

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G422	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/24/2013
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 5843 N SHERMAN AVE INDIANAPOLIS, IN 46220
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W000000	<p>This visit was for investigation of complaint #IN00135301.</p> <p>Complaint #IN00135301: Substantiated. Federal and state deficiencies related to the allegation are cited at W102, W104, W122, W149, W153, W154, W186, W318, W331, W368 and W382. Unrelated deficiencies cited at W140, W210, W322, W436 and W460.</p> <p>Dates of Survey: September 9, 10, 11 and 24, 2013.</p> <p>Facility Number: 000936 Provider Number: 15G422 AIMS Number: 100244610</p> <p>Surveyor: Claudia Ramirez, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on 10/2/2013 by W. Chris Greeney 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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W000102	<p><b>483.410 GOVERNING BODY AND MANAGEMENT</b> The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 3 of 3 sampled clients (A, B and C) and for 4 additional clients (D, E, F and G). The governing body failed: To ensure the staff immediately reported abuse, neglect and mistreatment to the administrator; to develop a system/policy and procedure which ensured the facility conducted complete and thorough investigations of all allegations of abuse/neglect/mistreatment/exploitation for clients A and B; to ensure clients A, B, C, D, E, F and G received health care services timely for their medical needs; to implement policies and procedures which prohibited client neglect, abuse, mistreatment and exploitation and to ensure a sufficient number of staff were in the clients' home to provide client care, ensure their safety and prevent medications from being taken by a client (client A) without staff supervision, resulting in a overdose.</p> <p>Findings include:</p> <p>1. Please refer to W122, the Condition of</p>	W000102	<p><b>CORRECTION:</b>The facility must ensure that specific governing body and management requirements are met. Specifically: The employment of the staff person who failed to report the allegations of sleeping and misappropriation of funds has been terminated. Additionally, the governing body has overseen has retraining of direct support staff regarding the need to immediately report all allegations of abuse, neglect and mistreatment immediately to a supervisor. The governing body will assure that the facility investigates a medication error that occurred with Client B on 7/29/13 and that the facility obtains investigation records from Client A's former day service regarding an incident of elopement that occurred on 7/18/13: The governing body has terminated the employment of the staff who left Client C and Client F unattended on the facility van and the supervisor who was found to have been sleeping while on duty. The governing body has placed a new supervisory team at the facility. All staff have been retrained regarding the need to keep medication secure at all times. Additional staff have been</p>	10/24/2013
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	<p>Participation: Client Protections for for 3 of 3 sampled clients (clients A, B, and C) and 4 additional clients (clients D, E, F and G), for the Governing Body's failure:</p> <p>__ To ensure the staff immediately reported abuse, neglect and mistreatment to the administrator.</p> <p>__ To develop a system/policy and procedure which ensured the facility conducted complete and thorough investigations of all allegations of abuse/neglect/mistreatment/exploitation for clients A and B.</p> <p>__ To develop a system/policy procedure which provides adequate supervision to ensure safety, prevent medications from not being secure resulting in an overdose and not ensuring client funds have accurate accountings.</p> <p>2. Please see W318. The governing body failed to meet the Condition of Participation: Health Care Services for for 3 of 3 sampled clients (clients A, B and C), to ensure they received health care services for their medical needs by failing to ensure client A did not receive too much medication; by failing to ensure client B received a re-evaluation for her falls and by failing to obtain physician follow-up recommendations.</p> <p>3. Please refer to W104 for 3 of 3 sampled clients (A, B and C) and for 4</p>		<p>placed on the day and evening shifts to eliminate distractions and to provide enhanced supervision of all clients. When sufficient direct support staff are not available to cover a shift, professional/supervisory staff will provide active treatment services. The governing body has replaced the facility nurse. The governing body has established protocols to assure medication will be counted no less than once per shift. In addition to regularly scheduled counts, any time a breach in security occurs that results in or has the potential to result in a medication error, the facility nurse will oversee a count of all medications in the home. The governing body has directed the team to assure that a Physical Therapy assessment for Client B is completed. Additionally, the nurse has reviewed all facility medical records and additional PT assessments have been scheduled based on the results of the record review. Client C has received an annual physical examination. A review of facility records indicated all other clients have received a physical examination within the past 12 months. With assistance from administrative staff, the Health Services Team will conduct a thorough audit of facility medical records to assure that all other recommended medical follow-up has</p>		

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	<p>additional clients (D, E, F and G), the facility's governing body failed to exercise general policy and operating direction over the facility:</p> <p>__ To ensure the facility implemented/developed its written policy and procedures to immediately report all allegations of abuse/neglect/mistreatment to the administrator. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse/neglect/mistreatment/exploitation were thoroughly investigated,</p> <p>__ To ensure sufficient staff were in the home to supervise clients and keep them safe,</p> <p>__ To ensure medications were not available (client A) without staff supervision,</p> <p>__ To ensure clients received timely medical care (clients B and C).</p> <p>This federal tag relates to complaint #IN00135301.</p> <p>9-3-1(a)</p>		<p>occurred. PREVENTION:Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Quality Assurance Manager who will in turn coordinate and follow-up with the facility Clinical Supervisor to assure appropriate follow-up occurs. Training of direct support staff toward expectations for reporting abuse, neglect and mistreatment will be ongoing and occur no less than monthly. The new QIDP trained regarding the need to document all investigations, criteria for conducting investigations at the facility 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 and nursing staff 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 Clinical Supervisor will also follow-up with the Nurse Manager no less than weekly to assure that</p>		

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			timely investigations occur for significant medical incidents. 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. The Administrative Team will monitor facility staff schedules to assure adequate direct support staff are assigned to all shifts. Specifically the Program Manager will perform weekly checks of facility labor hours and take corrective action as needed. Additionally, on an ongoing basis, members of the Administrative Team will spot check time and attendance records to assure hours worked match the facility schedule. Members of the Administrative Team, including the Executive Director and Program Manager, will maintain an increased presence at the facility, performing unscheduled observation of active treatment no less than five times weekly for the next 30 days, no less than three times weekly for an additional 30 days and no less than weekly for an additional 30 days to assure that medications are administered per physician's orders and are secured properly. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the	

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			home to no less than monthly. The governing body has directed the facility nurse to maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to visual evaluations, occur within required time frames. Members of the Administrative Team will incorporate medical chart reviews into the formal audit process, which will occur no less than quarterly to assure appropriate medical follow-up takes place as required. Additionally the Nurse Manager will monitor the facility's tracking system and will participate in Administrative Team audits. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Administrative Team	

