

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G476	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/10/2014
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NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2944 DIETZ ST INDIANAPOLIS, IN 46203
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W000000	<p>This visit was for an annual recertification and state licensure survey. This visit included the investigation of complaint #IN00149542.</p> <p>Complaint #IN00149542: Substantiated, federal and state deficiencies related to the allegations are cited at: W102, W104, W122, W149, W153, W154, W156, W159, W264 and W289.</p> <p>Dates of Survey: 6/4/14, 6/5/14, 6/6/14, 6/9/14 and 6/10/14.</p> <p>Facility Number: 000990 Provider Number: 15G476 AIMS Number: 100244930</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/17/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific</p>			

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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	governing body and management requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 3 of 4 sampled clients (A, B, D) plus 3 additional clients (F, G and H). The governing body failed to exercise general policy and operating direction over the facility by failing to implement policies and procedures which included/addressed the Elder Justice Act; which requires specific individuals in applicable long term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility; (pursuant to 6703(B)(3) of The Patient Protection and Affordable Care Act of 2010 according to section 1150B of the Social Security Act.) regarding the alleged theft of clients A, B, F, G and H's personal petty cash funds, by failing to ensure the facility secured a surrogate to assist client D with making informed choices and decisions, by failing to ensure the facility implemented its policy and procedures to prevent neglect of client B regarding the implementation of his GBP (Gait Belt Protocol) to prevent injuries from seizures and falls, to ensure an allegation of staff neglect regarding client A and two separate injuries of unknown origin regarding	W000102	Please See 104 Please See 122	07/10/2014			

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	<p>client B were reported to the BDDS (Bureau of Developmental Disabilities Services) within 24 hours, to ensure the investigations of an injury of unknown origin regarding client A, two separate injuries of unknown origin and an allegation of staff neglect regarding client B were thoroughly investigated, and to ensure the investigations of an allegation of staff neglect regarding client A and a fall resulting in a fracture regarding client B were completed within 5 business days of the incidents and by failing to ensure the QIDP (Qualified Intellectual Disabilities Professional) monitored, integrated and coordinated client B's active treatment program by failing to convene the facility's HRC (Human Rights Committee) to review, monitor and approve the use of a wheelchair with a lap belt restraint regarding client B and to ensure client B's ISP (Individual Support Plan)/BSP (Behavior Support Plan) included the use of a lap belt restraint for client B's wheelchair.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility by failing to implement policies and procedures which included/addressed the Elder Justice Act; which requires specific individuals in</p>			

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	<p>applicable long term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility;</p> <p>(pursuant to 6703(B)(3) of The Patient Protection and Affordable Care Act of 2010 according to section 1150B of the Social Security Act.) regarding the alleged theft of clients A, B, F, G and H's personal petty cash funds,</p> <p>by failing to ensure the facility secured a surrogate to assist client D with making informed choices and decisions,</p> <p>by failing to ensure the facility implemented its policy and procedures to prevent neglect of client B regarding the implementation of his GBP to prevent injuries from seizures and falls,</p> <p>to ensure an allegation of staff neglect regarding client A and two separate injuries of unknown origin regarding client B were reported to the BDDS (Bureau of Developmental Disabilities Services) within 24 hours, to ensure the investigations of an injury of unknown origin regarding client A, two separate injuries of unknown origin and an allegation of staff neglect regarding client B were thoroughly investigated, and to ensure the investigations of an allegation of staff neglect regarding client A and a fall resulting in a fracture regarding client B were completed within 5 business days of the incidents and by failing to ensure</p>			

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	<p>the QIDP monitored, integrated and coordinated client B's active treatment program by failing to convene the facility's HRC to review, monitor and approve the use of a wheelchair with a lap belt restraint regarding client B and to ensure client B's ISP/BSP included the use of a lap belt restraint for client B's wheelchair. Please see W104.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility by failing to ensure the facility implemented its policy and procedures to prevent neglect of client B regarding the implementation of his GBP to prevent injuries from seizures and falls, to ensure an allegation of staff neglect regarding client A and two separate injuries of unknown origin regarding client B were reported to the BDDS within 24 hours, to ensure the investigations of an injury of unknown origin regarding client A, two separate injuries of unknown origin and an allegation of staff neglect regarding client B were thoroughly investigated, and to ensure the investigations of an allegation of staff neglect regarding client A and a fall resulting in a fracture regarding client B were completed within 5 business days of the incidents. Please see W122.</p> <p>This federal tag relates to complaint</p>						

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W000104	<p>#IN00149542.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 3 of 4 sampled clients (A, B and D) plus 3 additional clients (F, G and H), the governing body failed to exercise general policy and operating direction over the facility by failing to implement policies and procedures which included/addressed the Elder Justice Act; which requires specific individuals in applicable long term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility; (pursuant to 6703(B)(3) of The Patient Protection and Affordable Care Act of 2010 according to section 1150B of the Social Security Act.) regarding the alleged theft of clients A, B, F, G and H's personal petty cash funds, by failing to ensure the facility secured a surrogate to assist client D with making informed choices and decisions, by failing to ensure the facility implemented its policy and procedures to</p>	W000104	<p>1. <i>Addendum</i> <i>Area Director will retrain Home Manager and Program Director on the Elder Justice Act and when to file a police report; including money theft. Program Director and Home Manager will retrain staff on the Elder Justice Act and when a police report needs to be filed. Ongoing, the Area Director will review all BDDS reports to ensure that police reports are filed as needed for any incidents, such as money theft that fall under the Elder Justice Act to be reported to the police.</i></p> <p><i>Responsible Party: Area Director, Program Director, Home Manager</i></p> <p>2. See 125 3. See 149 4. See 153 5. See 154 6. See 156 7. See 159 8. See 264 9. See 289</p>	07/10/2014			

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	<p>prevent neglect of client B regarding the implementation of his GBP (Gait Belt Protocol) to prevent injuries from seizures and falls,</p> <p>to ensure an allegation of staff neglect regarding client A and two separate injuries of unknown origin regarding client B were reported to the BDDS (Bureau of Developmental Disabilities Services) within 24 hours, to ensure the investigations of an injury of unknown origin regarding client A, two separate injuries of unknown origin and an allegation of staff neglect regarding client B were thoroughly investigated, and to ensure the investigations of an allegation of staff neglect regarding client A and a fall resulting in a fracture regarding client B were completed within 5 business days of the incidents and by failing to ensure the QIDP (Qualified Intellectual Disabilities Professional) monitored, integrated and coordinated client B's active treatment program by failing to convene the facility's HRC (Human Rights Committee) to review, monitor and approve the use of a wheelchair with a lap belt restraint regarding client B and to ensure client B's ISP (Individual Support Plan)/BSP (Behavior Support Plan) included the use of a lap belt restraint for client B's wheelchair.</p> <p>Findings include:</p>			

