

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G568		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2013	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250			
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W0000	<p>This visit was for the investigation of complaint #IN00122085.</p> <p>Complaint #IN00122085: Substantiated, federal and state deficiency related to the allegation is cited at W148.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: 2/6/13, 2/7/13, 2/14/13 and 2/15/13.</p> <p>Facility Number: 001082 Provider Number: 15G568 AIMS Number: 100245520</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/22/13 by Ruth Shackelford, Medical Surveyor III.</p>			W0000			

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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W0148	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &</p> <p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview for 1 of 4 sampled clients (B), the facility failed to notify the client's guardian of the group home's bed bug infestation.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, incident reports and investigations were reviewed on 2/6/13 at 12:45 PM. The review indicated the following:</p> <p>-BDDS report dated 12/11/12 indicated on 12/11/12, "It was discovered that the home had bed bugs. The home cannot be treated until Friday, December 14 in the morning. As a result, all consumers have been relocated to a hotel in (sic) [name of city] area until the home can be treated. It is anticipated that the clients will be able to return to the group home on Saturday morning December 15. All linens, (sic) clothing professionally treated and cleaned." The 12/11/12 BDDS report did not indicate documentation client B's</p>	W0148	<p>Home Manager and Program Director will be retrained on the need to ensure that all consumers' parents and/or guardians are notified within 24 hours of any significant incidents or changes in consumers' conditions, including anytime the consumers have to be relocated out of the home for any reason.</p> <p>Ongoing, HM and/or PD will notify all consumers' parents and/or guardians within 24 hours of any significant incidents or changes in consumers' condition. When completing paperwork for consumer incidents, the Program Director will work with the Home Manager to ensure that they have notified guardians of significant incidents or changes in the consumers' condition and if the HM have not done this, the Program Director will ensure it is completed. The Area Director will review all incident reports to ensure that documentation of guardian notification is listed as needed.</p> <p>Responsible party: Home Manager, Program Director, Area</p>	03/17/2013			

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	<p>guardian had been notified of the group home being closed due to bed bug infestation.</p> <p>Client B's record was reviewed on 2/7/13 at 9:47 AM. Client B's ISP (Individual Support Plan) dated 11/16/12 indicated client B had a legal guardian.</p> <p>Client B's guardian was interviewed on 2/6/13 at 11:00 AM. Client B's guardian indicated she was not notified of the group home being closed due to bed bug infestation on 12/11/12.</p> <p>HM #1 (Home Manager) was interviewed on 2/7/13 at 9:47 AM. HM #1 indicated client B's guardian had not been notified client B was relocated to a hotel due to the group home being closed for treatment of bedbug infestation.</p> <p>AS #1 (Administrative Staff) was interviewed on 2/7/13 at 10:30 AM. AS #1 indicated client B's guardian should have been notified of client B staying in a hotel due to the group homes bed bug infestation on 12/11/12.</p> <p>This federal tag relates to complaint #IN00122085.</p> <p>9-3-2(a)</p>		Director				