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review for 3 of 3 sampled clients (A, B and C) and for 4 additional clients (D, E, F and G), the facility's governing body failed to exercise general policy and operating direction over the facility:</p> <p>___ To ensure the facility implemented/developed its written policy and procedures to immediately report all allegations of abuse/neglect/mistreatment to the administrator. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse/neglect/mistreatment/exploitation were thoroughly investigated,</p> <p>___ To ensure sufficient staff were in the home to supervise clients and keep them safe,</p> <p>___ To ensure medications were not available (client A) without staff supervision,</p> <p>___ To ensure clients received timely medical care (clients B and C).</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction</p>	W000104	<p>CORRECTION: The governing body must exercise general policy, budget and operating direction over the facility. Specifically: The employment of the staff person who failed to report the allegations of sleeping and misappropriation of funds has been terminated. Additionally, the governing body has overseen has retraining of direct support staff regarding the need to immediately report all allegations of abuse, neglect and mistreatment immediately to a supervisor. The governing body will assure that the facility investigates a medication error that occurred with Client B on 7/29/13 and that the facility obtains investigation records from Client A's former day service regarding an incident of elopement that occurred on 7/18/13: The governing body has terminated the employment of the staff who left Client C and Client F unattended on the facility van and the supervisor who was found to have been sleeping while on duty. The governing body has placed a new supervisory team at the facility. All staff have been retrained regarding the need to keep medication secure at all times. Additional staff have been placed on the day and evening</p>	10/24/2013	

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	<p>over the facility for clients A, B and C, to maintain an accurate accounting system for each client's individual personal fund accounts. Please see W140.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to:            __ Develop and implement written policies and procedures to ensure all allegations of abuse/neglect/injuries of unknown sources/exploitation were reported immediately to the administrator and were thoroughly investigated.            __ Develop and implement written policies and procedures to ensure a sufficient number of staff were in the home were present to ensure client safety and provide for clients A, B, C, D, E, F and G's individual needs. Please see W149.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure all incidents of abuse, neglect, injuries of unknown sources and/or mistreatment were reported immediately to the administrator in accordance with state law for client A. Please see W153.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure all incidents of</p>		<p>shifts to eliminate distractions and to provide enhanced supervision of all clients. When sufficient direct support staff are not available to cover a shift, professional/supervisory staff will provide active treatment services. The governing body has replaced the facility nurse. The governing body has established protocols to assure medication will be counted no less than once per shift. In addition to regularly scheduled counts, any time a breach in security occurs that results in or has the potential to result in a medication error, the facility nurse will oversee a count of all medications in the home. The governing body has directed the team to assure that a Physical Therapy assessment for Client B is completed. Additionally, the nurse has reviewed all facility medical records and additional PT assessments have been scheduled based on the results of the record review. Client C has received an annual physical examination. A review of facility records indicated all other clients have received a physical examination within the past 12 months. With assistance from administrative staff, the Health Services Team will conduct a thorough audit of facility medical records to assure that all other recommended medical follow-up has occurred.            PREVENTION:Supervisory staff</p>	

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	<p>abuse/neglect/mistreatment/exploitation were thoroughly investigated for clients A and B. Please see W154.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility to provide sufficient staff to provide care to meet client needs and to ensure staff not sleep on duty for 7 of 7 clients living in the home (clients A, B, C, D, E, F and G); by failing to provide sufficient staff to monitor clients and keep them safe (client A, B and F). Please see W186.</p> <p>This federal tag relates to complaint #IN00135301.</p> <p>9-3-1(a)</p>		<p>will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Quality Assurance Manager who will in turn coordinate and follow-up with the facility Clinical Supervisor to assure appropriate follow-up occurs. Training of direct support staff toward expectations for reporting abuse, neglect and mistreatment will be ongoing and occur no less than monthly. The new QIDP trained regarding the need to document all investigations, criteria for conducting investigations at the facility 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 and nursing staff 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 Clinical Supervisor will also follow-up with the Nurse Manager no less than weekly to assure that timely investigations occur for</p>	

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			significant medical incidents. 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. The Administrative Team will monitor facility staff schedules to assure adequate direct support staff are assigned to all shifts. Specifically the Program Manager will perform weekly checks of facility labor hours and take corrective action as needed. Additionally, on an ongoing basis, members of the Administrative Team will spot check time and attendance records to assure hours worked match the facility schedule. Members of the Administrative Team, including the Executive Director and Program Manager, will maintain an increased presence at the facility, performing unscheduled observation of active treatment no less than five times weekly for the next 30 days, no less than three times weekly for an additional 30 days and no less than weekly for an additional 30 days to assure that medications are administered per physician's orders and are secured properly. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than	

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			monthly. The governing body has directed the facility nurse to maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to visual evaluations, occur within required time frames. Members of the Administrative Team will incorporate medical chart reviews into the formal audit process, which will occur no less than quarterly to assure appropriate medical follow-up takes place as required. Additionally the Nurse Manager will monitor the facility's tracking system and will participate in Administrative Team audits. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Administrative Team	

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 3 of 3 sampled clients (clients A, B, and C) and 4 additional clients (clients D, E, F and G). The facility failed to implement its written policies and procedures to prevent neglect by failing to provide adequate supervision to ensure safety, prevent medications from not being secure resulting in an overdose and not ensuring client funds have accurate accountings.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Please refer to W140. The facility neglected for 3 of 3 sample clients (clients A, B and C), to maintain an accurate accounting system for each client's personal fund account.</li> <li>Please refer to W149. The facility neglected for 3 of 11 BDDS (Bureau of Developmental Disabilities Services) reports, to implement the facility's policy/procedure and neglected to: report allegations staff abuse immediately (client A); investigate an allegation of staff abuse (client A); provide 24 hour supervision to clients by not leaving them on the van</li> </ol>	W000122	<p>CORRECTION: The facility must ensure that specific client protections requirements are met. Specifically, The employment of the staff person who failed to report the allegations of sleeping and misappropriation of funds has been terminated. Additionally, the facility has retrained direct support staff regarding the need to immediately report all allegations of abuse, neglect and mistreatment immediately to a supervisor. The facility will investigate a medication error that occurred with Client B on 7/29/13 and the facility will obtain investigation records from Client A's former day service regarding an incident of elopement that occurred on 7/18/13: The facility has terminated the employment of the staff who left Client C and Client F unattended on the facility van and the supervisor who was found to have been sleeping while on duty. A new supervisory team is in place at the facility. All staff have been retrained regarding the need to keep medication secure at all times. Additional staff have been placed on the day and evening shifts to eliminate distractions and to provide enhanced supervision of all clients. PREVENTION: Supervisor y staff will review all facility documentation to assure</p>	10/24/2013			

