

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G554	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/29/2016
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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1435 W CONGRESS ST MIDDLETOWN, IN 47356
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W 0000  Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 4/18, 4/19, 4/20, 4/21, 4/22, 4/25, and 4/29/2016.</p> <p>Facility Number: 001068 Provider Number: 15G554 AIMS Number: 100239880</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/12/16.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview, for 3 of 3 sample clients (clients #1, #2, and #3) and 3 additional clients (clients #4, #5, and #6), the governing body failed to exercise operating direction over the facility to ensure maintenance and repairs were completed at the group home for clients #1, #2, #3, #4, #5, and #6.</p> <p>Findings include:</p>	W 0104	<p>The following repair needs have been completed; the overheadlight in the medication room has been fixed so that it is no longer blinking,the electric outlet cover has been replaced, the bathroom has been repainted,and the light cover in the bathroom has been replaced. Additionally new livingroom furniture has been ordered to replace the worn vinyl covered furniture andreplacement of the living room flooring is scheduled to</p>	05/29/2016

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

TITLE

(X6) DATE

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

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	<p>Observations and interviews were conducted at the group home on 4/18/16 from 3:20pm until 6:55pm and on 4/19/16 from 5:40am until 7:35am. Clients #1, #2, #3, #4, #5, and #6 were observed at the group home. During both observation periods the following needed repairs were observed with the Program Quality Coordinator (PQC) and the Residential Manager (RM):</p> <p>-On 4/18/16 the medication room overhead lighting blinked repeatedly and GHS (Group Home Staff) #3 stated while clients #2, #4, #5, and #6 had medications administered during the medication administration, the blinking lights "annoyed" the clients, and "several" clients had seizures. GHS #3 did not identify which clients had seizures. GHS #3 stated the lights had been blinking for "awhile." During the medication administration on 4/19/16 the medication room lights blinked repeatedly at a faster rate than on 4/18/16 and GHS #1 stated the blinking lights "bothered" client #4 during her medication administration.</p> <p>-The living room eye level electrical outlet cover was cracked and the RM stated the cover had "broken jagged edges."</p>		<p>be completed. Agency administrators have a routine presence in the facility this includes an assessment for any maintenance needs. A log of maintenance needs is kept electronically and is accessible to the administrator and maintenance supervisor for review. When a maintenance need is observed or reported to the administrator she ensures the need is listed on the log. The maintenance supervisor is notified immediately to coordinate repair of any immediate maintenance needs. The administrator will have ongoing communication with the maintenance supervisor to ensure maintenance needs are met in a timely manner. Agency QIDPs and administrators will also note on a facility home visit note if any maintenance needs are observed. Completed house visit notes are circulated to administrators to ensure compliance. Responsible Party: Area Director</p>	

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	<p>-The living room vinyl covered furniture including the love seat, two sofas, and two chairs were worn and the stuffing/padding in the furniture could be seen through the vinyl material.</p> <p>-The peach bathroom had three of three (3 of 3) walls with worn chipped paint and needed to be repainted.</p> <p>-On 4/18/16 at 5:20pm, the PQC stated the living room carpet was "worn and stained."</p> <p>-The bathroom outside of the medication room was missing a light cover and exposed the bare light bulb in the ceiling.</p> <p>On 4/20/16 at 9:00am, the PQC provided an undated list with documented pending maintenance. The undated maintenance list indicated "4/2015 Kitchen counter tops are in poor condition...5/5/15 girls (peach) bathroom needs attention...3/1/16 furniture old and worn - replace (sic)...3/1/16 repair/paint (sic) walls...3/1/16 evaluate floors and replace flooring in kitchen, living rooms, and bathrooms..."</p> <p>On 4/20/16 at 9:00am, an interview with the PQC was conducted. The PQC indicated the listed items had not been</p>			