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	<p>1. The facility's BDDS reports and investigations were reviewed on 6/4/14 at 1:00 PM. The review indicated the following:</p> <p>-BDDS report dated 5/28/14 indicated, "On 5/27/14 at 1:00 PM, [HM (Home Manager) #1], found that the following clients had petty cash missing when she was getting money ready for them to go out to eat that night [client A] missing \$10.00, [client B] missing \$20.00, [client F] missing \$20.00, [client G] missing \$164.14 and [client H] missing \$70.10." The BDDS report did not indicate documentation of police being notified regarding the missing client funds.</p> <p>-SIIR (Summary of Internal Investigation Report) dated 5/28/14 indicated the conclusion of the investigation was "Petty cash was stolen from the clients in the home." The 5/28/14 SIIR did not determine the person(s) responsible for the theft of clients A, B, F, G and H's personal petty cash. The SIIR did not indicate documentation of police being notified regarding the missing client funds.</p> <p>QIDP #1 was interviewed on 6/5/14 at 1:55 PM. QIDP #1 indicated the police had not been notified regarding the theft</p>			

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	<p>of clients A, B, F, G and H's personal petty cash.</p> <p>AD (Area Director) #1 was interviewed on 6/4/14 at 1:53 PM. AD #1 indicated the police had not been notified regarding the theft of clients A, B, F, G and H's personal petty cash. AD #1 indicated the theft of client funds should be reported to police as indicated in the Elder Justice Act.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility by failing to ensure the facility secured a surrogate to assist client D with making informed choices and decisions. Please see W125.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility by failing to ensure the facility implemented its policy and procedures to prevent neglect of client B regarding the implementation of his GBP to prevent injuries from seizures and falls, to ensure an allegation of staff neglect regarding client A and two separate injuries of unknown origin regarding client B were reported to the BDDS within 24 hours, to ensure the investigations of an injury of unknown origin regarding client A, two separate injuries of unknown origin and an</p>			

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	<p>allegation of staff neglect regarding client B were thoroughly investigated, and to ensure the investigations of an allegation of staff neglect regarding client A and a fall resulting in a fracture regarding client B were completed within 5 business days of the incidents. Please see W149.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility by failing to ensure an allegation of staff neglect regarding client A and two separate injuries of unknown origin regarding client B were reported to the BDDS within 24 hours. Please see W153.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility by failing to ensure the investigations of an injury of unknown origin regarding client A, two separate injuries of unknown origin and an allegation of staff neglect regarding client B were thoroughly investigated. Please see W154.</p> <p>6. The governing body failed to exercise general policy and operating direction over the facility by failing to ensure the investigations of an allegation of staff neglect regarding client A and a fall resulting in a fracture regarding client B were completed within 5 business days of</p>			

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	<p>the incident. Please see W156.</p> <p>7. The governing body failed to exercise general policy and operating direction over the facility by failing to ensure the QIDP monitored, integrated and coordinated client B's active treatment program by failing to convene the facility's HRC to review, monitor and approve the use of a wheelchair with a lap belt restraint regarding client B and to ensure client B's ISP/BSP included the use of a lap belt restraint for client B's wheelchair. Please see W159.</p> <p>8. The governing body failed to exercise general policy and operating direction over the facility by failing to ensure the facility's HRC reviewed, monitored and approved the use of a wheelchair with a lap belt restraint regarding client B. Please see W264.</p> <p>9. The governing body failed to exercise general policy and operating direction over the facility by failing to ensure client B's ISP/BSP included the use of a lap belt restraint for client B's wheelchair. Please see W289.</p> <p>This federal tag relates to complaint #IN00149542.</p> <p>9-3-1(a)</p>			

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 2 of 4 sampled clients (A and B). The facility failed to implement its policy and procedures to prevent neglect of client B regarding the implementation of his GBP (Gait Belt Protocol) to prevent injuries from seizures and falls, to ensure an allegation of staff neglect regarding client A and two separate injuries of unknown origin regarding client B were reported to the BDDS (Bureau of Developmental Disabilities Services) within 24 hours, to ensure the investigations of an injury of unknown origin regarding client A, two separate injuries of unknown origin and an allegation of staff neglect regarding client B were thoroughly investigated, and to ensure the investigations of an allegation of staff neglect regarding client A and a fall resulting in a fracture regarding client B were completed within 5 business days of the incidents.</p> <p>Findings include:</p>	W000122	<p>Program Nurse will retrain staff on Chris' gait belt protocol and all remaining clients in the home with a fall risk protocol. Home Manager will complete active treatment observations 3 times a week for 30 days to ensure implementation. Ongoing, Home Manager will complete active treatment observations per established frequency. Area Director will retrain Program Director on submitting BDDS reports within 24 hours. Program Director and Home Manager will retrain staff on incident reporting and immediately reporting all incidents to the manager. Home Manager will complete documentation review 3 times a week for next 30 days; including DSRs and Behavioral tracking to ensure all reportable incidents have been reported. Area Director will retrain Program Director on completing thorough investigations within 5 business days. Quality Assurance Specialist reviews all investigations submitted to ensure it has been investigated thoroughly. Area Director and Quality Assurance Specialist record all BDDS reports filed and track days of investigation to ensure timely</p>	07/10/2014			

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	<p>1. The facility failed to implement its policy and procedures to prevent neglect of client B regarding the implementation of his GBP to prevent injuries from seizures and falls, to ensure an allegation of staff neglect regarding client A and two separate injuries of unknown origin regarding client B were reported to the BDDS within 24 hours, to ensure the investigations of an injury of unknown origin regarding client A, two separate injuries of unknown origin and an allegation of staff neglect regarding client B were thoroughly investigated, and to ensure the investigations of an allegation of staff neglect regarding client A and a fall resulting in a fracture regarding client B were completed within 5 business days of the incidents. Please see W149.</p> <p>2. The facility failed to ensure an allegation of staff neglect regarding client A and two separate injuries of unknown origin regarding client B were reported to the BDDS within 24 hours. Please see W153.</p> <p>3. The facility failed to ensure the investigations of an injury of unknown origin regarding client A, two separate injuries of unknown origin and an allegation of staff neglect regarding client B were thoroughly investigated. Please</p>		<p>completion. Responsible Party: Program Nurse, Home Manager, Area Director, Program Director, Quality Assurance Specialist. 1. See 149 <i>Addendum:</i> 1. All direct care staff have been trained on Client B gait belt protocol as well as all fall risk protocols for any other consumers in the home that have them. Home Manager will complete Active treatment observations in the home a minimum of 3 times per week for 30 days to ensure implementation of Client B's gait belt protocol as well as all consumer fall protocols are being implemented as written. Ongoing the HM will complete active treatment observations a minimum of twice weekly to ensure that Client B's gait belt protocol as well as all consumer fall protocols are being implemented as written. 2. All Direct care staff will be receive retraining on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents. The Home Manager will receive retraining on documentation review including reviewing all consumer Daily support records, behavior tracking and narrative notes to ensure all incidents that have been documented have</p>	

