

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/28/2013
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46208		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 8/19/13, 8/20/13, 8/21/13, 8/26/13, 8/27/13 and 8/28/13.</p> <p>Facility Number: 000961 Provider Number: 15G447 AIMS Number: 100244750</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/10/13 by Ruth Shackelford, QIDP.</p>	W000000			

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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W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to keep a complete accounting of the clients' funds.</p> <p>Findings include:</p> <p>1. Client #1's FR (Financial Record) was reviewed on 8/20/13 at 12:05 PM. Client #1's ISP (Individual Support Plan) dated 12/7/12 indicated client #1 needed assistance with regard to management of her finances. Client #1's FR did not indicate documentation of a transaction ledger and/or receipts for client #1's COH (Cash On Hand) transactions for the month of July 2013. Client #1's RFMSS (Resident Fund Management Service Statements) dated 7/1/13 through 7/30/13 indicated the following COH withdrawals:</p> <p>-7/1/13, debit for weekly COH spending money in the amount of \$20.00</p> <p>-7/9/13, debit for weekly COH spending money in the amount of \$10.00</p> <p>-7/23/13, debit for weekly COH spending</p>	W000140	<p>CORRECTION: The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Specifically, for Clients 1 – 4, the Residential Manager will maintain an up to date ledger to track purchases for all clients including a sign-out log for money to be spent at day service and workshops. All staff will assure that clients provide receipts for purchases as appropriate and the QIDP will maintain copies of receipts for purchases recorded on the ledgers. PREVENTION: The Residential Manager will maintain responsibility for maintaining client financial records and the QIDP will audit these records no less than weekly. All staff will be retrained regarding the need to assist clients with budgeting and collecting receipts. The QIDP will turn in client financial records to the Business Manager no less than monthly for review and filing. Additionally, members of the Administrative Team will include audits of client finances as part of an ongoing facility audit process RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff,</p>	09/27/2013			

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	<p>money in the amount of \$10.00</p> <p>-7/30/13, debit for weekly COH spending money in the amount of \$10.00</p> <p>2. Client #2's FR was reviewed on 8/20/13 at 12:00 PM. Client #2's MOIR (Modification Of Individual's Rights) form dated 11/21/12 indicated, "Documentation demonstrates [client #2's] inability to provide for appropriate use of funds independently. Through ongoing assessment, the team has determined that [client #2] does not currently possess the skills necessary to appropriately independently safeguard his funds...." Client #2's FR did not indicate documentation of a transaction ledger and/or receipts for client #2's COH transactions for the month of July 2013. Client #2's RFMSS dated 7/1/13 through 7/30/13 indicated the following COH withdrawals:</p> <p>-7/1/13, debit for weekly COH spending money in the amount of \$20.00</p> <p>-7/9/13, debit for weekly COH spending money in the amount of \$10.00</p> <p>-7/23/13, debit for weekly COH spending money in the amount of \$10.00</p> <p>-7/25/13, debit for clothing/household in</p>		Administrative Team		

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	<p>the amount of \$300.00</p> <p>-7/25/13, debit for clothing in the amount of \$500.00</p> <p>-7/30/13, debit for weekly COH spending money in the amount of \$10.00</p> <p>3. Client #3's FR was reviewed on 8/20/13 at 11:55 AM. Client #3's ISP dated 8/14/12 indicated client #3 needed assistance with regard to management of her finances. Client #3's FR did not indicate documentation of a transaction ledger and/or receipts for client #3's COH transactions for the month of June 2013 and/or July 2013. Client #3's RFMSS dated 6/1/13 through 7/30/13 indicated the following COH withdrawals:</p> <p>-6/4/13, debit for weekly COH spending money in the amount of \$10.00</p> <p>-6/11/13, debit for weekly COH spending money in the amount of \$10.00</p> <p>-6/18/13, debit for weekly COH spending money in the amount of \$10.00</p> <p>-6/25/13, debit for weekly COH spending money in the amount of \$10.00</p> <p>-7/1/13, debit for weekly COH spending money in the amount of \$10.00</p>			