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	<p>unattended (clients C and F) and ensure staff not sleep on duty (clients A, B, C, D, E, F and G). The facility neglected to provide sufficient number of staff to ensure client care/protection and keep the medications locked to ensure clients could not access medications without staff supervision (client A).</p> <p>3. Please refer to W153. The facility neglected for 1 of 11 BDDS (Bureau of Developmental Disabilities Services) reports regarding allegations of abuse, neglect and/or injuries of unknown source reviewed, to report the allegations immediately in regard to alleged verbal abuse, staff sleeping on duty and misappropriation of client funds (client A) by staff #7.</p> <p>4. Please refer to W154. The facility neglected for 2 of 11 BDDS (Bureau of Developmental Disabilities Services) reports regarding allegations of abuse, neglect and/or injuries of unknown source reviewed, to conduct an investigation in regard to client neglect for clients A and B.</p> <p>5. Please refer to W186. The facility failed for 7 of 7 clients living in the home (clients A, B, C, D, E, F and G), to provide sufficient staff to provide care to meet client needs and to ensure staff not</p>		<p>incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Quality Assurance Manager who will in turn coordinate and follow-up with the facility Clinical Supervisor to assure appropriate follow-up occurs. Training of direct support staff toward expectations for reporting abuse, neglect and mistreatment will be ongoing and occur no less than monthly. The new QIDP trained regarding the need to document all investigations, criteria for conducting investigations at the facility 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 and nursing staff 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 Clinical Supervisor will also follow-up with the Nurse Manager no less than weekly to assure that timely investigations occur for significant medical incidents. The Executive Director will monitor the</p>				

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	<p>sleep on duty and to provide sufficient staff to monitor clients and keep them safe (client A, B and F).</p> <p>This federal tag relates to complaint #IN00135301.</p> <p>9-3-2(a)</p>		<p>facility's incident – investigation tracking spreadsheet and follow-up as needed with the QIDP and Program Manager to provide for increased accountability. The Administrative Team will monitor facility staff schedules to assure adequate direct support staff are assigned to all shifts. Specifically the Program Manager will perform weekly checks of facility labor hours and take corrective action as needed. Additionally, on an ongoing basis, members of the Administrative Team will spot check time and attendance records to assure hours worked match the facility schedule. Members of the Administrative Team, including the Executive Director and Program Manager, will maintain an increased presence at the facility, performing unscheduled observation of active treatment no less than five times weekly for the next 30 days, no less than three times weekly for an additional 30 days and no less than weekly for an additional 30 days to assure that medications are administered per physician's orders and are secured properly. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONSIBLE PARTIES:QIDP, Residential</p>		

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			Manager, Direct Support Staff, Health Services Team, Administrative Team	

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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.</p> <p>Based on record review and interview, for 3 of 3 sample clients (clients A, B and C), the facility failed to maintain an accurate accounting system for each client's personal fund account.</p> <p>Findings include:</p> <p>On 09/11/13 at 11:12 AM a petty cash (spending money of the clients kept at the group home) review of client funds was conducted for clients A, B and C, along with a review of the monthly cash ledgers and receipts for petty cash funds from June 2013 to September 10, 2013. The review of ledgers indicated the following:</p> <p>Client A: The June 2013 ledger indicated client A received \$10.00 on 06/04/13 for spending money. There were no receipts to indicate how the \$10.00 was spent. The July 2013 ledger did not have receipts for one of the entries written on the sheet which indicated client A had made purchases for \$4.49. The August 2013 ledger did not have receipts for two of the entries written on the sheet which indicated client A had made purchases for</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 A, B, C and three additional clients D, E and F, 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 Operations and Quality Assurance Teams will include audits of client finances as part of an ongoing facility audit</p>	10/24/2013

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	<p>\$2.56 and \$1.07.</p> <p>Client A's records were reviewed on 09/10/13 at 9:26 AM. Client A's ISP (Individual Support Plan) dated 04/22/13 indicated client A was not able to independently handle her money and required assistance. An Individual Financial Assessment dated 04/18/13 indicated, "Individual requires assistance. Individual will have access to weekly spending money not to exceed \$10.00 without receipts. Staff is responsible for assisting individual with purchases, maintaining receipts and balancing bank accounts...."</p> <p>Client B: The August 2013 ledger indicated client B received \$5.00 on 08/22/13 for spending money. A receipt dated 08/22/13 indicated client B had made purchases in the amount of \$4.28. The ledger sheet entered that fund withdrawal as \$0.72 instead of \$4.28. A withdrawal on 08/26/13 indicated client B had spent \$3.00. The account was at a negative of \$2.28, but the ledger sheet indicated client B had \$1.28 in the account.</p> <p>Client B's records were reviewed on 09/10/13 at 10:24 AM. Client B's ISP dated 03/11/13 indicated client B was not able to independently handle her money</p>		<p>process. Additionally, members of the Administrative Team, including the Executive Director and Program Manager, will maintain an increased presence at the facility, performing unscheduled observation of active treatment no less than five times weekly for the next 30 days, no less than three times weekly for an additional 30 days and no less than weekly for an additional 30 days. Team members will incorporate reviews of client financial records into these visits. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Administrative Team</p>	

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	<p>and required assistance. An Individual Financial Assessment dated 03/11/13 indicated, "Individual requires total assistance and will not have access to monies. All money will be accounted for with receipts...."</p> <p>Client C: The June 2013 ledger indicated client C received \$20.00 on 06/17/17 and withdrew the \$20.00 on 06/17/17 from the account. Client C also received on 06/20/13 \$10.00 into the account and he withdrew the \$10.00 on 06/20/13. The ledger contained no receipts for how the \$30.00 was spent.</p> <p>Client C's records were reviewed on 09/10/13 at 11:25 AM. Client C's ISP (Individual Support Plan) dated 07/15/13 indicated client C was not able to independently handle his money and required assistance. An Individual Financial Assessment dated 07/15/13 indicated client C was not independent with his money and required assistance.</p> <p>An interview was conducted on 09/11/13 at 11:40 AM, with the Clinical Supervisor #1 (CS #1). The CS #1 indicated clients A, B and C were not independent in handling their money and required total assistance from the agency/staff. The CS#1 indicated all of the money should be accounted for with receipts and all</p>			

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	ledger pages should balance.  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.</p> <p>Based on record review and interview for 3 of 11 BDDS (Bureau of Developmental Disabilities Services) reports, the facility neglected to implement the facility's policy/ procedure and neglected to: report allegations staff abuse immediately (client A); investigate an allegation of staff abuse (client A); provide 24 hour supervision to clients by not leaving them on the van unattended (clients C and F) and ensure staff not sleep on duty (clients A, B, C, D, E, F and G). The facility neglected to keep the medications locked to ensure clients could not access medications without staff supervision (client A).</p> <p>Findings include:</p> <p>On 09/09/13 at 11:29 AM the facility's BDDS Reports and investigations were reviewed from 06/01/13 through 09/08/13 and indicated the following:</p> <p>1. 06/27/13: A BDDS report indicated, "The Executive Director received a report alleging that staff [staff #7] had been sleeping while on duty and had made threatening remarks towards [client A]... [staff #7] has been suspended pending</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 employment of the staff person who failed to report the allegations of sleeping and misappropriation of funds has been terminated. Additionally, the facility has retrained direct support staff regarding the need to immediately report all allegations of abuse, neglect and mistreatment immediately to a supervisor. The facility will investigate a medication error that occurred with Client B on 7/29/13 and the facility will obtain investigation records from Client A's former day service regarding an incident of elopement that occurred on 7/18/13: The facility has terminated the employment of the staff who left Client C and Client F unattended on the facility van and the supervisor who was found to have been sleeping while on duty. A new supervisory team is in place at the facility. All staff have been retrained regarding the need to keep medication secure at all times. Additional staff have been placed on the day and evening shifts to eliminate distractions and to provide enhanced supervision of all</p>	10/24/2013			