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W 0137 Bldg. 00	<p>repaired and/or replaced.</p> <p>9-3-1(a)</p> <p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, interview, and record review, for 3 of 6 clients (clients #3, #5, and #6), the facility failed to ensure client #3 had access to her personal clothing at the day service location and failed to ensure clients #3, #5, and #6 had unimpeded access to their locked personal belongings.</p> <p>Findings include:</p> <p>1. On 4/18/16 from 3:20pm until 6:55pm, observation and interviews were conducted at the group home. At 3:20pm, the van drove up to the group home with clients #1, #2, #3, #4, #5, and #6 at the group home. At 3:20pm, clients #1, #2, #4, #5, and #6 went inside the group home and client #3 stayed on the facility van. At 3:40pm, client #3 was still exiting the van in the driveway with the facility staff and walked barefoot over the driveway rocks to enter the group home. From 3:20pm until 3:40pm, client</p>	W 0137	<p>The QIDP is responsible for ensuring that the day program has adequate spare clothing for client #3 and for any other clients who may need it. She will develop a system with day program staff and the group home staff to ensure adequate clothing is provided. She will train the direct care staff on this system and will provide routine oversight at the home to ensure staff are following this plan. She will also routinely communicate with day program staff to ensure needed clothing is available. The QIDP will also train direct care staff in the facility to ensure that clients' personal belongings including client #3 and #5's communication devices and client #6's IPAD are not stored in a locked area such that the clients always have access to their items. The QIDP and agency administrators have a routine presence in the facility. The QIDP is in the home no less than weekly. During these visits the QIDP and administrator will ensure the</p>	05/29/2016

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	#3 was barefoot, held up her pants with her hands, and wore an oversized tee shirt with the handwritten in marker the name of the day service site. From 3:40pm until 6:45pm, the PQC (Program Quality Coordinator), the QIDP (Qualified Intellectual Disabilities Professional), the Residential Manager (RM), and GHS (Group Home Staff) #3, GHS #7, and GHS #8 prompted client #3 to change her clothing because client #3 had been incontinent while at workshop during the day and her clothing and shoes had become soiled. From 3:40pm until 6:45pm, client #3 exited the facility into the front yard twice and back yard three times barefoot and wearing oversized clothing holding up her pants with her hands. At 6:00pm, client #3 walked throughout the group home, let go of the waist of her pants, her pants dropped to her knees, and exposed a bare private area because client #3 was not wearing underwear. At 6:15pm, the QIDP indicated client #3 had been incontinent while at day services during the day and was wearing clothing the day service staff had available to use. The QIDP indicated the clothing belonged to the day services and did not belong to client #3. The QIDP indicated client #3 had the behavior of being incontinent and should have had her clothing available to her. The QIDP indicated that was why client		clients have access to their personal items. Additionally the QIDP reviews camera footage for the home weekly. During these reviews she will also monitor to ensure clients have access to their personal items. The agency utilized a home visit note that the QIDP must complete when completing visits in the home. The form will require the QIDP to document that evidence of compliance with evidence that clothing has been provided to day program accordingly and with client access to personal items. Completed house visit notes are circulated to administrators to ensure compliance.  Responsible Party: QIDP	

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	<p>#3 arrived home from day services barefoot today. At 6:45pm, client #3 changed her clothing with the assistance of facility staff.</p> <p>On 4/19/16 from 5:40am until 7:35am, client #3 was observed to wear her own clothing and at 7:35am was preparing to leave for day services. From 9:35am until 11:40am, client #3 was observed at the day service. During the observation period client #3 wore oversized slacks, no shoes (barefoot), and the same top client #3 had been wearing at 7:35am. At 10:00am, WKS (Workshop Staff) #1 indicated client #3 had been incontinent of urine at the day services that morning, client #3 had no extra shoes available, and was wearing another day service client's clothing because client #3 had no clothing available for her use at the day service location to change into. At 10:25am, WKS #1 obtained an extra pair of shoes and indicated the shoes belonged to a different workshop client. WKS #1 indicated the shoes were too large for client #3, the shoes slipped off and on client #3's feet when she walked, and the shoes made a slapping sound when the empty foot ends made contact with the tile floor when client #3 walked or moved her feet.</p> <p>Client #3's record was reviewed on</p>			