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W0149	<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 interview and record review for 4 of 13 allegations of abuse, neglect, mistreatment, exploitation or injuries of unknown origin reviewed for clients A, B, C, D, E and G, the facility failed to implement its policy and procedures to ensure the facility immediately notified BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an allegation of theft for client A, an incident of client to client aggression with injury for clients D and G and an incident of missing controlled medication for clients B and E. The facility failed to implement its policy and procedures to ensure the facility initiated an investigation regarding an allegation of theft for client A. The facility failed to implement its policy and procedure to ensure the facility completed a thorough investigation regarding an incident of missing controlled medication for clients B and E. The facility failed to implement its policy and procedures to ensure the facility reported the results of an investigation of an incident of missing controlled medication for clients B and E, an allegation of staff misconduct for client C and an incident of client to client aggression resulting in injury for clients D and G.</p> <p>Findings include:</p> <p>1. Confidential interview A indicated on 12/9/12 client A reported to staff #1 two of</p>	W0149	<p>1.A BDDS report was completed for the allegation that Client A's jerseys had been stolen. An investigation was completed to attempt to determine who took the jerseys. The investigation was inconclusive and Indiana Mentor will replace Client A's jerseys.</p> <p>All Direct Care staff will be retrained on the need to ensure that all BDDS reportable incidents including incidents of theft are reported to the Home Manager, Program Director and/or on call supervisor within designated timeframes. Home Manager will be retrained on the need to ensure that all BDDS reportable incidents including incidents of theft are reported to the Program Director and/or on call supervisor within designated timeframes so BDDS reports can be completed as needed</p> <p>2,3,4 All direct care staff working at this home will be retrained 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.</p>	03/17/2013
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	<p>his sports jerseys were stolen. Confidential interview A indicated client A's sport jerseys were valued between \$75.00 to \$100.00.</p> <p>The facility's BDDS reports, incident reports and investigations were reviewed on 2/6/13 at 12:45 PM. The review indicated the 12/9/12 allegation of theft regarding client A's sports jerseys was not reported to BDDS.</p> <p>2. The facility BDDS reports indicated the following:</p> <p>-BDDS report dated 12/17/12 indicated on 12/15/12, "While the residents were staying in a hotel for a few days, it was discovered that the controlled count for [client B]'s Concerta (Attention Deficit Hyper Activity Disorder) 36 milligrams was off by one pill. There was one pill missing from the correct count. There was no documentation stating what happened to the pill."</p> <p>-BDDS report dated 12/17/12 indicated on 12/15/12, "While the residents were staying in a hotel for a few days, it was discovered that the controlled count for [client E]'s Concerta (Attention Deficit Hyper Activity Disorder) 54 milligrams was off by one pill. There was one pill missing from the correct count. There was no documentation stating what happened to the pill."</p> <p>-Investigation dated 12/18/12 indicated, "[HM #1 (house manager)] said she was notified on 12/15/12 at approximately 11:45 PM that medication count was off. [HM #1]</p>		<p>The Home Manager will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 3 times per week for 2 months to ensure that all incidents that fall under the BDDS reportable guidelines are reported to the Program Director within the designated timeframes.</p> <p>After the 2 month period, the HM will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 1 time per week to ensure that all incidents that fall under the BDDS reportable guidelines are reported to the Program Director within the designated timeframes.</p> <p>The Program Director received retraining on investigations including reporting to the administrator or designee the results within 5 work days.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough</p>		

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	<p>said she was not on call so she redirected the staff to call the on call house manager, [HM #2]." The 12/18/12 investigation indicated staff #2 and staff #3 were aware of the medication count discrepancy on 12/15/12. The 12/18/12 investigation regarding the 12/15/12 incident of missing medication for clients B and E indicated, "[HM #1] said she was notified on 12/15/12 at approximately 11:45 PM that medication count was off. [HM #1] said she was not on call so she redirected the staff to call the on call house manager, [HM #2]." The 12/18/12 investigation did not indicate an interview with HM #2. The 12/18/12 investigation indicated the date of the investigation was 12/21/12. The 12/18/12 investigation regarding the 12/15/12 incident of missing medication for clients B and E did not indicate documentation of the facility administrator being notified of the results.</p> <p>3. BDDS report dated 12/21/12 indicated on 12/21/12, "While [client C] was at his counseling appointment this morning, he told his counselor that his staff, [staff #4], gives him Xanax in exchange for cigarettes."</p> <p>-Investigation dated 1/4/13 regarding the 12/21/12 incident of staff misconduct for client C was not completed within 5 business days of the incident.</p> <p>4. BDDS report dated 1/25/13 indicated on 1/20/13, "On Sunday, 1/20/13 at approximately 8:00 PM (sic) [client D] and [client G] got into an altercation. [Client D]</p>		<p>enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</p>	