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	<p>-7/9/13, debit for weekly COH spending money in the amount of \$10.00</p> <p>-7/23/13, debit for weekly COH spending money in the amount of \$10.00</p> <p>4. Client #4's FR was reviewed on 8/20/13 at 11:50 AM. Client #4's ISP dated 11/14/12 indicated client #4 needed assistance with regard to management of her finances. Client #4's FR did not indicate documentation of a transaction ledger and/or receipts for client #4's COH transactions for the month of July 2013. Client #4's RFMSS dated 7/1/13 through 7/30/13 indicated the following COH withdrawals:</p> <p>-7/1/13, debit for weekly COH spending money in the amount of \$10.00</p> <p>-7/9/13, debit for weekly COH spending money in the amount of \$10.00</p> <p>-7/23/13, debit for weekly COH spending money in the amount of \$10.00</p> <p>RM #1 (Residential Manager) was interviewed on 8/20/13 at 12:10 PM. RM #1 indicated each client that received weekly COH spending money should have a transaction ledger that accounts for COH transactions and receipts. RM #1</p>						

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	indicated there were no additional ledgers to review. 9-3-2(a)			

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W000149	<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 record review and interview for 2 of 4 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to implement its policy and procedures to conduct a thorough investigation regarding an injury of unknown origin for client #3. The facility failed to implement its policy and procedures to report the results of an investigation of an injury of unknown origin for client #4.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, incident reports and investigations were reviewed on 8/19/13 at 1:03 PM. The review indicated the following:</p> <p>-BDDS report dated 5/17/13 indicated, "An investigation was completed and in (sic) the findings of what had caused the bruising on [client #3] (sic) on her buttocks and upper back right side. One of the group home staff, [staff #1], explained to [RM #1 (Residential Manager)] at the time of the interview</p>	W000149	<p>CORRECTION: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically: The facility will investigate the origin of an injury sustained by Client #3 that was discovered on 5/16/13. The facility will provide documentation showing the date of investigation completion and a listing of appropriately notified parties for investigations an injury of unknown origin sustained by Client #4 that was discovered on 5/20/13. PREVENTION: Professional staff will be retrained regarding the need to document all investigations and will receive an updated copy of the agency's incident-investigation tracking spreadsheet no less than weekly to assure thorough investigations are conducted within required timeframes and appropriate parties are notified of the investigation results within 5 working days. The QIDP will turn in copies of completed investigations to the Clinical Supervisor responsible for Quality Assurance to allow for appropriate oversight and follow-up. Additionally, the facility's QIDP will meet with the Clinical Supervisor responsible</p>	09/27/2013			

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	<p>that both [staff #1] and [client #3] were passing each other and [client #3] was walking very close and they ended up bumping into each other, causing them both to fall. [Staff #1] was able to get [client #3] up off the floor and assist in helping [client #3] up. [Staff #1] check (sic) out [client #3] at the time and no bruising was found. The group home staff, [staff #1], failed to report the incident to her supervisor and the on call nurse at the time of the incident."</p> <p>The review did not indicate documentation of an investigation regarding client #3's 5/17/13 injury of unknown origin.</p> <p>-BDDS report dated 5/21/13 indicated, "The oncoming shift was assisting [client #4] (sic) notice (sic) a bruise around her left eye. [Client #4] was unable to explain what had happened. An investigation is being conducted into the cause of the injury."</p> <p>-Investigation dated 5/21/13 regarding client #4's 5/21/13 injury of unknown origin did not include documentation of the investigation findings/conclusion and when/if the administrator had been notified of the investigation findings.</p> <p>QIDPD (Qualified Intellectual Disabilities</p>		<p>for Quality Assurance weekly to review incidents that require follow-up and investigation to assure timely completion. The Executive Director will monitor the facility's incident – investigation tracking spreadsheet and follow-up as needed with the QIDP and Program Manager to provide for increased accountability. RESPONSIBLE PARTIES:QIDP, Residential Manager, Direct Support Staff, Administrative Team</p>		