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	<p>investigation of the allegations.</p> <p>07/16/13: A Follow-up BDDS report indicated, "Evidence gathered through investigation did not substantiate that [staff #7] made threatening remarks to [client A]. Specifically, [staff #7] denied [client A's] allegation and the only other witness did not corroborate her testimony. Evidence did however, substantiate that [staff #7] slept while on duty. [Staff #7's] employment with [agency] has been terminated."</p> <p>An Investigative Summary dated 06/27/13 indicated, "Introduction: [Client A]...and [staff #2] reported to [client A's counselor] on 6/27/13 that during the week of 6/24/13 - 6/27/13 [staff #7] was rude to [client A]. [Client A] also reported on an occasion during the week of 6/17/13 - 6/21/13, [staff #7] told her that, 'if you weren't a client, I would have hit you' in response to [client A] almost sitting on [staff #7's] hand. [Client A] also told her counselor that [staff #7] fails to give [client A] spending money each week and also has been witnessed sleeping while working at the house on multiple occasions. [Client A's counselor] said that [staff #2] was present when [client A] made the allegations... Summary of Interviews: [Client A] said that on the night of 5/23/13, when [staff</p>		<p>clients. PREVENTION:Supervisor y staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Quality Assurance Manager who will in turn coordinate and follow-up with the facility Clinical Supervisor to assure appropriate follow-up occurs. Training of direct support staff toward expectations for reporting abuse, neglect and mistreatment will be ongoing and occur no less than monthly. The new QIDP trained regarding the need to document all investigations, criteria for conducting investigations at the facility 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 and nursing staff 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 Clinical Supervisor will also follow-up with the Nurse Manager no less than weekly to assure that</p>	

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	<p>#7] and [staff #2] picked her up from work, when [client A] was getting into the van, [staff #7] told her not to sit on her hand and then said if [client A] wasn't a client she would hit her. She said she did not report these allegations to [Clinical Supervisor #3] but that she told [staff #2] and her counselor. [Client A] also said that [staff #2] told her counselor. [Client A] also said that [staff #7] sleeps while she is at work. She said that [staff #7] locks herself in the medication room and sleeps. When first interviewed, [client A] said that many people had told her about [staff #7] sleeping but she had not actually seen [staff #7] asleep. When re-interviewed and asked about a specific alleged sleeping incident on 6/20/13, [client A] said that [staff #7] was asleep when she got up and she also said that [staff #7] had slept during her counseling appointments. [Client A] said that the fact that [staff #7] sleeps frequently while she is at work is common knowledge.</p> <p>[Staff #2] said that on 6/20/13, she came into work at 7:00 AM, rang the doorbell and [client #7] opened the door for her and she came in and saw [staff #7] sleeping in a chair by the television. She said she spoke to [staff #7] and [staff #7] responded by saying 'hey'. She said [staff #7] picked something up off the table and then went back to sleep. She said [staff</p>		<p>timely investigations occur for significant medical incidents. 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. The Administrative Team will monitor facility staff schedules to assure adequate direct support staff are assigned to all shifts. Specifically the Program Manager will perform weekly checks of facility labor hours and take corrective action as needed. Additionally, on an ongoing basis, members of the Administrative Team will spot check time and attendance records to assure hours worked match the facility schedule. Members of the Administrative Team, including the Executive Director and Program Manager, will maintain an increased presence at the facility, performing unscheduled observation of active treatment no less than five times weekly for the next 30 days, no less than three times weekly for an additional 30 days and no less than weekly for an additional 30 days to assure that medications are administered per physician's orders and are secured properly. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the</p>		

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	<p>#7] remained asleep through breakfast and was still asleep when she left to transport the individuals to work. [Staff #2] said she did not report this to a supervisor because she did not trust that the situation would be handled. [Staff #2] said that on 6/22/13, [client A] told her and [staff #1] that on the night of the dance 5/23/13 when [staff #7] and [staff #5] picked her up from work, when [client A] was getting into the van, [staff #7] told her not to sit on her hand and then said if [client A] wasn't a client she would hit her. [Staff #2] said she did not report these allegations to a supervisor but that while assisting [client A] with attending an (sic) counselor's appointment on 6/26/13, she observed [client A] explaining the allegations to the counselor who said she would report them. [Staff #2] said she did not prompt [client A] to make the allegations to her counselor.</p> <p>[Staff #5] said that on the night of 5/23/13, she and [staff #7] picked up [client A] from work. She said as [client A] was getting into the back seat, [staff #7] saw something on the seat and reached back to grab it. She said [client A] acknowledged [staff #7's] hand being on the seat and proceeded to act as if she was going to sit on it. She said [staff #7] did tell tell [client A] that if she wasn't a client, she would hit her...</p>		home to no less than monthly. RESPONSIBLE PARTIES:QIDP, Residential Manager, Direct Support Staff, Health Services Team, Administrative Team				

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	<p>[Staff #7] said that due to her sleep apnea, she takes measures to stay awake on th (sic) job including vitamin supplements and energy drinks. She said that she does not sleep while on duty and that the only time she locks herself in the medication room is when she is having a private conversation with [CS #3] or a staff person. [Staff #7] said that on the night of 5/23/13, she and [staff #5] picked up [client A] from work. She said when [client A] was getting on the van she attempted to move an object off the seat so [client A] would not sit on it. She said she told [client A], 'Wow. Don't you see me moving this so you don't sit on this?' [Staff #7] said she has never told [client A] or any other individuals supported by [agency] that she would hit them if they weren't clients...</p> <p>[Client F] said that on the morning of 6/21/13, [staff #7] was sleeping in the living room when [staff #2] arrived at work. He said she remained asleep through breakfast. He said he has seen [staff #7] sleeping while at work on other occasions.</p> <p>[Client E] said that on the morning of 6/21/13, [staff #7] was sleeping in the living room when [staff #2] arrived at work. He said she remained asleep</p>			

