual Disabilities Professional) the evening meal of Mixed Vegetables, Tossed Salad, Salisbury</p>	W000488	<p>meeting consumers developmental needs. Any needs that need to be addressed will be brought to the attention of the Program Director, Area Director and/or Program Nurse as needed to ensure needs are getting resolved in a timely manner.</p> <p>Responsible Party: Home Manager, Program Director, Area Director</p> <p>All direct care staff will receive retraining to include allowing and encouraging all consumers to assist with meal preparation, setting the table, cleaning up after the meal, etc. In addition, retraining will include ensuring that all consumers are allowed to eat in a way consistent with developmental levels. Retraining will include ensuring that consumers are allowed to serve themselves at mealtime or are provided had over hand assistance as needed.</p> <p>For 4 weeks the Home Manager and/or Program director will complete mealtime observations a minimum of twice weekly to ensure that direct care staff are allowing and encouraging consumers to assist with meal preparation and clean up; are</p>	10/15/2014			

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	<p>Steak, Bread Slice, and Mashed Potatoes. At 4:45pm, GHS #1 and the QIDP uncovered a tray of eight (8) individually dipped 15ml (milliliters) plastic medication cups of butter and eight (8) individually poured 30ml of Ranch Dressing. At 4:45pm, GHS #5 indicated she had dipped the butter and salad dressing into individual containers for each client before the evening meal and no client assisted. GHS #5 indicated no choice of salad dressing was offered. From 4:45pm until 5:20pm, GHS #1 walked from client to client cutting their steak with a knife from the kitchen (client #3 had a pureed diet texture). Clients #1, #2, #4, #5, #6, #7, and #8 did not have a knife offered to them nor were they taught to use a knife. From 4:45pm until 5:20pm, clients #1, #2, #4, #5, #6, #7, and #8 lay their slice of bread on the dining room table without a plate and/or a barrier between the table and their slice of bread. No teaching or redirection was encouraged. From 4:45pm until 5:20pm, clients #1, #2, #3, #4, #5, #6, and #7 handled foods of Salisbury Steak pieces, Mashed Potatoes, Tossed Salad, and Mixed Vegetables with their fingers to push the foods to load their spoons with a bite of food. No teaching or redirection was encouraged.</p> <p>On 9/11/14 at 1:05pm, an interview with</p>		<p>eating in a way consistent with developmental levels and are running consumers mealtime objectives.</p> <p>Ongoing after the 4 weeks the HM and/or Program director will complete mealtime observations a minimum of weekly to ensure that direct care staff are allowing and encouraging consumers to assist with meal preparation and clean up; are eating in a way consistent with developmental levels and are running consumers mealtime objectives.</p>				

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	AD (Area Director) and the QIDP was conducted. The QIDP and AD both indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 should have been taught how to use utensils and to serve themselves condiments during dinner. 9-3-8(a)				