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	<p>4/20/16 at 10:15am. Client #3's 11/5/15 ISP (Individual Support Plan) indicated she needed staff assistance to change her clothing. Client #3's record indicated she had clothing available for her use at the group home. Client #3's 11/2015 BSP (Behavior Support Plan) indicated she had targeted behaviors of Incontinence when she refused a request or task and inappropriate nudity. Client #3's plans indicated clean appropriate clothing should be available and encouraged.</p> <p>On 4/21/16 at 8:30am, an interview with the Program Quality Coordinator (PQC) was conducted. The PQC indicated client #3 should have had appropriate clothing available and encouraged when opportunities existed. The PQC indicated the facility staff should have ensured client #3's clothing and extra shoes were available for use at the day service location.</p> <p>On 4/25/16 at 8:30am, and on 4/29/16 at 3:40pm, the PQC indicated no further information was available for review.</p> <p>2. On 4/18/16 from 3:20pm until 6:55pm, and on 4/19/16 from 5:40am until 7:35am, clients #3 and #5 were observed to be non verbal at the group home. During both observation periods clients #3 and #5's communication</p>			

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	<p>devices and client #6's iPad were locked inside the medication room. On 4/19/16 at 7:30am, GHS #1 indicated clients #3 and #5 were non verbal and their communication devices and client #6's iPad were kept locked inside the medication room.</p> <p>On 4/19/16 from 9:35am until 11:40am, observation and interview were conducted at Day Services Site (DDS) #1. At 10:00am, GHS (Group Home Staff) #1 indicated client #3 and #5's communication devices were locked inside the medication room at the group home and not available at the day service location. GHS #1 indicated client #6's iPad was locked inside the medication room at the group home and not available for his use at the day service location. GHS #1 indicated clients #3, #5, and #6's devices were their property and owned by each client.</p> <p>Client #3's record was reviewed on 4/20/16 at 10:15am. Client #3's 11/5/15 ISP (Individual Support Plan) indicated a goal/objective to sign "more" during dining. Client #3's record did not indicate an identified need for locked personal communication device.</p> <p>Client #5's record was reviewed on 4/20/16 at 10:25am. Client #5's 4/7/16</p>			

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W 0149 Bldg. 00	<p>and 8/2015 ISP's indicated he was non verbal. Client #5's record indicated he had an augmented communication device. Client #5's record did not indicate an identified need for locked personal communication device.</p> <p>Client #6's record was reviewed on 4/21/16 at 9:45am. Client #6's record did not indicate the identified need for his personal iPad to be kept locked.</p> <p>On 4/21/16 at 8:30am, an interview with the Program Quality Coordinator (PQC) was conducted. The PQC indicated clients #3, #5, and #6's personal belongings should not have been kept locked inside the medication room. The PQC indicated clients #3, #5, and #6 had not been assessed as needing the restriction for locked personal items.</p> <p>On 4/25/16 at 8:30am, and on 4/29/16 at 3:40pm, the PQC indicated no further information was available for review.</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</p>	W 0149	Correction completed and submitted	05/29/2016

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	<p>interview, for 1 of 16 BDDS (Bureau of Developmental Disabilities Services) reports reviewed for 1 of 6 clients (client #5), the facility neglected to implement their policy and procedures for abuse, neglect, and/or mistreatment and to ensure staff supervised client #5 when he was left alone inside a parked facility vehicle.</p> <p>Findings include:</p> <p>On 4/19/16 from 5:40am until 7:35am, client #5 was observed to be non verbal at the group home. On 4/19/16 at 7:30am, GHS #1 indicated client #5 was non verbal and his communication device was kept locked inside the medication room.</p> <p>On 4/19/16 from 9:35am until 11:40am, observation and interview were conducted at Day Services Site (DDS) #1. At 10:00am, GHS (Group Home Staff) #1 walked into the back room at the contracted day service. At 10:00am, GHS #1 indicated she was at the day services location to pick up a client from a different facility owned group home to take back to client #5's group home because of the other client's behaviors at day services. GHS #1 indicated she was on duty at the group home with client #5 on 4/19/16. At 10:00am, the Surveyor</p>		<p>on 5/31/16: The administrator assigned the completion of an investigation immediately when notified of the observed incident of neglect to client #5 on 4/19/16. The staff person responsible was suspended pending completion of the investigation. The investigation found that the staff person was responsible for leaving client #6 alone in the vehicle. She was going into the facility to pick up another client that the day program requested be picked up early. The day program staff did not provide assistance to DSA staff with this client leaving. This DSA staff received disciplinary action for this incident. This staff person has no prior discipline issues and is observed to be a hard working employee who interacts very well with all clients she works with, including client #6. Additionally it was identified that there is a need for a protocol for staff to follow when picking up any client early from day program. All facility staff have been retrained that they must not leave any of the clients unsupervised at any time, including in vehicles. Evidence of this training is attached. This also includes day program staff being trained on expectations for assistance when clients are picked up early from their facility at their request. This was discussed at a meeting with administrators at the day program on 5/25/16. The DSA administrator attended and</p>	