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	<p>Professional Designee) #1 was interviewed on 8/19/13 at 2:56 PM. When asked if there was an investigation available to review regarding client #3's 5/17/13 injury of unknown origin, QIDPD #1 stated, "We did one but it got discarded." When asked if client #3's 5/17/13 injury was of a known origin at the time of knowledge, QIDPD #1 stated, "No, it had not been reported to [RM #1]." QIDPD #1 indicated client #3's 5/17/13 injuries were the result of a fall that had occurred on the morning of 5/16/13. When asked how QIDPD #1 and/or RM #1 had determined client #3's injuries were the result of a fall on 5/16/13, QIDPD #1 stated, "We had to interview staff." When asked if injuries of unknown origin should be investigated, QIDPD #1 stated, "Yes." When asked if the 5/21/13 investigation regarding client #4's injury was available for review, QIDPD #1 stated, "I will have to finish it. It's not complete." When asked if the results of investigations of injuries of unknown origin should be reported to the administrator within 5 business days, QIDPD #1 stated, "Yes, it should be done in 5 days." QIDPD #1 indicated the facility's policy and procedures should be implemented.</p> <p>The facility's policy and procedures were reviewed on 8/26/13 at 12:39 PM. The</p>			
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	<p>facility's 9/14/07 policy and procedure entitled, "Investigations" indicated, "Practices: 3. (b) Ensure alleged incident of abuse, neglect, mistreatment, exploitation or injuries of unknown origin are fully investigated within 5 calendar days from the date the allegations were made and investigation was initiated." The 9/14/07 policy indicated, "A thorough investigation final report will be written at the completion of the investigation."</p> <p>9-3-2(a)</p>			

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 4 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to conduct a thorough investigation regarding an injury of unknown origin for client #3.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, incident reports and investigations were reviewed on 8/19/13 at 1:03 PM. The review indicated the following:</p> <p>-BDDS report dated 5/17/13 indicated, "An investigation was completed and in (sic) the findings of what had caused the bruising on [client #3] (sic) on her buttocks and upper back right side. One of the group home staff, [staff #1], explained to [RM #1 (Residential Manager)] at the time of the interview that both [staff #1] and [client #3] were passing each other and [client #3] was walking very close and they ended up bumping into each other, causing them both to fall. The [staff #1] (sic) was able</p>	W000154	<p>CORRECTION:The facility must have evidence that all alleged violations are thoroughly investigated. Specifically for Client #3, the facility will investigate the origin of an injury discovered on 5/16/13. PREVENTION:Professional staff will be retrained regarding the need to document all investigations and will receive an updated copy of the agency's incident-investigation tracking spreadsheet no less than weekly to assure thorough investigations are conducted within required timeframes. The QIDP will turn in copies of completed investigations to the Clinical Supervisor responsible for Quality Assurance to allow for appropriate oversight and follow-up. Additionally, the facility's QIDP will meet with the Clinical Supervisor responsible for Quality Assurance weekly to review incidents that require follow-up and investigation to assure timely completion. The Executive Director will monitor the facility's incident – investigation tracking spreadsheet and follow-up as needed with the QIDP and Program Manager to provide for increased accountability. RESPONSIBLE PARTIES:QIDP, Residential</p>	09/27/2013	

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	<p>to get [client #3] up off the floor and assist in helping [client #3] up. [Staff #1] check (sic) out [client #3] at the time and no bruising was found. The group home staff, [staff #1], failed to report the incident to her supervisor and the on call nurse at the time of the incident."</p> <p>The review did not indicate documentation of an investigation regarding client #3's 5/17/13 injury of unknown origin.</p> <p>QIDPD (Qualified Intellectual Disabilities Professional Designee) #1 was interviewed on 8/19/13 at 2:56 PM. When asked if there was an investigation available to review regarding client #3's 5/17/13 injury of unknown origin, QIDPD #1 stated, "We did one but it got discarded. When asked if client #3's 5/17/13 injury was of a known origin at the time of knowledge, QIDPD #1 stated, "No, it had not been reported to [RM #1]." QIDPD #1 indicated client #3's 5/17/13 injuries were the result of a fall that had occurred on the morning of 5/16/13. When asked how QIDPD #1 and/or RM #1 had determined client #3's injuries were the result of a fall on 5/16/13, QIDPD #1 stated, "We had to interview staff." When asked if injuries of unknown origin should be investigated, QIDPD #1 stated, "Yes."</p>		<p>Manager, Direct Support Staff, Administrative Team</p>	