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	<p>see W154.</p> <p>4. The facility failed to ensure the investigations of an allegation of staff neglect regarding client A and a fall resulting in a fracture regarding client B were completed within 5 business days of the incident. Please see W156.</p> <p>This federal tag relates to complaint #IN00149542.</p> <p>9-3-2(a)</p>		<p><i>been reported to the Program Director so reports can be made to the Bureau of Developmental Disability Services and investigations can be completed as needed.</i></p> <p><i>Ongoing, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of twice weekly for 30 days to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines. After the 30 days, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of once per week to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines</i></p> <p>3. <i>The Program Director will receive retraining on investigation requirements to include what requires an investigation, what documents should be reviewed, who should be interviewed, when the investigation is to be completed, as well as how to write the report of findings. As soon as the retraining has been completed the Area Director and/or the Quality Assurance</i></p>		

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			<p><i>Specialist will complete a daily follow-up regarding any outstanding investigations to be completed by this Program Director.</i></p> <p><i>The Area Director will take corrective action if needed when investigation requirements have not been met. 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 Program Director and necessary changes will be made.</i></p> <p><i>4. 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. As soon as the retraining has been completed the Area Director and/or the Quality Assurance Specialist will complete a daily follow-up regarding any outstanding investigations to be completed by this Program Director</i></p>	

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			<p><i>The Area Director will take corrective action if needed when investigation requirements have not been met. 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 Program Director and necessary changes will be made.</i></p> <p><i>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</i></p> <p><i>2. See 153 Addendum</i></p> <p><i>All Direct care staff will be receive retraining on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents.</i></p> <p><i>The Home Manager will receive retraining on documentation review including reviewing all consumer Daily support records, behavior tracking and narrative notes to ensure all incidents that</i></p>	

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			<p><i>have been documented have been reported to the Program Director so reports can be made to the Bureau of Developmental Disability Services and investigations can be completed as needed.</i></p> <p><i>Ongoing, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of twice weekly for 30 days to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines. After the 30 days, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of once per week to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines</i></p> <p><i>Responsible Party: Home Manager, Program Director, Area Director</i></p> <p><i>3. See 154</i></p> <p><i>Addendum:</i></p> <p><i>The Program Director will receive retraining on investigation requirements to include what requires an investigation, what documents should be reviewed, who should be interviewed, when</i></p>	

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			<p><i>the investigation is to be completed, as well as how to write the report of findings. As soon as the retraining has been completed the Area Director and/or the Quality Assurance Specialist will complete a daily follow-up regarding any outstanding investigations to be completed by this Program Director.</i></p> <p><i>The Area Director will take corrective action if needed when investigation requirements have not been met. 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 Program Director and necessary changes will be made.</i></p> <p><i>Responsible Staff: Program Director, Area Director, Quality Assurance Specialist</i></p> <p><i>4. See 156</i></p> <p><i>Addendum:</i></p> <p><i>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</i></p>	

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W000125	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		<p><i>interviewed so that a thorough investigation can be completed. As soon as the retraining has been completed the Area Director and/or the Quality Assurance Specialist will complete a daily follow-up regarding any outstanding investigations to be completed by this Program Director</i></p> <p><i>The Area Director will take corrective action if needed when investigation requirements have not been met. 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 Program Director and necessary changes will be made.</i></p> <p><i>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</i></p>	

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	<p>citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview for 1 of 4 sampled clients (D), the facility failed to secure a surrogate to assist client D with making informed choices and decisions.</p> <p>Findings include:</p> <p>Client D's record was reviewed on 6/5/14 at 11:20 AM. Client D's ISP (Individual Support Plan) dated 5/2/14 indicated one of client D's three siblings was her guardian. Client D's ISP indicated client D's diagnoses included but were not limited to intermittent explosive disorder, depression, legally blind and mild intellectual disorder. Client D's ISP indicated, "List areas that, [client D], can provide informed consent: [Client D] has not demonstrated the skills to give informed consent in the areas of photograph consent, authorization to assist in financial affairs, release of information, understanding the implications of the endangered adults act, resident rights, dietary needs, psychotropic medication, IDT (Interdisciplinary Team) membership, behavior assessment, house rules, medical treatment needs, supervision level, grievance policy and procedures,</p>	W000125	<p>Potential guardian for client D has been identified sincethe recent passing of her guardian in the last 30 days. Program Director willconvene IDT with her sisters to discuss and document plan and timeline forofficially obtaining guardianship for client D. Responsible Party: Program Director</p> <p><i>Addendum: All other consumers in the home have guardians in place. Client D's sister has agreed to become her guardian. Client D's sister has filed the necessary paperwork but a court date has not been set yet.</i></p> <p><i>Indiana Mentor staff will continue to work with Client D's family to assist in any way in the guardianship process.</i></p> <p><i>The Program Director will receive retraining to include ensuring all consumers that are not able to fully make informed decisions on their own regarding healthcare needs and finances have a legal representative that can assist with making decisions on their behalf. Ongoing, the Program Director will ensure that upon admission and ongoing as circumstances change, all consumers that are not able to fully make informed decisions on their own have a legal representative that can assist in making decisions on their behalf. When reviewing consumers Individual Support</i></p>	07/10/2014

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W000149	<p>nor human rights committee membership."</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 6/5/14 at 1:00 PM. QIDP #1 stated, "[Client D's] guardian was her sister. [Client D's] sister passed away and now her other two sisters are both wanting to be her, [client D's], guardian. [Client D] is trying to decide which of her two sisters she wants to be her guardian." QIDP #1 indicated the facility was in the process of working with client D and her sisters to establish guardianship for client D. When asked how long client D had been without a guardian, QIDP #1 stated, "Her, [client D's], sister died about a month ago. I don't know the exact date off the top of my head but it's been within the last month." QIDP #1 indicated client D needed a guardian.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 2 of 4 sampled clients (A</p>	W000149	<p><i>Plans, the Area Director will review if all consumers that are not able to fully make decisions on their own regarding healthcare or finances have legal representation and if not will follow up with the Program Director to ensure the process is started to obtain legal representation.</i></p> <p><i>Responsible Party: Home Manager, Program Director, Area Director</i></p> <p>Program Nurse will retrain staff on Chris' gait belt protocol and all remaining clients in the home with</p>	07/10/2014