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	<p>through breakfast. He said he did not know if she had slept at work on other occasions.</p> <p>[Client D] said that on the morning of 6/21/13, [staff #7] was sleeping in the living room when [staff #2] arrived at work. She said [staff #7] woke up for breakfast and then went back to sleep. [Client D] said she has seen [staff #7] sleeping on other occasions.</p> <p>[Client G] said that on the morning of 6/21/13, [staff #7] was sleeping in the living room when [staff #2] arrived at work. He said [staff #7] woke up for breakfast.</p> <p>[Client B] said that on the morning of 6/21/13, [staff #7] was sleeping in the living room when [staff #2] arrived at work. She said [staff #7] remained asleep through breakfast.</p> <p>[Client C] said that on the morning of 6/21/13, [staff #7] was sleeping in the living room when [staff #2] arrived at work. He said she remained asleep through breakfast. [Client C] said that he has seen [staff #7] sleeping at work frequently. [Staff #1] said that on 6/22/13, [client A] told her that [staff #7] told [client A] she would punch her (sic) wasn't a client. She said [client A] also</p>			

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	<p>told her that [staff #7] had asked her to sign a check and not given any of the money. [Staff #1] said she did not report these allegations to a supervisor. [Staff #1] said that on the first day she worked with [staff #7], [staff #7] slept in the medication room from 9:00 AM - 12:00 PM. She said she did nor (sic) report that [staff #7] was sleeping to a supervisor...</p> <p>[Client A's counselor] reported via email that [client A] discussed [staff #7's] failing to give [client A] her spending money each week. When interviewed, [client A] said that specifically she did not receive money she signed for on 6/21/13. [Staff #1] said that on 6/22/13, [client A] told her that [staff #7] asked her to sign for a check but did not give her any money. [Client A] signed am (sic) Acknowledgment of Receipt Form for \$10.00 on 6/16/13. A check of [client A's] financial records indicated that no receipts were available for purchases made after 6/19/13. [Staff #1] said she did not report [client A's] allegation of exploitation to a supervisor. [Client A's counselor] reported via email that [client A] said [staff #7] has been witnessed sleeping while working at the house on multiple occasions...she noticed (counselor) that [staff #7] had 'dozed off' in the [counselor] waiting room during [client A's] appointments 'on a few</p>			

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	<p>occasions'...</p> <p>Conclusion:</p> <ol style="list-style-type: none"> <li>1. The evidence does not substantiate that [staff #7] made threatening and disrespectful remarks toward [client A] at an unspecified date and time.</li> <li>2. The evidence partially substantiates [staff #7] withheld or misappropriated [client A's] weekly spending money on an unspecified week during June 2013. Specifically, although a preponderance of evidence did not demonstrate that [staff #7] failed to give [client A] weekly spending disbursement, no receipts were available to account for the spending of [client A's] 6/21/13 check.</li> <li>3. The evidence substantiates that [staff #7] slept while on duty.</li> <li>4. The evidence substantiates that [staff #2] failed to report allegations of abuse and mistreatment to a supervisor immediately.</li> <li>5. The evidence substantiates that [staff #1] failed to report allegations of abuse and mistreatment to a supervisor immediately."</li> </ol> <p>Client A's record was reviewed on 09/10/13 at 9:26 AM. Client A's ISP (Individual Support Plan) was dated 04/22/13 and indicated client A required 24 hour supervision.</p>			

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	<p>Client B's record was reviewed on 09/10/13 at 10:24 AM. Client B's ISP was dated 03/11/13 and indicated client B required 24 hour supervision.</p> <p>Client C's record was reviewed on 09/10/13 at 11:25 AM. Client C's ISP was dated 07/15/13 and indicated client C required 24 hour supervision.</p> <p>An interview was conducted on 09/11/13 at 11:40 AM, with the Clinical Supervisor #1 (CS #1). The CS #1 indicated staff failed to follow the policy/procedure and failed to immediately report allegations of abuse, mistreatment, exploitation and failed to report staff sleeping on the job. The CS #1 indicated staff #2 and staff #7 have both been terminated with the agency. The CS #1 indicated all of the clients in the home required 24 hour supervision and awake staff.</p> <p>2. 07/09/13: A BDDS report indicated, "On 07/09/13 it was alleged that a staff [staff #2] left [client C] and [client F]...unattended on the van while it was still running. [Staff #2] has been suspended pending a (sic) investigation...."</p> <p>An investigation dated 07/09/13 indicated, "Introduction: On 07/09/13, at 3:40 PM, [staff #5] reported that [staff</p>			

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	<p>#2] left [client F] and [client C]...unattended on the...van, while the vehicle was running...</p> <p>Summary of Interviews: [Staff #5] said on 7/9/13, she arrived at [group home address] at 3:00 PM. She said [staff #2] was away in the van until 3:26 PM. [Staff #5] said she was in the house doing some cleaning and [staff #2] came into he (sic) house, clocked out and went outside. She said [staff #2] came back into the house and dropped off the...card and left the house. [Staff #5] said she then opened the door to ask [staff #2] about the location of the can (sic) keys and [staff #2] pointed to the van and drove away. She said she (staff #5) closed the door and got dinner out and then left the house for evening transport. She said she saw that the van was running and that [client C] and [client F]...were in the van unattended. She said she was unaware that [client C] and [client F] had been picked up...</p> <p>[Client C] said that on the afternoon of 7/9/13, [staff #2] left him and [client F] on the van at [group home] after she picked them up from day service. He said that [staff #2] seemed upset but that she did not say anything when she left them on the van. He said the van was parked in front of the house and that he did not see</p>			

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	<p>[staff #5] when [staff #2] went into the house.</p> <p>[Client F] said that on the afternoon of 7/9/13, [staff #2] left him and [client C] on the van at [group home]. He said that [staff #2] did not say anything to them when she left. He said [staff #2] parked the van in front of the house and that he did not see [staff #5] when [staff #2] went into the house...</p> <p>[Staff #2] said that she was asked to pick up [client C] from day service before 3:00 PM and picked up [client F] as well. She said she arrived back at [group home] at approximately 3:30 PM. She said when she pulled up, the door was open and [staff #5] was standing in the doorway. She said she told [client F] and [client C] to stay in the van and that she told [staff #5] that [client C] and [client F] were waiting in the van. She said she left the van running so the air conditioner would stay on because it was hot outside. She said that she went into the house, dropped of the...card and left for the day. She said when she got into her vehicle, [staff #5] was sitting in the van.</p> <p>Factual Findings: Time and Attendance Records for [group home] indicate that on 7/9/13, [staff #2] worked from 6:57 AM - 3:29 PM and [staff #5] worked from 3:19</p>			

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	<p>PM - 11:00 PM...[Staff #2] signed the [agency] Driver Safety Code on 4/2/13 agreeing that 'I understand that consumers at no time are to be left unsupervised in any [agency] vehicle.' Conclusion: 1. The evidence substantiates that [staff #2] left [client F] and [client C]...unattended on the [group home] van, while the vehicle was running, on the afternoon of 7/9/13...Recommendations: 1. Term [staff #2] for leaving 2 individuals unattended in a running van."</p> <p>An interview was conducted on 09/11/13 at 11:40 AM, with the Clinical Supervisor #1 (CS #1). The CS #1 indicated clients C and F both required 24 hour supervision and staff #2 should not have left them alone in the running van. He indicated staff #2 had been terminated from the agency.</p> <p>3. 08/13/13: A BDDS report indicated, "[Client A]...told staff that she did not feel well because she took too much medication the previous night. Staff took [client A's] vital signs, which were within normal limits and called the supervisor. While staff was speaking to the supervisor, [client A] called 911. EMS (Emergency Medical Services) arrived and transported her to the [hospital #1] Emergency Department (ED). Tests indicated that [client A] had elevated liver</p>			