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W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 4 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to report the results of an investigation of an injury of unknown origin for client #4.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, incident reports and investigations were reviewed on 8/19/13 at 1:03 PM. The review indicated the following:</p> <p>-BDDS report dated 5/21/13 indicated, "The oncoming shift was assisting [client #4] (sic) notice (sic) a bruise around her left eye. [Client #4] was unable to explain what had happened. An investigation is being conducted into the cause of the injury."</p> <p>-Investigation dated 5/21/13 regarding client #4's 5/21/13 injury of unknown origin did not include documentation of the investigations findings and when/if</p>	W000156	CORRECTION:The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Specifically, the facility will provide documentation showing the date of investigation completion and a listing of appropriately notified parties for investigations an injury of unknown origin sustained by Client #4 that was discovered on 5/20/13. PREVENTION:The QIDP will turn in copies of completed investigations to the Clinical Supervisor responsible for Quality Assurance to allow for appropriate oversight and follow-up. Additionally, the facility's QIDP will meet with the Clinical Supervisor responsible for Quality Assurance weekly to review incidents that require follow-up and investigation to assure timely notification of the administrator and other parties as required. The Executive Director will monitor the facility's incident – investigation tracking spreadsheet and follow-up as needed with the QIDP and Program Manager to provide for increased	09/27/2013			

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	<p>the administrator had been notified of the investigation findings.</p> <p>QIDP (Qualified Intellectual Disabilities Professional Designee) #1 was interviewed on 8/19/13 at 2:56 PM. When asked if the 5/21/13 investigation regarding client #4's injury was available for review, QIDP #1 stated, "I will have to finish it. It's not complete." When asked if the results of investigations of injuries of unknown origin should be reported to the administrator within 5 business days, QIDPD #1 stated, "Yes, it should be done in 5 days."</p> <p>9-3-2(a)</p>		<p>accountability. RESPONSIBLE PARTIES:QIDP, Residential Manager, Direct Support Staff, Administrative Team</p>		

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 2 of 4 sampled clients (#3 and #4), the QIDPD (Qualified Intellectual Disability Professional Designee) failed to monitor clients #3 and #4's programs in regard to assessing the clients' ability to participate in a day service program.</p> <p>Findings include:</p> <p>1. Client #3's record was reviewed on 8/20/13 at 10:01 AM. Client #3's ATS (Active Treatment Schedule) dated 8/14/12 indicated client #3 did not attend/participate in a day service program Monday through Friday. Client #'s PCPP (Person Centered Planning Profile) dated 8/14/12 indicated, "Currently, [client #3] is not attending any day programming and was discharged from day services due to aggressing towards other consumers and staff. She will be evaluated on an intermittent basis in order to determine eligibility for day program services." Client #3's record did not indicate documentation of client #3 being assessed for eligibility for day service programming.</p>	W000159	<p>CORRECTION: Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. The Administrative Team will work to provide additional training, mentorship and guidance to the QIDP to assure the QIDP has the resources necessary to properly integrate, coordinate and monitor each client's active treatment program. This training and oversight training will focus on but not be limited to: The need for quarterly review of ability of clients to participate in day service. Additionally, The QIDP has made arrangements to enroll Client #3 and Client #4 in day programming. PREVENTION: The QIDP will turn in copies of quarterly meeting notes for all Clients to the Clinical Supervisor to allow for cross checking of assessment data and additional oversight. Members of the Administrative team will audit support documents at the facility no less than monthly to assure that appropriate assessment occurs as required. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Administrative Team</p>	09/27/2013			

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	<p>2. Client #4's record was reviewed on 8/20/13 at 12:52 PM. Client #4's ATS dated 11/14/12 indicated client #4 did not attend/participate in a day service program Monday through Friday. Client #4's record indicated client #4 should be assessed to determine her eligibility for day service programs. Client #4's record did not indicate documentation of client #4 being assessed for eligibility for day service programming.</p> <p>QIDPD #1 was interviewed on 8/20/13 at 2:12 PM. QIDPD #1 stated, "[Client #3] hasn't been at a day services in over a year, not since I've been at this house." When asked if client #3 should be assessed to determine eligibility for day service programming, QIDPD #1 stated, "Yes, she should be assessed." When asked when or how often client #3 should be assessed for eligibility for day service programming, QIDPD #1 indicated the IDT (Interdisciplinary Team) should assess client #3 on a quarterly basis to determine her eligibility for day program services. QIDPD #1 indicated client #3 had not been assessed by the IDT to determine her eligibility for day program services. QIDPD #1 indicated client #4 did not attend day service programming. QIDPD #1 indicated client #4 should be assessed by the IDT on a quarterly basis to determine her eligibility for day</p>			

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	<p>program services. QIDPD #1 indicated client #4 had not been assessed by the IDT to determine her eligibility for day program services.</p> <p>9-3-3(a)</p>			