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	<p>and B), the facility failed to implement its policy and procedures to prevent neglect of client B regarding the implementation of his GBP (Gait Belt Protocol) to prevent injuries from seizures and falls, to ensure an allegation of staff neglect regarding client A and two separate injuries of unknown origin regarding client B were reported to the BDDS (Bureau of Developmental Disabilities Services) within 24 hours, to ensure the investigations of an injury of unknown origin regarding client A, two separate injuries of unknown origin and an allegation of staff neglect regarding client B were thoroughly investigated, and to ensure the investigations of an allegation of staff neglect regarding client A and a fall resulting in a fracture regarding client B were completed within 5 business days of the incidents.</p> <p>Findings include:</p> <p>The facility's BDDS reports and investigations were reviewed on 6/4/14 at 1:00 PM. The review indicated the following:</p> <p>1. BDDS report dated 1/30/14 indicated, "When staff woke up [client A] on 1/30/14 they observed [client A] with a right upper and lower lip swollen (sic), laceration to inside upper lip and scab to</p>		<p>a fall risk protocol Home Manager will complete active treatment observations 3 times a week for 30 days to ensure implementation. Ongoing, Home Manager will complete active treatment observations per established frequency. Area Director will retrain Program Director on submitting BDDS reports within 24 hours. Program Director and Home Manager will retrain staff on incident reporting and immediately reporting all incidents to the manager. Home Manager will complete documentation review 3 times a week for next 30 days; including DSRs and Behavioral tracking to ensure all reportable incidents have been reported. Area Director will retrain Program Director on completing thorough investigations within 5 business days. Quality Assurance Specialist reviews all investigations submitted to ensure it has been investigated thoroughly. Area Director and Quality Assurance Specialist record all BDDs reports filed and track days of investigation to ensure timely completion. Responsible Party: Program Nurse, Home Manager, Area Director, Program Director, Quality Assurance Specialist.</p> <p><i>Addendum:</i></p> <p>1. All direct care staff have been trained on Client B gait belt protocol as well as all fall risk protocols for any other consumers in the home that have</p>	

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	<p>left lower lip, 4 inch by 1 inch dark purple bruise to (his) right inner upper arm, and a 3 inch by 1 inch dark purple bruise to (his) right knee."</p> <p>-Summary of Internal Investigation Report (SIIR) dated 2/6/14 regarding client A's 1/30/14 injuries of unknown origin indicated, "On 1/30/14 day staff woke [client A] up to find bruising. [Client A] stated that [staff #5] and [staff #6] had physical aggression (sic) when asked the first time. [Client A] stated that [staff #5] has physical aggression (sic) when asked every time since. Both staff, [staff #5 and staff #6], suspended pending investigation." The SIIR dated 2/6/14 indicated staff #5, staff #6, staff #7, client A and client A's guardian had been interviewed. The SIIR dated 2/6/14, amended 2/11/14, amended 2/14/14 indicated the facility had completed additional interviews with staff #7, staff #8, staff #9, staff #10, RN #1 and clients D and E. The initial SIIR dated 2/6/14 did not indicate documentation of interviews being conducted with staff #7, staff #8, staff #9, staff #10, RN #1 and clients D and E.</p> <p>2. BDDS report dated 2/25/14 indicated, "Staff, [staff #7], reported to her home manager on 2/20/14 that on 2/14/14 when her and another staff got back to the</p>		<p><i>them. Home Manager will complete Active treatment observations in the home a minimum of 3 times per week for 30 days to ensure implementation of Client B's gait belt protocol as well as all consumer fall protocols are being implemented as written. Ongoing the HM will complete active treatment observations a minimum of twice weekly to ensure that Client B's gait belt protocol as well as all consumer fall protocols are being implemented as written.</i></p> <p><i>2. All Direct care staff will be receive retraining on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents. The Home Manager will receive retraining on documentation review including reviewing all consumer Daily support records, behavior tracking and narrative notes to ensure all incidents that have been documented have been reported to the Program Director so reports can be made to the Bureau of Developmental Disability Services and investigations can be completed as needed.</i></p> <p><i>Ongoing, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of twice weekly for 30 days to</i></p>	

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	<p>home from evening transport that, [staff #11], was asleep on the couch. [Client A] was in the house with her while the other two staff were picking up the other clients from day program. Staff that was said to sleeping suspended pending investigation as well as staff that reported neglect late."</p> <p>-SIIR dated 2/28/14 regarding the 2/20/14 reported allegation of staff neglect for client A was not completed within 5 business days of the 2/20/14 reported allegation of neglect.</p> <p>3. BDDS report dated 5/18/14 indicated, "[Client B] had a seizure and fell on 5/17/14. It was reported to the on call home manager on 5/18/14 because [client B] was in foot pain (sic) and limping. Staff advised to take the client to the immediate care facility in which x-rays were taken. X-rays revealed a fracture of his left foot."</p> <p>-SIIR dated 5/20/14 indicated, "[Client B] had a seizure on 5/17/14 that lasted for 2 minutes resulting in a fall. No injuries were found at the time of the incident. [Client B] woke up the next morning with a swollen right foot and was limping. [Client B] was taken to [emergency care facility] where his foot was x-rayed and his 2-5 metatarsals were</p>		<p><i>ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines. After the 30 days, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of once per week to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines</i></p> <p>3. <i>The Program Director will receive retraining on investigation requirements to include what requires an investigation, what documents should be reviewed, who should be interviewed, when the investigation is to be completed, as well as how to write the report of findings. As soon as the retraining has been completed the Area Director and/or the Quality Assurance Specialist will complete a daily follow-up regarding any outstanding investigations to be completed by this Program Director. The Area Director will take corrective action if needed when investigation requirements have not been met. All future incident reports will be reviewed by the Area Director and Regional</i></p>				

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	<p>reported as broken. [Client B] woke up on 5/19/14 with a swollen and bruised left wrist. [Client B] was taken to [hospital] to have his wrist x-rayed and there were no signs of fracture or a broken wrist." The SIIR dated 5/20/14 included a statement from staff #1, who discovered and reported client B's swollen foot on 5/18/14, which indicated, "[Client B's] wrist was not swollen on 5/18/14 at all or I would have reported it." The 5/20/14 SIIR did not indicate documentation of review of client B's GBP, if client B's GBP had been appropriately implemented by facility staff regarding client B's 5/17/14 fall and how client B sustained a swollen and bruised left wrist on 5/19/14. The 5/20/14 SIIR indicated the facility administrator reviewed the SIIR on 5/28/14.</p> <p>The BDDS and investigation review did not indicate documentation of client B's 3/27/14 swollen index finger being reported to BDDS or investigated as an injury of unknown origin.</p> <p>Client B's SDR (Seizure Description Record) was reviewed on 6/4/14 at 6:00 PM. Client B's SDR dated 4 (sic) /17/14 indicated, "[Client B] was talking to his mother on the phone and he walked down the hallway of his bedroom. Staff, [staff #2, staff #3 and staff #4], heard a thud</p>		<p><i>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 Program Director and necessary changes will be made.</i></p> <p><i>4. 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. As soon as the retraining has been completed the Area Director and/or the Quality Assurance Specialist will complete a daily follow-up regarding any outstanding investigations to be completed by this Program Director</i></p> <p><i>The Area Director will take corrective action if needed when investigation requirements have not been met. 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</i></p>	