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	<p>enzymes and she was admitted to the hospital. An investigation was initiated and [client A] said that the medication room was unlocked and the keys to the medication cabinet were not being held by staff. [Staff #1] was the only employee on duty at the time of the incident and she has been suspended pending investigation. A review of the service site's medication indicated [client A] took the following medications prescribed to her: 16 Tylenol ES (Extra Strength) 500 mg (milligram) tabs (tablets) (pain), 5 Mylicon 80 mg tabs (gas relief) and 3 Hydroxyzine 25 mg tabs (anxiety/nausea/vomiting)...Her liver function had not improved on the morning of 08/14/13 and [client A] is being prepared for transfer to the [hospital #2]...."</p> <p>08/20/13: A Follow-up BDDS report to the 08/13/13 incident indicated, "[Client A] remains hospitalized at [hospital #2] and is being treated for liver failure. Evidence gathered through investigation substantiated that Direct Support Staff (DSS) [staff #1] failed to lock the medication room and left the keys to the medication room accessible to [client A], enabling her to access the medication. Staff [staff #1] remained suspended throughout the investigation and terminated of her employment has been</p>						

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	<p>approved. Staff have been retrained regarding the need to keep medications secured at all times and carry the keys at all times...."</p> <p>08/22/13: A BDDS report indicated, "....On 08/15/13 at 4:00 PM ResCare nurse, [name] visited [client A] and spoke with [client A's] nurse and hospital case manager. [name] was told that [client A's] condition was critical and guarded. [Client A] was on a ventilator but breathing on her own. Her LFTs (Liver Function Tests) were elevated...[Client A's] [aunt], at this time, stated that any communication regarding [client A's] condition would have to go through her and ResCare was not given access to the password to see [client A] in the hospital. On 08/16/13, QIDP (Qualified Intellectual Disabilities Professional) [name] and ResCare nurse, [name] attempted to visit [client A]. [Aunt] stated she would call them with an update and [QIDP] and [nurse] were asked to leave the hospital. From 08/17-08/22 ResCare staff included nursing, QIDP and Clinical Supervisor made daily attempts to corresponded (sic) with [client A's] aunt for updates on her condition. On 08/19/13, [client A's] aunt stated that [client A] would most likely need a liver transplant and her condition remained critical. On 08/23/13, [aunt] contacted PM (Program Manager) [name]</p>			

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	<p>and stated that [client A] had passed away at approximately 3:30 on 08/22/13. [Aunt] stated that [client A] had died from liver and kidney failure...."</p> <p>An Investigative Summary dated 08/13/13 indicated, "[Client A]...told [staff #8] on 08/13/13 at approximately 6:00 am that she did not feel well because she took too much medication the previous night. Staff took [client A's] vital signs, which were within normal limits. [Client A] took the phone an went upstairs and called 911. EMS (Emergency Medical Services) arrived and transported her to the [hospital #1] Emergency Department. [Client A] told EMS that she overdosed on Tylenol. Tests indicated that [client A] had elevated liver enzymes and she was admitted to the hospital. An investigation was initiated and [client A] said that the medication room was unlocked and she went in and got what she wanted. [Staff #1] was the only employee on duty at the time of the incident. A review of the service site's medication indicated [client A] took the following medications prescribed to her: 16 Tylenol ES 500 mg tabs, 6 Mylicon 80 mg tabs and 3 Hydroxyzine 25 mg tabs. Additional information indicated that a lock on one of the medication cabinets containing some of [client A's] PRN (as needed) medications was not functioning</p>			

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	<p>properly.</p> <p>On the morning of 8/14/13 her liver function had not improved and [client A] was prepared to transfer to the [hospital #2].</p> <p>[Staff #1] was suspended on 8/13/13 pending investigation of the allegations...</p> <p>Summary of Interviews:</p> <p>[Client G] said...he did see the medication room door open...</p> <p>[Client E] said...he did see the medication room door open...</p> <p>[Client C] said...the door to the medication room was open.</p> <p>[Staff #1] said that on 8/12/13, she worked at [group home] from 3:00 PM - 11:00 PM. She said [staff #9] was present until about 5:30 PM and [CS #2] and [QIDP] brought back [client A] about 4:45 PM and they were there for awhile. She said [QIDP] and [CS #2] left without even seeing that [client A] was back in the house. She said no one was helping her with the work.</p> <p>The visitors log provides evidence that [CS #2] was present in the home until 6:29 PM. [CS #2] states that she did check in with [client A] prior to leaving</p>			

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	<p>the home.</p> <p>The visitors log also provides evidence that [QIDP] was present in the home until 5:45 PM and she also stated that she check in with [client A] prior to leaving the home.</p> <p>[Staff #9] stated that he left the home around 6:30 PM that evening and assisted with preparing dinner.</p> <p>[Staff #1] said the medication keys at [group home] are kept in one of the drawers in the medication room and the keys to the medication room door are in the desk in the medication room. She said she has never seen anyone lock the medication room. She said on the weekends she and [staff #3] have locked it a few times. She said nobody ever goes in there except when they call the individuals to take their meds...</p> <p>When asked, 'when you received medication training in orientation, what were you told about the medication keys?' [Staff #1] said, 'Keep them on you at all times and away from the clients.'...[Staff #1] said that [QIDP] told her that on the morning of 8/12/13, [client A] had snapped out, hit one of the other clients and took off walking. [Staff #1] also stated that [QIDP] told (sic) that she</p>			

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	<p>[QIDP] had to call the police and that they took [client A] to the hospital to get checked out and then took her to the psych ward. [Staff #1] said that when [client A] returned from her psych evaluation, she wouldn't speak to anyone when she came home for an hour or two. She said [client A] sat outside with [staff #9] as he tried to get her to speak. [Staff #1] said [client A] finally grabbed her by the arm and made her walk around the neighborhood. She said [client A] opened up to her and told her how she felt. [Client A] said she felt mistreated and no one paid attention to her and she was tired of [agency]. [Staff #1] said that on 8/12/13, I guess [client A] just went down there (med room) on her own and did whatever she needed to do. [Staff #1] stated that she had just left the med room to assist one of [client A's] roommates with a shower and when she was turning the corner to return to the med room, [client A] was walking back up stairs. I thought she had just come from the laundry room and she was just doing her laundry. [Staff #1] said the lock is broken on one of the med cabinets where [client A's] along with two other client's medication is kept. Nobody ever locks the med room. The cabinets are always left open when I come in on my shift to pass meds. Even though the med room door is never locked, none of the clients</p>			