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	<p>asked GHS #1 "Where is [client #5]?" GHS #1 responded "He's on the van." The surveyor and GHS #1 walked through the back room at the day services, into the second room which was a lunch room, through a small hallway, and walked out the side door where the facility van was parked with the keys in the ignition. Client #5 was seated in the front passenger seat. At 10:25am, GHS #1 indicated client #5 was non verbal, did not have his communication device to communicate his wants/needs, and did not have the skill to summon for assistance and/or recognize danger. At 10:25am, GHS #1, client #5, and another client left on the facility van from the sheltered workshop/day services.</p> <p>On 4/18/16 at 1:50pm and on 4/20/16 at 11:30am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports, non reportable incident reports, and investigations were reviewed and included the following for client #5:</p> <p>-A 4/20/16 BDDS report for an incident on 4/19/16 at 9:00am indicated client #5 "was left unattended on the van at [Name] sheltered workshop for approximately 2 minutes while staff attended to another consumer inside of [Name of Day Services]."</p>		<p>participated in this meeting. The QIDP has also developed and placed an emergency information sheet in the facility vehicle to include a listing of phone numbers for each day program and DSA management staff so that a staff can call for assistance as needed to prevent future incidents of this nature. An administrator did verify on 5/25/16 that this is in place. The QIDP and administrator provide ongoing monitoring to ensure compliance. The Program Quality Coordinator completed a visit on 5/25/16, attached are notes of this observation.</p> <p>Responsible Party: QIDP</p>	

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	<p>On 4/20/16 at 10:25am, client #5's record was reviewed. Client #5's 4/7/16 and 8/2015 ISP (Individual Support Plan) indicated he was non verbal, communicated by pointing/grunting, did not have safety skills, and "required" twenty-four hour staff supervision. Client #5's 8/2015 "Risk" plans indicated client #5 was non verbal and needed staff supervision "at all times." Client #5's plans indicated he did not have the skill to recognize dangers in the van, community, or surroundings.</p> <p>On 4/21/16 at 8:30am, an interview with the Program Quality Coordinator (PQC) was conducted. The PQC indicated the facility followed the BDDS reporting guidelines for abuse, neglect, and/or mistreatment. The PQC indicated client #5 should not have been left alone on the facility van. The PQC indicated client #5 did not recognize dangers and did not have the skills to be alone "in any environment." The PQC indicated the facility neglected to supervise client #5 when he was left alone on the facility van.</p> <p>On 4/25/16 at 8:30am, and on 4/29/16 at 3:40pm, the PQC indicated no further information was available for review.</p> <p>On 4/18/16 at 12:00noon, a record review</p>			

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	<p>was conducted of the 10/2005 "Bureau of Developmental Disabilities Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse or exploitation by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The BDDS policy indicated each allegation of abuse, neglect, and/or mistreatment should be immediately reported.</p> <p>On 4/18/16 at 12:00noon, the facility's 10/13 "Preventing Abuse and Neglect" policy and procedure indicated "Abuse means the following: 1. Intentional or willful infliction of physical injury...7. Corporal Punishment which includes forced physical (sic), hitting, pinching, application of painful or noxious stimuli, use of electric shock, and the infliction of physical pain...9. Violation of individual rights....Neglect means failure to provide</p>			