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	<p>and ran to the hall where [client B] was on the floor. [Client B] was stiff then started convulsing. Both arms, legs and whole body was (sic) jerking. This lasted about 45 seconds but he didn't start talking for a minute and 30 seconds (total) after he stopped. [Client B] had a scrape mark on his right elbow and it looks like his tooth hit his lip on the right side of his mouth. A very small amount of blood came from his lip. The skin did not break on the elbow. [Client B] was helped into his bedroom where he was checked over and his elbow and lip cleaned."</p> <p>Staff #2 was interviewed on 6/4/14 at 5:50 PM. Staff #2 indicated she was working on 5/17/14 during client B's seizure/fall. Staff #2 indicated staff #3 and staff #4 were also working during the 5/17/14 incident. Staff #2 stated, "I was in the kitchen and [client B] was talking on the phone to his mother. We heard a noise and found [client B] on the floor in the hallway." Staff #2 indicated client B was walking in the hallway without staff stand by assistance.</p> <p>Staff #3 was interviewed on 6/4/14 at 6:00 PM. Staff #3 indicated she had been working on 5/17/14 when client B had a seizure and fell. Staff #3 indicated she had been in the group home's kitchen</p>		<p><i>Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</i></p> <p><i>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</i></p>	

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	<p>with staff #2 while staff #4 was in the group home's medication administration area. Staff #3 indicated client B was walking in the hallway while talking on the phone to his mother. Staff #3 indicated she and staff #2 heard a noise and went to check on client B who was found lying on the floor having a seizure in the hallway. Staff #3 indicated client B was walking in the hallway without staff stand by assistance.</p> <p>Observations were conducted at the group home on 6/4/14 from 5:15 PM through 6:15 PM. The group home's kitchen area was separated from the hallway leading to client B's bedroom by a wall. There was not a clear line of sight from the kitchen to hallway leading to client B's bedroom.</p> <p>Client B's record was reviewed on 6/5/14 at 10:00 AM. Client B's GBP, undated indicated, "[Client B's] podiatrist has released him to begin to bear (weight) on the right leg. [Client B] is to wear the boot at all times along with a gait belt. The purpose of the gait belt is to have something to hold on to in the event he would fall or start to sit down on the ground. Using the gait belt, the person assisting with ambulation can use it to lower him to the ground preventing a fall. Remember, he has osteoporosis which</p>			

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	<p>caused softening of the bones and any injury could cause a fracture." Client B's GBP, undated indicated, "[Client B] is always to wear the gait belt when he is up and ambulating. Staff ambulating with him is to have a hold of the gait belt at all times."</p> <p>Client B's 3/27/14 HCC/MHR (Health Care Coordination/Monthly Health Review) form dated April 2014 indicated, "3/27/14 seen by [medical facility] for evaluation of swollen left index finger with no fracture noted...."</p> <p>RN (Registered Nurse) #1 was interviewed on 6/5/14 at 1:04 PM. RN #1 indicated she was the facility nurse for client B's group home. RN #1 indicated she had completed client B's GBP. RN #1 indicated the date of the client B's GBP should be 2/2014. RN #1 indicated client B had broken his foot in July 2013 and had a cast through December 2013. RN #1 indicated client B's diagnoses included osteoporosis. RN #1 indicated facility staff should have provided client B with stand by assistance during ambulation on 5/17/14. RN #1 indicated she had been notified on 5/18/14 regarding client B's swollen foot and advised staff to take client B to a local medical care facility to be examined. RN #1 indicated she was not aware of an injury to client B's left wrist until notified by facility staff on</p>			
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	<p>5/19/14.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 6/5/14 at 1:55 PM. QIDP #1 indicated she had completed the 5/20/14 SIIR regarding client B's 5/17/14 seizure/fall. QIDP #1 indicated the 5/20/14 investigation did not include a review of client B's GBP to determine if facility staff had implemented client B's care plan appropriately. QIDP #1 indicated client B should have had stand by assistance from staff on 5/17/14. QIDP #1 indicated client B's 3/27/14 swollen finger was discovered at the day services. QIDP #1 indicated there was not a BDDS report or investigation available for review regarding client B's 3/27/14 injury of unknown origin.</p> <p>AD (Area Director) #1 was interviewed on 6/4/14 at 1:53 PM. AD #1 indicated the facility's abuse and neglect policy should be implemented. AD #1 indicated allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be reported to BDDS within 24 hours of knowledge of the incident, thoroughly investigated and the results of the investigation should be reported to the administrator within 5 business days of the incident.</p>			
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	<p>The facility's policy and procedures were reviewed on 6/6/14 at 1:15 PM. The facility's April 2011 policy and procedure entitled Quality Risk Management indicated the following:</p> <p>-"Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed."</p> <p>-"Inadequate staff support for an individual, including inadequate supervision, with the potential for; (1.) Significant harm or injury to an individual; or (2.) Death of an individual."</p> <p>-"An initial report regarding an incident (allegation of abuse, neglect, mistreatment, exploitation, injury of unknown origin) shall be submitted within twenty four (24) hour of; (a) the occurrence of the incident; or (b) the reported becoming aware of or receiving information about an incident."</p> <p>-"Indiana Mentor is committed to completing a thorough investigation for</p>			

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W000153	<p>any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee. (1.) Investigation findings will be submitted to the AD for review and development of further recommendations as needed within 5 days of the incident."</p> <p>This federal tag relates to complaint #IN00149542.</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 27 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to ensure an allegation of staff neglect regarding client A and two separate injuries of unknown origin regarding client B were reported to the BDDS (Bureau of Developmental Disabilities Services) within 24 hours.</p> <p>Findings include:  The facility's BDDS reports and</p>	W000153	<p>Area Director will retrain Program Director on submittingBDDS reports within 24 hoursProgram Director and Home Manager will retrain staff on incidentreporting and immediately reporting all incidents to the manager.Home Manager will complete documentation review 3 times aweek for next 30 days; including DSRs and Behavioral tracking to ensure allreportable incidents have been reported.Responsible Party: Area Director, Program Director, HomeManagerAddendum All Direct care staff will be receive</p>	07/10/2014			

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	<p>investigations were reviewed on 6/4/14 at 1:00 PM. The review indicated the following:</p> <p>-BDDS report dated 2/25/14 indicated, "Staff, [staff #7], reported to her home manager on 2/20/14 that on 2/14/14 when her and another staff got back to the home from evening transport that, [staff #11], was asleep on the couch. [Client A] was in the house with her while the other two staff were picking up the other clients from day program. Staff that was said to sleeping suspended pending investigation as well as staff that reported neglect late." The review indicated the 2/20/14 reported allegation of staff neglect was reported to the BDDS on 2/25/14.</p> <p>Client B's record was reviewed on 6/5/14 at 10:00 AM. Client B's 3/27/14 HCC/MHR (Health Care Coordination/Monthly Health Review) form dated April 2014 indicated, "3/27/14 seen by [medical facility] for evaluation of swollen left index finger with no fracture noted...."</p> <p>The BDDS and investigation review did not indicate documentation of client B's 3/27/14 swollen index finger being reported to BDDS.</p>		<p><i>retraining on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents. The Home Manager will receive retraining on documentation review including reviewing all consumer Daily support records, behavior tracking and narrative notes to ensure all incidents that have been documented have been reported to the Program Director so reports can be made to the Bureau of Developmental Disability Services and investigations can be completed as needed. Ongoing, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of twice weekly for 30 days to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines. After the 30 days, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of once per week to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director</i></p>				