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	<p>bit [client G] on the chest which broke the skin. [Client G] sent to the emergency room. Treated and given a tetanus shot."</p> <p>-Investigation dated 2/1/13 regarding the 1/20/13 incident of client to client aggression between clients D and G did not indicate documentation of the facility administrator being notified of the results. The 2/1/13 investigation was not completed within 5 business days of the 1/20/13 incident.</p> <p>Interview with HM #1 on 2/7/13 at 9:45 AM indicated she had been notified on 12/9/12 by staff #1 of client A's allegation of theft of two sports jerseys. HM #1 indicated allegations of theft should be reported to BDDS. HM #1 indicated client A's 12/9/12 allegation of theft was not reported to BDDS. HM #1 indicated allegations of theft should be investigated. HM #1 indicated client A's 12/9/12 allegation of theft was not investigated. HM #1 indicated staff had notified her regarding clients D and G's altercation on 1/20/13. HM #1 indicated the 1/20/13 incident of client to client aggression for clients D and G was not reported within 24 hours to BDDS. HM #1 indicated she was not on call when notified of the 12/17/12 missing medications for clients B and E. HM #1 indicated clients B and E's missing medications incident was reported to HM #2 who was the on call home manager for 12/15/12. HM #1 indicated clients B and E's missing medications should have been reported to BDDS within 24 hours.</p> <p>Interview with QMRP #1 (Qualified Mental</p>			

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	<p>Retardation Professional) on 2/6/13 at 1:15 PM indicated the results of investigations should be reported to the administrator within 5 business days of the incident.</p> <p>AS #1 (Administrative Staff) was interviewed on 2/7/13 at 10:30 AM. AS #1 indicated allegations of theft, client to client aggression and incidents of missing medications should have been reported to BDDS within 24 hours of knowledge of the incidents. AS #1 indicated allegations of theft and incident of missing medications should have been thoroughly investigated. AS #1 indicated the results of investigations should be reported to the administrator within 5 business days of the incident.</p> <p>The facility's policy and procedures were reviewed on 2/14/13 at 6:38 PM. The 4/2011 facility's policy entitled Quality and Risk Management indicated, "Indiana Mentor follows the BDDS Incident Reporting policy as outlined in the Provider Standards. An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS: B(1)(e) Failure to provide appropriate supervision, care or training. 4.(f) Event with the potential for causing significant harm or injury and requiring medical or psychiatric treatments or services to or for an individual receiving services; 4.(p) Inadequate staff support of an individual, including inadequate supervision, with the potential for: (1) significant harm or injury to an individual;</p>						

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	<p>5. An initial report regarding an incident shall be submitted within twenty-four (24) hours of: (a) the occurrence of the incident; or (b) the reporter becoming aware of or receiving information about an incident."</p> <p>The 4/2011 facility's policy entitled Quality and Risk Management indicated:</p> <p>"C. Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardized the health and safety of any individual served or other employee.</p> <p>1. Investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident."</p> <p>9-3-2(a)</p>				

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W0153	<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 interview and record review for 3 of 13 allegations of abuse, neglect, mistreatment, exploitation or injuries of unknown origin reviewed, the facility failed to immediately notify BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an allegation of theft for client A, an incident of client to client aggression with injury for clients D and G and an incident of missing controlled medication for clients B and E.</p> <p>Findings include:</p> <p>1. Confidential interview A indicated on 12/9/12 client A reported to staff #1 two of his sports jerseys were stolen. Confidential interview A indicated client A's sport jerseys were valued between \$75.00 to \$100.00.</p> <p>The facility's BDDS reports, incident reports and investigations were reviewed on 2/6/13 at 12:45 PM. The review indicated the 12/9/12 allegation of theft regarding client A's sports jerseys was not</p>			W0153	<p>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.</p> <p>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.</p> <p>Ongoing the HM will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 3 times per week for 2 months to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the program director within the</p>		03/17/2013