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#4) plus one additional client (#8), the facility failed to implement clients #4 and #8's training objectives during formal/informal training opportunities.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/20/13 from 6:30 AM through 8:30 AM. At 7:27 AM Client #4 was prompted by DSP #1 (Direct Support Professional) to come to the group home's medication administration room. DSP #1 administered client #4's Clonazepam 2 milligram tablet (anxiety), Citalopram 10 milligram tablet (depression), Citalopram 20 milligram tablet, Levetiracetam 500 milligram tablet (epilepsy) and Quetiapine 300 milligram tablet (anti-psychotic). Client #4 was not encouraged or prompted to participate in the administration of her medications. At 7:38 AM client #8 was prompted by DSP #1 to come to the group home's</p>	W000249	<p>CORRECTION:As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Specifically for Client #4 and #8, direct support staff have been retrained on the need to implement medication goals per the implementation schedule. PREVENTION: Facility supervisors will monitor medication administration on all shifts on a weekly basis, providing coaching and accountability to direct support staff to assure training occurs toward self-medication goals for all clients. Members of the Administrative Team will conduct active treatment observations no less than monthly to confirm the effectiveness of the facility supervisor's training initiatives. RESPONSIBLE PARTIES:QIDP, Residential</p>	09/27/2013
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	<p>medication administration room. DSP #1 administered client #8's Fluoxetine 20 milligram tablet (depression) and Haloperidol 2 milligrams (psychosis). Client #8 was not encouraged to participate in the administration of her medications.</p> <p>Client #4's record was reviewed on 8/20/13 at 12:52 PM. Client #4's ISP (Individual Support Plan) dated 11/14/12 indicated client #4 was not independent in medication administration. Client #4's ISP dated 11/14/12 indicated client #4 should receive training to increase her medication administration skills. Client #4's ISP dated 11/14/12 indicated client #4 had a formal training objective to identify her Seroquel/Quetiapine by pointing to the pill.</p> <p>Client #8's record was reviewed on 8/20/13 at 12:42 PM. Client #8's ISP dated 7/31/13 indicated client #8 was not independent in medication administration. Client #8's ISP dated 7/31/13 indicated, "Requires several prompts to repeat the names of her medication at this time." Client #8's ISP dated 7/31/13 indicated client #8 had a formal training objective to identify her Haldol.</p> <p>DSP #1 was interviewed on 8/20/13 at 7:50 AM. When asked if client #4 had a</p>		<p>Manager, Direct Support Staff, Administrative Team</p>				

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	<p>medication administration goal, DSP #1 stated, "No, I'm not aware of any." DSP #1 indicated client #8 did not have a medication training goal.</p> <p>QIDPD (Qualified Intellectual Disability Professional Designee) #1 was interviewed on 8/20/13 at 2:12 PM. QIDPD #1 indicated active treatment should occur at each medication administration time.</p> <p>9-3-4(a)</p>			

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure nursing services met the health needs of client #3.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 8/20/13 at 10:01 AM. Client #3's Record of Visit form dated 6/21/12 indicated the recommendation to "Proceed with plans for video fluoroscopic swallow study." Client #3's record did not indicate documentation of a video fluoroscopic swallow study.</p> <p>LPN #1 (Licensed Practical Nurse) #1 was interviewed on 8/20/13 at 3:36 PM. LPN #1 stated, "The medication coach for this home at the time is now assigned at a different home. I talked to [MC #1 (Medication Coach)] and she thinks [client #3] had the video fluoroscopic study but doesn't remember a date and couldn't find the paperwork for it." LPN #1 indicated there was no documentation of client #3 having a video fluoroscopic swallow study.</p> <p>9-3-6(a)</p>	W000331	<p>CORRECTION: The facility must provide clients with nursing services in accordance with their needs. Specifically for client #3, a copy of the record for a video fluoroscopic swallow study that was completed on 7/26/13. The record will be available at revisit. Client #3's risk plan and diet orders are consistent with the recommendations from the swallow study. Addendum: 9/27/13: An audit conducted by the administration team determined that no other records are missing from the facility's medical charts.</p> <p>PREVENTION: Copies of all medical records will be stored in a chart at the facility. Additional copies of the records will be filed in the agency's nursing office. Additionally, the nurse manager will develop universal system for chart monitoring to be completed by nursing staff and members of the administrative team on a monthly basis. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Nursing Team, Administrative Team</p>	09/27/2013			