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W000154	<p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 6/5/14 at 1:55 PM. QIDP #1 indicated client B's 3/27/14 swollen finger was discovered at the day services. QIDP #1 indicated there was not a BDDS report or investigation available for review regarding client B's 3/27/14 injury of unknown origin.</p> <p>AD (Area Director) #1 was interviewed on 6/4/14 at 1:53 PM. AD #1 indicated allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be reported to BDDS within 24 hours of knowledge of the incident.</p> <p>This federal tag relates to complaint #IN00149542.</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 4 of 27 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to ensure the investigations of an injury of unknown origin regarding</p>	W000154	<p><i>within the designated reporting guidelines Responsible Party: Home Manager, Program Director, Area Director</i></p> <p>Area Director will retrain Program Director on completing thorough investigations within 5 business days. Quality Assurance Specialist reviews all investigations submitted to ensure it has been investigated thoroughly. Area Director and</p>	07/10/2014

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	<p>client A, two separate injuries of unknown origin and an allegation of staff neglect regarding client B were thoroughly investigated.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 6/4/14 at 1:00 PM. The review indicated the following:</p> <p>1. BDDS report dated 1/30/14 indicated, "When staff woke up [client A] on 1/30/14 they observed [client A] with a right upper and lower lip swollen (sic), laceration to inside upper lip and scab to left lower lip, 4 inch by 1 inch dark purple bruise to (his) right inner upper arm, and a 3 inch by 1 inch dark purple bruise to (his) right knee."</p> <p>-Summary of Internal Investigation Report (SIIR) dated 2/6/14 regarding client A's 1/30/14 injuries of unknown origin indicated, "On 1/30/14 day staff woke [client A] up to find bruising. [Client A] stated that [staff #5] and [staff #6] had physical aggression (sic) when asked the first time. [Client A] stated that [staff #5] has physical aggression (sic) when asked every time since. Both staff, [staff #5 and staff #6], suspended</p>		<p>Quality Assurance Specialist record all BDDs reports filed and track days of investigation to ensure timely completion. Responsible Party: Area Director, Program Director, Quality Assurance Specialist</p> <p><i>Addendum:</i> The Program Director will receive retraining on investigation requirements to include what requires an investigation, what documents should be reviewed, who should be interviewed, when the investigation is to be completed, as well as how to write the report of findings. As soon as the retraining has been completed the Area Director and/or the Quality Assurance Specialist will complete a daily follow-up regarding any outstanding investigations to be completed by this Program Director.</p> <p>The Area Director will take corrective action if needed when investigation requirements have not been met. 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>	

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	<p>pending investigation." The SIIR dated 2/6/14 indicated staff #5, staff #6, staff #7, client A and client A's guardian had been interviewed. The SIIR dated 2/6/14, amended 2/11/14, amended 2/14/14 indicated the facility had completed additional interviews with staff #7, staff #8, staff #9, staff #10, RN #1 and clients D and E. The initial SIIR dated 2/6/14 did not indicate documentation of interviews being conducted with staff #7, staff #8, staff #9, staff #10, RN #1 and clients D and E.</p> <p>2. BDDS report dated 5/18/14 indicated, "[Client B] had a seizure and fell on 5/17/14. It was reported to the on call home manager on 5/18/14 because [client B] was in foot pain (sic) and limping. Staff advised to take the client to the immediate care facility in which x-rays were taken. X-rays revealed a fracture of his left foot."</p> <p>-SIIR dated 5/20/14 indicated, "[Client B] had a seizure on 5/17/14 that lasted for 2 minutes resulting in a fall. No injuries were found at the time of the incident. [Client B] woke up the next morning with a swollen right foot and was limping. [Client B] was taken to [emergency care facility] where his foot was x-rayed and his 2-5 metatarsals were reported as broken. [Client B] woke up</p>		<p><i>Program Director and necessary changes will be made.</i></p> <p><i>Responsible Staff: Program Director, Area Director, Quality Assurance Specialist</i></p>				

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	<p>on 5/19/14 with a swollen and bruised left wrist. [Client B] was taken to [hospital] to have his wrist x-rayed and there were no signs of fracture or a broken wrist." The SIIR dated 5/20/14 included a statement from staff #1, who discovered and reported client B's swollen foot on 5/18/14, which indicated, "[Client B's] wrist was not swollen on 5/18/14 at all or I would have reported it." The 5/20/14 SIIR did not indicate documentation of review of client B's GBP, if client B's GBP had been appropriately implemented by facility staff regarding client B's 5/17/14 fall and how client B sustained a swollen and bruised left wrist on 5/19/14.</p> <p>The BDDS and investigation review completed on 6/4/14 at 1:00 PM, did not indicate documentation of client B's 3/27/14 swollen index finger being investigated as an injury of unknown origin.</p> <p>Client B's SDR (Seizure Description Record) was reviewed on 6/4/14 at 6:00 PM. Client B's SDR dated 4 (sic) /17/14 indicated, "[Client B] was talking to his mother on the phone and he walked down the hallway of his bedroom. Staff, [staff #2, staff #3 and staff #4], heard a thud and ran to the hall where [client B] was on the floor. [Client B] was stiff then</p>			

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	<p>started convulsing. Both arms, legs and whole body was (sic) jerking. This lasted about 45 seconds but he didn't start talking for a minute and 30 seconds (total) after he stopped. [Client B] had a scrape mark on his right elbow and it looks like his tooth hit his lip on the right side of his mouth. A very small amount of blood came from his lip. The skin did not break on the elbow. [Client B] was helped into his bedroom where he was checked over and his elbow and lip cleaned."</p> <p>Staff #2 was interviewed on 6/4/14 at 5:50 PM. Staff #2 indicated she was working on 5/17/14 during client B's seizure/fall. Staff #2 indicated staff #3 and staff #4 were also working during the 5/17/14 incident. Staff #2 stated, "I was in the kitchen and [client B] was talking on the phone to his mother. We heard a noise and found [client B] on the floor in the hallway." Staff #2 indicated client B was walking in the hallway without staff stand by assistance.</p> <p>Staff #3 was interviewed on 6/4/14 at 6:00 PM. Staff #3 indicated she had been working on 5/17/14 when client B had a seizure and fell. Staff #3 indicated she had been in the group home's kitchen with staff #2 while staff #4 was in the group home's medication administration</p>			