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	<p>enter the room unless the staff is down there....</p> <p>[QIDP] stated that the cabinet was locked everyday. It was just that the key would get stuck...A work order was submitted to repair the lock on 08/08/13.</p> <p>[Maintenance] went to the home on 08/13/13 and stated, 'when I arrived the key was stuck in the lock...</p> <p>[Staff #9] said he witnessed that the lock was broken on the left upper cabinet when he administered meds on 08/09/13. He said when he placed the key in the lock it would just pin and not lock. He said he mentioned it to his [QIDP] and she said a work order had been submitted. [Staff #9] said that [client A's] PRN and overflow medications were located in this cabinet.</p> <p>[Client A] said she obtained the medication that she took on 8/12/13 from the lower medication cabinet according to a statement from [PD #2]. [Client A] did not respond to questions about whether or not the cabinet was locked. When re-interviewed, [client A] said she waited until the staff on duty was assisting [client B] with a bath and she opened the medication room door. She said she got the medication cabinet keys out of a</p>			

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	<p>drawer, unlocked the bottom cabinet and took the medication.</p> <p>When asked why only one staff (sic) on duty at [group home], [QIDP] said, normally there would be a split shift, but due to lack of staff...there was only one staff on duty...</p> <p>[LPN] (Licensed Practical Nurse) said Dr [PCP] (Primary Care Physician) made no recommendations regarding [client A's] elevated liver levels drawn on 4/20/12 and 10/25/12. She said she did not personally follow-up with Dr [PCP] but the results were in her chart when [client A] had her physical examination on 5/9/12 (sic). She said she did not discuss the lab results with [NM] (Nurse Manager)...</p> <p>Factual Findings: ...on the morning of 8/12/13, [client A] was standing by the front door and without apparent antecedent, began hitting [ client C]. When staff intervened, [client A] ran out the door and into the street. Staff followed and called 911 when [client A] was no longer in line of sight, per the elopement protocols in her Behavior Support Plan (BSP). Staff and police located [client A] approximately one mile from the service site. She remained agitated and the police transported her to</p>			

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	<p>the ER (Emergency Room) at [hospital] for a psychiatric evaluation. [Client A] was evaluated and released with a recommendation to meet with her counselor as scheduled on 8/13/13...On the record of visit for [client A] psychiatric evaluation, it states under Results/Findings of Examinations: Calm, regrettable, safe to return home; identifies coping skills.</p> <p>A review of [group home's] medication indicated the following medications prescribed to [client A] were missing from the bubble packs and were Not initialed as given: 16 Tylenol ES 500 mg tabs, 6 Mylicon 80 mg tabs and 3 Hydroxyzine 25 mg tabs...</p> <p>On the morning of 8/13/13, [client A] called 911 and was transported to [hospital] via ambulance where she was admitted at 7:16 AM with elevated liver enzymes.</p> <p>[Hospital], Lab Orders and results. Original note by [MD] (Medical Doctor) filed at 08/13/13 at 8:47 AM. History/Chief Complaint states: abdominal pain since 0500, Drug Overdose, took 10 Tylenol last noc (night) because she was upset and her stomach was hurting. Patient was evaluated by provider at 7:25</p>			

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	<p>AM...overdose of Tylenol last night at 20:00...Last night she states she took 10 Tylenol (325 mg) because she was upset and her stomach hurt. She states the med room was unlocked at her group home so she went in and got what she wanted.</p> <p>According to [group home] staffing matrix [staff #1] worked by herself at [group home] from approximately 6:30 PM - 11:07 AM (sic). (08/12/13).</p> <p>According to [group home] staffing matrix [staff #8] worked by herself at [group home] from 11:08 PM on 08/12/13 - 07:06 Am on 08/13/13.</p> <p>A work order was entered into the work order tracking sheet on 8/8/13 stating, 'need med cabinet to lock - top cabinet' at [group home], requested by [QIDP]...</p> <p>[Client A] received a CMP (Comprehensive Metabolic Panel) on 4/20/13 which included liver function tests...The abnormal (elevated) results were verified with a second test. Dr. [PCP] signed that he reviewed the results on 4/24/12. [Client A] received a CMP on 10/25/12 Liver function tests were elevated. The abnormal results were verified with a second test. Dr [PCP] signed that he reviewed the results on 10/31/12...</p>						

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	<p>Conclusion:</p> <ol style="list-style-type: none"> <li>1. The evidence substantiates that [staff #1] (alleged perpetrator) failed to secure the medications at [group home] on the evening of 8/12/13, which provided [client A] an opportunity to access medication without staff supervision.</li> <li>2. The evidence substantiates that [client A] accessed her medications without supervision on the evening of 8/12/13.</li> <li>3. The evidence substantiates that the actions of [staff #1] resulted in [client A] ingesting a toxic level of medication.</li> <li>4. The evidence substantiates that [QIDP] failed to assure that staff were held accountable for keeping the [group home] medication area secure at all times.</li> <li>5. The evidence substantiates that [QIDP] failed to provide sufficient protective measures when she discovered that the lock a a medication cabinet at [group home] was not functioning properly.</li> <li>6. The evidence substantiates that [QIDP] failed to assure that the staffing level at [group home] was sufficient on 8/12/13."</li> </ol> <p>Client A's record was reviewed on 09/10/13 at 9:26 AM. Client A's record</p>			
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	<p>included the following dated documents:</p> <p>04/23/13: The ISP indicated client A's diagnoses included but were not limited to: Mild Mental Retardation, Schizoaffective Disorder and Bipolar Disorder.</p> <p>07/18/13: Record of Visit form indicated client A was seen by her Dr for nausea and vomiting and medication was prescribed as needed for the nausea/vomiting and recommenced she follow a low fat diet due to his of gallbladder surgery.</p> <p>07/23/13: The BSP indicated client A's Target Behaviors and Goals included: Verbal Aggression, Physical Aggression, Non-Compliance, AWOL (Absent With Out Leave), Sexual Inappropriateness/Boundaries, Suicidal Attempts and Attention Seeking.</p> <p>07/23/13: Counselor's Record of Visit indicated client A was seen for individual therapy and had a follow-up appointment scheduled for 07/30/13.</p> <p>08/2013: MAR (Medication Administration Record) August 2013 indicated client A's medications included but were not limited to: Tylenol ES 500 mg tablets; Hydroxyzine 25 mg capsules</p>			