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	<p>reported to BDDS.</p> <p>2. The BDDS reports indicated the following:</p> <p>-BDDS report dated 12/17/12 indicated on 12/15/12, "While the residents were staying in a hotel for a few days, it was discovered that the controlled count for [client B]'s Concerta (Attention Deficit Hyper Activity Disorder) 36 milligrams was off by one pill. There was one pill missing from the correct count. There was no documentation stating what happened to the pill."</p> <p>-BDDS report dated 12/17/12 indicated on 12/15/12, "While the residents were staying in a hotel for a few days, it was discovered that the controlled count for [client E]'s Concerta (Attention Deficit Hyper Activity Disorder) 54 milligrams was off by one pill. There was one pill missing from the correct count. There was no documentation stating what happened to the pill."</p> <p>-Investigation dated 12/18/12 indicated, "[HM #1 (home manager)] said she was notified on 12/15/12 at approximately 11:45 PM that medication count was off. [HM #1] said she was not on call so she redirected the staff to call the on call house manager, [HM #2]." The 12/18/12</p>		<p>designated timeframes.</p> <p>After the 2 month period, the HM will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 1 time per week to ensure all incidents are reported the Program Director within the designated timeframes.</p> <p>For 2 months, the Program Director will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 1 time per week to ensure all incidents have been reported within the designated timeframes.</p> <p>The Program Director will receive retraining on ensuring that any incidents that fall within BDDS reportable incident guidelines are reported to the Bureau of Developmental Disability Services and the Area Director within the designated reporting guidelines.</p> <p>Ongoing, the Area Director will review all BDDS reports to ensure that they are being submitted within the designated reporting guidelines.</p> <p>Responsible Party: Home Manager, Program Director, Area Director</p>		

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	<p>investigation indicated staff #2 and staff #3 were aware of the medication count discrepancy on 12/15/12.</p> <p>3. BDDS report dated 1/25/13 indicated on 1/20/13, "On Sunday, 1/20/13 at approximately 8:00 PM (sic) [client D] and [client G] got into an altercation. [Client D] bit [client G] on the chest which broke the skin. [Client G] sent to the emergency room. Treated and given a tetanus shot."</p> <p>Interview with HM #1 (Home Manager) on 2/7/13 at 9:45 AM indicated she had been notified on 12/9/12 by staff #1 of client A's allegation of theft of two sports jerseys. HM #1 indicated allegations of theft should be reported to BDDS. HM #1 indicated client A's 12/9/12 allegation of theft was not reported to BDDS. HM #1 indicated staff had notified her regarding clients D and G's altercation on 1/20/13. HM #1 indicated the 1/20/13 incident of client to client aggression for clients D and G was not reported within 24 hours to BDDS. HM #1 indicated she was on call when notified of the 12/17/12 missing medications for clients B and E. HM #1 indicated clients B and E's missing medications should have been reported to BDDS within 24 hours.</p> <p>AS #1 (Administrative Staff) was</p>						

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
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	interviewed on 2/7/13 at 10:30 AM. AS #1 indicated allegations of theft, client to client aggression and incidents of missing medications should have been reported to BDDS within 24 hours of knowledge of the incidents. 9-3-1(b)(5) 9-3-2(a)			

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W0154	<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 interview and record review for 2 of 13 allegations of abuse, neglect, mistreatment, exploitation or injuries of unknown origin reviewed, the facility failed to initiate an investigation regarding an allegation of theft for client A. The facility failed to complete a thorough investigation regarding an incident of missing controlled medication for clients B and E.</p> <p>Findings include:</p> <p>1. Confidential interview A indicated on 12/9/12 client A reported to staff #1 two of his sports jerseys were stolen. Confidential interview A indicated client A's sport jerseys were valued between \$75.00 to \$100.00.</p> <p>The facility's BDDS reports, incident reports and investigations were reviewed on 2/6/13 at 12:45 PM. The review indicated the 12/9/12 allegation of theft regarding client A's sports jerseys was not investigated.</p> <p>2. The BDDS reports indicated the following:</p>	W0154	<p>The Program Director will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</p>	03/17/2013			

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	<p>-BDDS report dated 12/17/12 indicated on 12/15/12, "While the residents were staying in a hotel for a few days, it was discovered that the controlled count for [client B]'s Concerta (Attention Deficit Hyper Activity Disorder) 36 milligrams was off by one pill. There was one pill missing from the correct count. There was no documentation stating what happened to the pill."</p> <p>-BDDS report dated 12/17/12 indicated on 12/15/12, "While the residents were staying in a hotel for a few days, it was discovered that the controlled count for [client E]'s Concerta (Attention Deficit Hyper Activity Disorder) 54 milligrams was off by one pill. There was one pill missing from the correct count. There was no documentation stating what happened to the pill."</p> <p>-Investigation dated 12/18/12 regarding the 12/15/12 incident of missing medication for clients B and E indicated, "[HM #1 (home manager)] said she was notified on 12/15/12 at approximately 11:45 PM that medication count was off. [HM #1] said she was not on call so she redirected the staff to call the on call house manager, [HM #2]." The 12/18/12 investigation did not indicate an interview with HM #2. The 12/18/12 investigation indicated the date of the investigation was</p>			