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W 0249 Bldg. 00	<p>supervision, training, appropriate care, food, medical care, or medical supervision to an individual." The policy and procedure indicated "all" allegations of abuse and/or neglect should be immediately reported to the administrator and to BDDS in accordance with State Law and should be thoroughly investigated.</p> <p>9-3-2(a)</p> <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, interview, and record review, for 1 of 6 clients (client #5) living in the group home, the facility failed to ensure client #5 was supervised based on his identified need when he was left alone on the facility van.</p> <p>Findings include:</p> <p>On 4/19/16 from 9:35am until 11:40am, observation and interview were conducted at Day Services Site (DDS)</p>	W 0249	The administrator assigned the completion of an investigation immediately when notified of the observed incident of neglect to client #5 on 4/19/16. The staff person responsible was suspended pending completion of the investigation. The investigation found that the staff person was responsible for leaving client #6 alone in the vehicle. She was going into the facility to pick up another client that the day program requested be picked up early. The	05/29/2016

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	<p>#1. At 10:00am, GHS (Group Home Staff) #1 walked into the back room at the contracted day service. At 10:00am, GHS #1 indicated she was at the day services location to pick up a client from a different group home to take back to client #5's group home because of the other client's behaviors at day services. GHS #1 indicated she was on duty at the group home with client #5 on 4/19/16. At 10:00am, the Surveyor asked GHS #1 "Where is [client #5]?" GHS #1 responded "He's on the van." The surveyor and GHS #1 walked through the back room at the day services, into the second room which was a lunch room, through a small hallway, and walked out the side door where the facility van was parked with the keys in the ignition. Client #5 was seated in the front passenger seat. At 10:25am, GHS #1 indicated client #5 was non verbal, did not have his communication device to communicate his wants/needs, and did not have the skill to summon for assistance and/or recognize danger. At 10:25am, GHS #1, client #5, and another client left on the facility van from the sheltered workshop/day services.</p> <p>On 4/18/16 at 1:50pm and on 4/20/16 at 11:30am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports, non reportable incident reports,</p>		<p>day program staff did not provide assistance to DSA staff with this client leaving. This DSA staff received disciplinary action for this incident. This staff person has no prior discipline issues and is observed to be a hard working employee who interacts very well with all clients she works with, including client #6. Additionally it was identified that there is a need for a protocol for staff to follow when picking up any client early from day program. All facility staff are also being retrained that they must not leave any of the clients unsupervised at any time, including in vehicles. This also includes day program staff being trained on expectations for assistance when clients are picked up early from their facility at their request. This will be discussed in a meeting with administrators at the day program on 5/25/16. The QIDP has also developed and placed an emergency information sheet in the facility vehicle to include a listing of phone numbers for each day program and DSA management staff so that a staff can call for assistance as needed to prevent future incidents of this nature. The QIDP and administrator provide ongoing monitoring to ensure compliance. The home visit note will require the QIDP and administrators to note that supervision needs of all clients are met during observation. Completed house visit notes are circulated to administrators to</p>	

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	<p>and investigations were reviewed and included the following for client #5:</p> <p>-A 4/20/16 BDDS report for an incident on 4/19/16 at 9:00am indicated client #5 "was left unattended on the van at [Name] sheltered workshop for approximately 2 minutes while staff attended to another consumer inside of [Name of Day Services]."</p> <p>On 4/20/16 at 10:25am, client #5's record was reviewed. Client #5's 4/7/16 and 8/2015 ISP (Individual Support Plan) indicated he was non verbal, communicated by pointing/grunting, did not have safety skills, and "required" twenty-four hour staff supervision. Client #5's 8/2015 "Risk" plans indicated client #5 was non verbal and needed staff supervision "at all times." Client #5's plans indicated he did not have the skill to recognize dangers in the van, community, or surroundings.</p> <p>On 4/21/16 at 8:30am, an interview with the Program Quality Coordinator (PQC) was conducted. The PQC stated client #5 should not have been left alone on the facility van. The PQC indicated client #5 did not recognize dangers and did not have the skills to be alone "in any environment." The PQC indicated the facility failed to supervise client #5 when</p>		<p>ensure compliance. Responsible Party: QIDP</p>				