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	<p>area. Staff #3 indicated client B was walking in the hallway while talking on the phone to his mother. Staff #3 indicated she and staff #2 heard a noise and went to check on client B who was found lying on the floor having a seizure in the hallway. Staff #3 indicated client B was walking in the hallway without staff stand by assistance.</p> <p>Observations were conducted at the group home on 6/4/14 from 5:15 PM through 6:15 PM. The group home's kitchen area was separated from the hallway leading to client B's bedroom by a wall. There was not a clear line of sight from the kitchen to hallway leading to client B's bedroom.</p> <p>Client B's record was reviewed on 6/5/14 at 10:00 AM. Client B's GBP, undated indicated, "[Client B's] podiatrist has released him to begin to bear (weight) on the right leg. [Client B] is to wear the boot at all times along with a gait belt. The purpose of the gait belt is to have something to hold on to in the event he would fall or start to sit down on the ground. Using the gait belt, the person assisting with ambulation can use it to lower him to the ground preventing a fall. Remember, he has osteoporosis which caused softening of the bones and any injury could cause a fracture." Client B's</p>			

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	<p>GBP, undated indicated, "[Client B] is always to wear the gait belt when he is up and ambulating. staff ambulating with him is to have a hold of the gait belt at all times."</p> <p>Client B's 3/27/14 HCC/MHR (Health Care Coordination/Monthly Health Review) form dated April 2014 indicated, "3/27/14 seen by [medical facility] for evaluation of swollen left index finger with no fracture noted...."</p> <p>RN (Registered Nurse) #1 was interviewed on 6/5/14 at 1:04 PM. RN #1 indicated she was the facility nurse for client B's group home. RN #1 indicated she had completed client B's GBP. RN #1 indicated the date of the client B's GBP should be 2/2014. RN #1 indicated client B had broken his foot in July 2013 and had a cast through December 2013. RN #1 indicated client B's diagnoses included osteoporosis. RN #1 indicated facility staff should have provided client B with stand by assistance during ambulation on 5/17/14. RN #1 indicated she had been notified on 5/18/14 regarding client B's swollen foot and advised staff to take client B to a local medical care facility to be examined. RN #1 indicated she was not aware of an injury to client B's left wrist until notified by facility staff on 5/19/14.</p>			

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W000156	<p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 6/5/14 at 1:55 PM. QIDP #1 indicated she had completed the 5/20/14 SIIR regarding client B's 5/17/14 seizure/fall. QIDP #1 indicated the 5/20/14 investigation did not include a review of client B's GBP to determine if facility staff had implemented client B's care plan appropriately. QIDP #1 indicated client B should have had stand by assistance from staff on 5/17/14. QIDP #1 indicated client B's 3/27/14 swollen finger was discovered at the day services. QIDP #1 indicated there was not an investigation available for review regarding client B's 3/27/14 injury of unknown origin.</p> <p>AD (Area Director) #1 was interviewed on 6/4/14 at 1:53 PM. AD #1 indicated allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be thoroughly investigated</p> <p>This federal tag relates to complaint #IN00149542.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated</p>						

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	<p>representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview for 2 of 27 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to ensure the investigations of an allegation of staff neglect regarding client A and a fall resulting in a fracture regarding client B were completed within 5 business days of the incident.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 6/4/14 at 1:00 PM. The review indicated the following:</p> <p>1. BDDS report dated 2/25/14 indicated, "Staff, [staff #7], reported to her home manager on 2/20/14 that on 2/14/14 when her and another staff got back to the home from evening transport that, [staff #11], was asleep on the couch. [Client A] was in the house with her while the other two staff were picking up the other clients from day program. Staff that was said to sleeping suspended pending investigation as well as staff that reported neglect late."</p>	W000156	<p>Area Director will retrain Program Director on completing thorough investigations within 5 business days. Quality Assurance Specialist reviews all investigations submitted to ensure it has been investigated thoroughly. Area Director and Quality Assurance Specialist record all BDDs reports filed and track days of investigation to ensure timely completion. Responsible Party: Area Director, Program Director, Quality Assurance Specialist</p> <p><i>Addendum: 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. As soon as the retraining has been completed the Area Director and/or the Quality Assurance Specialist will complete a daily follow-up regarding any outstanding investigations to be completed by this Program Director. The Area Director will take corrective action if needed when investigation requirements have not been met. All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to</i></p>	07/10/2014

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	<p>-SIIR dated 2/28/14 regarding the 2/20/14 reported allegation of staff neglect for client A was not completed within 5 business days of the 2/20/14 reported allegation of neglect.</p> <p>2. BDDS report dated 5/18/14 indicated, "[Client B] had a seizure and fell on 5/17/14. It was reported to the on call home manager on 5/18/14 because [client B] was in foot pain (sic) and limping. Staff advised to take the client to the immediate care facility in which x-rays were taken. X-rays revealed a fracture of his left foot."</p> <p>-SIIR dated 5/20/14 indicated, "[Client B] had a seizure on 5/17/14 that lasted for 2 minutes resulting in a fall. No injuries were found at the time of the incident. [Client B] woke up the next morning with a swollen right foot and was limping. [Client B] was taken to [emergency care facility] where his foot was x-rayed and his 2-5 metatarsals were reported as broken."</p> <p>The 5/20/14 SIIR indicated the facility administrator reviewed the SIIR on 5/28/14.</p> <p>AD (Area Director) #1 was interviewed on 6/4/14 at 1:53 PM. AD #1 indicated the results of investigations of allegations of abuse, neglect,</p>		<p><i>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 Program Director and necessary changes will be made.</i></p> <p><i>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</i></p>	

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W000159	<p>mistreatment, exploitation and injuries of unknown origin should be reported to the administrator within 5 business days of the incident.</p> <p>This federal tag relates to complaint #IN00149542.</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 4 sampled clients (B), the QIDP (Qualified Intellectual Disabilities Professional) failed to monitor, integrate and coordinate client B's active treatment program by failing to convene the facility's HRC (Human Rights Committee) to review, monitor and approve the use of a wheelchair with a lap belt restraint regarding client B and to ensure client B's ISP (Individual Support Plan)/BSP (Behavior Support Plan) included the use of a lap belt restraint for client B's wheelchair.</p> <p>Findings include:</p> <p>1. The QIDP failed to monitor, integrate</p>	W000159	<p>Area Director will retrain Program Director on obtaining HRC approval for restrictions to clients. Program Director will obtain HRC approval for the wheelchair belt that causes restriction for client B. Program Director will update programming to include temporary wheelchair restriction for client B; including, BSP, ISP and Risk Plan. Program Director will review the programming for all clients in the home to ensure any restriction has both HRC and guardian approval. Responsible Party: Area Director, Program Director</p> <p><i>Addendum:</i> 1,2 The seatbelt restriction for Client B's wheelchair has been added into Client B's behavior plan, ISP and RMAP. The restrictive use of the seatbelt has</p>	07/10/2014