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W000336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility's nursing services failed to conduct quarterly nursing assessments of clients' health status and medical needs.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 8/20/13 at 2:43 PM. Client #1's PO (Physicians Orders) dated 7/24/13 indicated client #1's diagnoses included, but were not limited to, moderate to severe mental retardation, microcephaly, hypothyroidism, aortic systolic murmur, diabetes mellitus and generalized anxiety disorder. Client #1's QNA (Quarterly Nursing Assessment) form for the year 2013 did not indicate documentation of a nursing physical assessment of client #1's health status and medical needs from 1/1/13 through 7/25/13.</p> <p>2. Client #2's record was reviewed on 8/20/13 at 3:20 PM. Client #2's PO dated 7/24/13 indicated client #2's diagnoses included, but were not limited to, diabetes mellitus type 2, intermittent explosive</p>	W000336	<p>CORRECTION:Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Specifically, the facility has a new nurse that has been trained on expectations for quarterly nursing physicals and the nurse has completed physicals for the current quarter. PREVENTION:Copies of quarterly nursing physical examinations will be placed in the each individual's medical chart upon completion. The Nurse Manager will maintain a tracking system to assure quarterly nursing physical examinations are completed as required. Additionally, Administrative Team members will review medical documentation while auditing active treatment sessions, no less than monthly, to assure records of quarterly nursing evaluations are completed and filed appropriately. RESPONSIBLE PARTIES:QIDP, Residential Manager, Direct Support Staff, Nursing Team, Administrative Team</p>	09/27/2013
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	<p>disorder and bipolar disorder. Client #2's QNA form for the year 2013 did not indicate documentation of a nursing physical assessment of client #2's health status and medical needs from 1/1/13 through 7/25/13.</p> <p>3. Client #3's record was reviewed on 8/20/13 at 10:01 AM. Client #3's PO dated 7/24/13 indicated client #3's diagnoses included, but were not limited to, hypothyroidism, diabetes and severe mental retardation. Client #3's QNA form for the year 2013 did not indicate documentation of a nursing physical assessment of client #3's health status and medical needs from 1/1/13 through 7/25/13.</p> <p>4. Client #4's record was reviewed on 8/20/13 at 12:52 PM. Client #4's PO dated 7/24/13 indicated client #4's diagnoses included, but were not limited to, severe mental retardation, epilepsy, chronic neurodermatitis, edema, constipation and hypothyroidism. Client #4's QNA form for the year 2013 did not indicate documentation of a nursing physical assessment of client #4's health status and medical needs from 1/1/13 through 7/25/13.</p> <p>LPN #1 (Licensed Practical Nurse) was interviewed on 8/20/13 at 3:36 PM</p>			

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	<p>indicated nursing physical assessments of clients health status and medical needs should be conducted on a quarterly basis. LPN #1 indicated there were no additional nursing physical assessments available for review regarding clients #1, #2, #3 and/or #4.</p> <p>9-3-6(a)</p>			

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W000356	<p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure client #3 received recommended follow up dental treatment.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 8/20/13 at 10:01 AM. Client #3's Dental Progress note dated 9/26/12 indicated a recommendation for the extraction of three teeth. Client #3's Dental Evaluation form dated 12/11/12 indicated, "Periodontal disease of mandibular anterior teeth. Recommend extractions with mild sedation. Will call to schedule date and time." Client #3's record did not indicate documentation of dental extractions or follow up dental services.</p> <p>LPN #1 (Licensed Practical Nurse) #1 was interviewed on 8/20/13 at 3:36 PM. LPN #1 stated, "The medication coach for this home at the time is now assigned at a different home. I talked to [MC #1 (Medication Coach)] and she thinks [client #3] had the extractions but doesn't remember a date and couldn't find the</p>	W000356	<p>CORRECTION: The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Specifically, the facility will assist Client #3 with receiving recommended dental follow-up. Addendum: 9/27/13: An audit conducted by the administration team determined that dental follow-along and required follow-up has occurred for the other clients whoside in the facility. PREVENTION: The facility nurse will review dental records and follow up with other team members to assure recommendations are implemented as appropriate. The QIDP and members of the Administrative and Quality Assurance Teams will review medical records on an ongoing basis to assure dental treatment services occur as required. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Nursing Team, Administrative Team</p>	09/27/2013

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	paperwork for it." LPN #1 indicated there was no documentation of client #3 receiving additional dental services or extractions as recommend on the 12/11/12 Dental Evaluation form. 9-3-6(a)			