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W 0382 Bldg. 00	<p>he was left alone on the facility van.</p> <p>On 4/25/16 at 8:30am, and on 4/29/16 at 3:40pm, the PQC indicated no further information was available for review.</p> <p>9-3-4(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 1 of 12 medications administered during the morning medication administration period (client #4), the facility failed to keep client #4's medication secured.</p> <p>Findings include:</p> <p>On 4/19/16 at 6:30am, GHS (Group Home Staff) #1 prepared client #4's oral medications and administered them inside the medication room. At the end of client #4's medication administration period GHS #1 selected client #4's "Polyethylene Glycol 3350 (Miralax)" for constipation, poured 17 grams into a cup, poured the measured 17 grams into a sippy glass with a lid, and carried the</p>	W 0382	<p>The facility staff will be retrained by the facility nurse and QIDP to ensure medications are always secure. This training will include that this includes those medications that are already prepared and provided to the client, including Miralax in the drink for client #4. The staff will understand that once medication is provided to the client that they must remain with the client until they take all of, including drinking the complete mixture with Miralax. The facility nurse and QIDP have routine presence in the home. During these visits they will monitor to ensure medication is secured and administered as required. This will be noted on a home visit note. Completed house visit notes are circulated to administrators to ensure compliance.</p>	05/29/2016

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	<p>glass to the dining room table. At 6:41am, GHS #1 indicated client #4's medication mixture could be drunk with client #4's breakfast. At 6:45am, GHS #1 set the medication in the sippy glass on the table and walked away from the medication. From 6:45am until 7:35am, client #4 sat at the table with her sippy glass with the unsecured medication. At 7:30am, GHS #3 indicated client #4's sippy glass had half the liquid in the glass. At 7:30am, client #4, prompted by GHS #3, to carry her sippy glass with the unsecured medication one third of the medication mixture remaining in the glass to the kitchen sink.</p> <p>Client #4's record was reviewed on 4/19/16 at 6:41am. Client #4's 3/2016 Physician's Order and 4/2016 MAR (Medication Administration Record) both indicated "Polyethylene Glycol 3350" for constipation 17 grams in 8 ounces of liquid daily.</p> <p>An Interview with the PQC (Program Quality Coordinator) was conducted on 4/21/16 at 8:30am, and on 4/29/16 at 3:40pm. On 4/21/16 at 8:30am, the PQC indicated client #4's medication should be kept secured when not administered. The PQC indicated clients #1, #2, #3, #4, #5, and #6 had access to client #4's unsecured medication at the dining room</p>		Responsible Party: Nurse	

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W 0440 Bldg. 00	<p>table. The PQC indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>On 4/21/16 at 8:30am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated "Core Lesson 3: Principles of Administering Medication" indicated medications should be secured and staff should watch clients consume their medications.</p> <p>9-3-6(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 3 of 3 sampled clients (#1, #2, and #3) and 3 additional clients (#4, #5, and #6), by not ensuring an evacuation drill was conducted quarterly for the evening shift (2:00pm until 10:00pm) from 12/14/15 through 4/18/16.</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 4/18/16 at 5:20pm. The</p>	W 0440	The agency has a Professional Presence policy which includes the use of a home visit note that directs items professional staff review when in the program. The QIDP is in the home no less than weekly and completed the form. This form has been updated to include a review of evacuation drills that have been completed and to take steps to ensure any needed drills are completed. A copy of this form is provided for review as an attachment. The QIDP will be trained on this updated expectation.	05/29/2016

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	<p>review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, #4, #5, and #6 for the following:</p> <p>-An emergency drill after 12/14/15 at 3:35pm through 4/18/16 for the evening shift personnel.</p> <p>An Interview with the PQC (Program Quality Coordinator) was conducted on 4/21/16 at 11:00am, 4/25/16 at 8:30am, and on 4/29/16 at 3:40pm. The PQC indicated she was unable to locate any further evacuation drills for the evening shift of personnel for clients #1, #2, #3, #4, #5, and #6.</p> <p>9-3-7(a)</p>		<p>The QIDP will also will retrain all staff in the home regarding the expectations for completing evacuation drills. The administrator will be copied on provided training to verify completion. The administrator is also provided copies of the completed home visit notes to verify the QIDP is reviewing and ensuring completion of required evacuation drills.</p> <p>Responsible Party: QIDP</p>		