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W000264	<p>and coordinate client B's active treatment program by failing to convene the facility's HRC to review, monitor and approve the use of a wheelchair with a lap belt restraint regarding client B. Please see W264.</p> <p>2. The QIDP failed to monitor, integrate and coordinate client B's active treatment program by failing to ensure client B's ISP/BSP included the use of a lap belt restraint for client B's wheelchair. Please see W289.</p> <p>This federal tag relates to complaint #IN00149542.</p> <p>9-3-3(a)</p> <p>483.440(f)(3)(iii) PROGRAM MONITORING &amp; CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious</p>		<p><i>been approved by Client B's guardian and has also received HRC approval.</i></p> <p><i>The Program Director will receive retraining to ensure that all restrictions in place for each client are identified and outlined in each client's Behavior Support Plan as needed. The Program Director will ensure that all targeted behaviors, interventions for behaviors, all restrictive practices and psychotropic medication titration plans are included in all consumers Behavior Support Plans as needed and appropriate approvals by Guardian and HRC are obtained.</i></p> <p><i>For the next 3 months, the Area Director will review all of this Program Director's Behavior Support Plans to ensure all targeted behaviors, interventions for behaviors, all restrictive practices and psychotropic medication titration plans are included in all consumers Behavior Support Plans as needed and appropriate approvals by Guardian and HRC are obtained.</i></p> <p><i>Responsible Party: Program Director, Area Director, Behavior Consultant</i></p>				

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	<p>stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (B) with restrictive programs, the facility's HRC (Human Rights Committee) failed to review, monitor and approve the use of a wheelchair with a lap belt restraint regarding client B.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 6/4/14 from 5:15 PM through 6:15 PM. Client B was observed in the group home throughout the observation period. Client B was seated in a wheelchair with a lap belt secured across his pelvis throughout the observation period.</p> <p>Observations were conducted at the group home on 6/5/14 from 5:45 AM through 7:15 AM. Client B was observed in the group home throughout the observation period. Client B was seated in a wheelchair with a lap belt secured across his pelvis throughout the observation period.</p> <p>Client B's record was reviewed on 6/5/14 at 10:00 AM. Client B's record did not indicate documentation of HRC review</p>	W000264	<p>Area Director will retrain Program Director on obtaining HRC approval for restrictions to clients. Program Director will obtain HRC approval for the wheelchair belt that causes restriction for client B. Program Director will review the programming for all clients in the home to ensure any restriction has both HRC and guardian approval. Responsible Party: Area Director, Program Director</p> <p><i>Addendum:</i> The seatbelt restriction for Client B's wheelchair has been added into Client B's behavior plan, ISP and RMAP. The restrictive use of the seatbelt has been approved by Client B's guardian and has also received HRC approval. The Program Director will receive retraining to ensure that all restrictions in place for each client are identified and outlined in each client's Behavior Support Plan as needed. The Program Director will ensure that all targeted behaviors, interventions for behaviors, all restrictive practices and psychotropic medication titration plans are included in all consumers Behavior Support Plans as needed and appropriate approvals by Guardian and HRC are obtained. For the next 3 months, the Area Director will review all of this</p>	07/10/2014

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W000289	<p>or approval regarding the use of a wheel chair lap belt.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 6/5/14 at 1:55 PM. QIDP #1 indicated client B was not able to independently release the lap belt on his wheelchair. QIDP #1 indicated client B's wheelchair had a lap belt to assist client B to remain non weight bearing on his foot which was fractured. QIDP #1 indicated client B's wheelchair lap belt was modified in order to prevent client B from being able to release the belt. QIDP #1 indicated there was not documentation of HRC review or approval for the use of the client B's lap belt as a restraint.</p> <p>This federal tag relates to complaint #IN00149542.</p> <p>9-3-4(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on observation, record review and interview for 1 of 4 sampled clients (B),</p>	W000289	<p><i>Program Director's Behavior Support Plans to ensure all targeted behaviors, interventions for behaviors, all restrictive practices and psychotropic medication titration plans are included in all consumers Behavior Support Plans as needed and appropriate approvals by Guardian and HRC are obtained.</i></p> <p><i>Responsible Party: Program Director, Area Director, Behavior Consultant</i></p> <p>Area Director will retrain Program Director on including the use of restraint in programming to</p>	07/10/2014			

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	<p>the facility failed to ensure client B's ISP (Individual Support Plan)/BSP (Behavior Support Plan) included the use of a lap belt restraint for client B's wheelchair.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 6/4/14 from 5:15 PM through 6:15 PM. Client B was observed in the group home throughout the observation period. Client B was seated in a wheelchair with a lap belt secured across his pelvis throughout the observation period.</p> <p>Observations were conducted at the group home on 6/5/14 from 5:45 AM through 7:15 AM. Client B was observed in the group home throughout the observation period. Client B was seated in a wheelchair with a lap belt secured across his pelvis throughout the observation period.</p> <p>Client B's record was reviewed on 6/5/14 at 10:00 AM. Client B's ISP dated 11/15/13 and BSP dated 3/1/13 did not indicate the use of a wheelchair lap belt restraint.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 6/5/14 at 1:55 PM. QIDP</p>		<p>include; ISP and BSP. Program Director will update programming to include temporary wheelchair restriction for client B; including, BSP, ISP and Risk Plan. Program Director will review the programming for all clients in the home to ensure any restriction has both HRC and guardian approval. Responsible Party: Area Director, Program Director</p> <p><i>Addendum:</i> The seatbelt restriction for Client B's wheelchair has been added into Client B's behavior plan, ISP and RMAP. The restrictive use of the seatbelt has been approved by Client B's guardian and has also received HRC approval. The Program Director will receive retraining to ensure that all restrictions in place for each client are identified and outlined in each client's Behavior Support Plan as needed. The Program Director will ensure that all targeted behaviors, interventions for behaviors, all restrictive practices and psychotropic medication titration plans are included in all consumers Behavior Support Plans as needed and appropriate approvals by Guardian and HRC are obtained. For the next 3 months, the Area Director will review all of this Program Director's Behavior Support Plans to ensure all targeted behaviors, interventions for behaviors, all restrictive practices and psychotropic medication titration plans are</p>	

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	<p>#1 indicated client B was not able to independently release the lap belt on his wheelchair. QIDP #1 indicated client B's wheelchair had a lap belt to assist client B to remain non weight bearing on his foot which was fractured. QIDP #1 indicated client B's wheelchair lap belt was modified in order to prevent client B from being able to release the belt. QIDP #1 stated, "[Client B] can't put weight on his foot. He tries to stand up. He will try to walk. [Client B's] mother/guardian wanted the belt so he won't get up. The wheelchair was ordered by the podiatrist but the belt is not part of his formal plan."</p> <p>This federal tag relates to complaint #IN00149542.</p> <p>9-3-5(a)</p>		<p><i>included in all consumers Behavior Support Plans as needed and appropriate approvals by Guardian and HRC are obtained.</i></p> <p><i>Responsible Party: Program Director, Area Director, Behavior Consultant</i></p>				