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	<p>12/21/12.</p> <p>Interview with HM #1 on 2/7/13 at 9:45 AM indicated she had been notified on 12/9/12 by staff #1 of client A's allegation of theft of two sports jerseys. HM #1 indicated allegations of theft should be investigated. HM #1 indicated client A's 12/9/12 allegation of theft was not investigated. HM #1 indicated she was not on call when notified of the 12/17/12 missing medications for clients B and E. HM #1 indicated clients B and E's missing medications was reported to HM #2 who was the on call home manger for 12/15/12.</p> <p>AS #1 (Administrative Staff) was interviewed on 2/7/13 at 10:30 AM indicated allegations of theft and incident of missing medications should have been thoroughly investigated.</p> <p>9-3-2(a)</p>			

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W0156	<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.</p> <p>Based on interview and record review for 3 of 13 allegations of abuse, neglect, mistreatment, exploitation or injuries of unknown origin reviewed, the facility failed to report the results of an investigation of an incident of missing controlled medication for clients B and E, an allegation of staff misconduct for client C and an incident of client to client aggression resulting in injury for clients D and G.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, incident reports and investigations were reviewed on 2/6/13 at 12:45 PM. The review indicated the following:</p> <p>1. BDDS report dated 12/17/12 indicated on 12/15/12, "While the residents were staying in a hotel for a few days, it was discovered that the controlled count for [client B]'s Concerta (Attention Deficit Hyper Activity Disorder) 36 milligrams was off by one pill. There was one pill</p>	W0156	<p>The Program Director will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director</p>	03/17/2013			

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	<p>missing from the correct count. There was no documentation stating what happened to the pill."</p> <p>-BDDS report dated 12/17/12 indicated on 12/15/12, "While the residents were staying in a hotel for a few days, it was discovered that the controlled count for [client E]'s Concerta (Attention Deficit Hyper Activity Disorder) 54 milligrams was off by one pill. There was one pill missing from the correct count. There was no documentation stating what happened to the pill."</p> <p>-Investigation dated 12/18/12 regarding the 12/15/12 incident of missing medication for clients B and E did not indicate documentation of the facility administrator being notified of the results.</p> <p>2. BDDS report dated 12/21/12 indicated on 12/21/12, "While [client C] was at his counseling appointment this morning, he told his counselor that his staff, [staff #4], gives him Xanax in exchange for cigarettes."</p> <p>-Investigation dated 1/4/13 regarding the 12/21/12 incident of staff misconduct for client C was not completed within 5 business days of the incident.</p> <p>3. BDDS report dated 1/25/13 indicated</p>			

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	<p>on 1/20/13, "On Sunday, 1/20/13 at approximately 8:00 PM (sic) [client D] and [client G] got into an altercation. [Client D] bit [client G] on the chest which broke the skin. [Client G] sent to the emergency room. Treated and given a tetanus shot."</p> <p>-Investigation dated 2/1/13 regarding the 1/20/13 incident of client to client aggression between clients D and G did not indicate documentation of the facility administrator being notified of the results. The 2/1/13 investigation was not completed within 5 business days of the 1/20/13 incident.</p> <p>Interview with QMRP #1 (Qualified Mental Retardation Professional) on 2/6/13 at 1:15 PM indicated the results of investigations should be reported to the administrator within 5 business days of the incident.</p> <p>AS #1 (Administrative Staff) was interviewed on 2/7/13 at 10:30 AM. AS #1 indicated the results of investigations should be reported to the administrator within 5 business days of the incident.</p> <p>9-3-2(a)</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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