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	<p>and Mylicon 80 mg tablets.</p> <p>08/06/13: Record of Visit form indicated client A was seen by her psychiatrist. No medication changes indicated and she was to continue her current medications.</p> <p>08/08/13: Record of Visit form indicated client A was seen by her Internal Medicine Dr (doctor) for vomiting, nausea and sore throat. The form indicated her diagnosis for the visit was: 1. (sore throat) R/O (rule/out) strep. 2. vomiting/abd (abdominal) pains. A throat culture was obtained, she was given a prescription and was to be referred for stomach issues.</p> <p>08/12/13: Record of Visit form indicated client A was seen by the therapist for verbal/physical aggression; elopement; and she was brought in by the police. The therapist indicated client A was "calm, regretful, safe to return home" and they identified coping skills. Recommendations: "therapy tomorrow at 11 AM."</p> <p>08/13/13: [Hospital] reports indicated client A was brought into the Emergency Room at 7:16 AM. The ER History and Physical indicated, "...overdose of Tylenol last night at 20:00. Pt (patient) sts (states) she took ten Tylenol last night because</p>			

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	<p>'she was upset.' Pt (patient) sts (states) lower abd (abdominal) pain which radiates low back since 0500. Pain is constant and moderate. Pt also c/o (complains of) nausea and non-bloody emesis since 0500...."</p> <p>The record indicated client A's Acetaminophen level (Tylenol) was 54 (reference range 10-30) and her liver enzymes were elevated as follows: AST (Aspartate Amino Transfer) was 799 (reference range 14-36); ALT (Alanine Amino Transter) was 719 (range 9-52); Alkaline Phosphatase - 169 (range 38-126); Bilirubin, Total 3.3 (range 0.2-1.2) and Bilirubin Direct 2.4 (range 0.0-0.5). Client A's liver enzyme values continue to increase and on 08/14/13 at 8:10 AM the values were as follows: AST 7687; ALT 5554; Alkaline Phosphatase 171; Bilirubin, Total 6.8 and Bilirubin Direct was low at 3.4 (normal 3.5-5.0). Lab values on 08/14/13 at 9:31 AM indicated the following: ALT 5598; AST 7747; Alkaline Phosphatase 175 and Bilirubin, Total 6.7.</p> <p>08/14/13: Hospital Discharge Summary indicated, "...She has been complaining of abdominal pain since June. She states it is worse in her RUQ (right upper quadrant). She has a previous cholecystectomy (removal of gall bladder). She states she took 10 tables of</p>			

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	<p>Tylenol (325 mg) because she was upset and her stomach hurt. She states the med room was unlocked at her group home so she went in and got what she wanted. Pt today with liver failure her ALT/AST in the thousands...will arrange transfer to [hospital #2] might need liver transplant, for liver failure...Plan: I discussed her condition with her care team and have decided that [hospital #2] is better equipped to manage her hepatic failure and should be able to give her every consideration for liver transplant if she might become a candidate...."</p> <p>08/23/13: Nurse's Medical Notes indicated the LPN had been notified client A died at [Hospital #2] on 08/22/13.</p> <p>An interview was conducted on 09/11/13 at 11:40 AM, with the Clinical Supervisor #1 (CS #1). The CS #1 indicated client A died of liver failure and the incident should never have happened. He indicated after client A was discharged from the hospital on 08/12/13 when the police took her there, the QIDP should have put something in place to ensure she was monitored until she could see her counselor the following day. He indicated there should not have been only one staff on duty and if there was a problem with the lock it should</p>			

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	<p>have been fixed immediately in order to keep the medications secure. He indicated staff were trained and should keep the medication keys on them at all times and the keys should not be in the drawer. He indicated staff #1 had been terminated from the agency and the QIDP had resigned.</p> <p>On 09/11/13 at 10:50 AM, a review of the facility's 09/14/07 Policy on "Abuse, Neglect, Exploitation" indicated, "Adept employees actively advocate for the rights and safety of all individuals...Intimidation/emotional abuse: the act or failure to act that results or could result in emotional injury to an individual. The act of insulting or coarse language or gestures directed toward an individual that subject him/her to humiliation or degradation.</p> <p>Discouraging or inhibiting behavior by threatening both actual or implied.</p> <p>Attitude or acts that interfere with the psychological and social well being of an individual. Exploitation: an act that deprives an individual of real or personal property by fraudulent or illegal means. Utilization of another person for selfish purposes. Emotional/physical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's</p>			

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	<p>psychological and social well being. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment. Program intervention neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to implement a support plan...Medical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide necessary medical attention, proper nutritional support or administering medications as prescribed. 3. All employees will be trained on the types of incidents that are reportable to BDDS...The incident types are: Suspected abuse, neglect or exploitation...Injuries of unknown origin, Significant injuries...Inadequate staff support...."</p> <p>An interview was conducted on 09/11/13 at 11:40 AM, with the CS #1. The CS indicated staff failed to follow the policy/procedure as they failed to provide appropriate supervision of the clients and the clients were unsupervised for an unknown period of time. The CS indicated clients A, B, C, D, E, F and G required 24 hour supervision and staff should not have been sleeping on duty. He indicated the clients should not have</p>			
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	<p>been unsupervised as their needs required staff supervision at all times.</p> <p>This federal tag relates to complaint #IN00135301.</p> <p>9-3-2(a)</p>			
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W000153	<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.</p> <p>Based on record review and interview for 1 of 11 BDDS (Bureau of Developmental Disabilities Services) reports regarding allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to report the allegations immediately to the Administrator, in regard to alleged verbal abuse, staff sleeping on duty and misappropriation of client funds (client A) by staff #7.</p> <p>Findings include:</p> <p>On 09/09/13 at 11:29 AM the facility's BDDS Reports, investigations and internal incident/accident reports were reviewed from 06/01/13 through 09/08/13 and indicated the following:</p> <p>06/27/13: A BDDS report indicated, "The Executive Director received a report alleging that staff [staff #7] had been sleeping while on duty and had made threatening remarks towards [client A]... [staff #7] has been suspended pending investigation of the allegations.</p>	W000153	<p>CORRECTION: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. Specifically, the employment of the staff person who failed to report the allegations of sleeping and misappropriation of funds has been terminated. Additionally, the facility has retrained direct support staff regarding the need to immediately report all allegations of abuse, neglect and mistreatment immediately to a supervisor. PREVENTION:Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Quality Assurance Manager who will in turn coordinate and follow-up with the facility Clinical Supervisor to assure appropriate follow-up occurs. Training of direct support staff toward expectations for reporting abuse, neglect and mistreatment will be ongoing and</p>	10/24/2013

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	<p>07/16/13: A Follow-up BDDS report indicated, "Evidence gathered through investigation did not substantiate that [staff #7] made threatening remarks to [client A]. Specifically, [staff #7] denied [client A's] allegation and the only other witness did not corroborate her testimony. Evidence did however, substantiate that [staff #7] slept while on duty. [Staff #7's] employment with [agency] has been terminated."</p> <p>An Investigative Summary dated 06/27/13 indicated, "...Conclusion: ...3. The evidence substantiates that [staff #7] slept while on duty.</p> <p>4. The evidence substantiates that [staff #2] failed to report allegations of abuse and mistreatment to a supervisor immediately.</p> <p>5. The evidence substantiates that [staff #1] failed to report allegations of abuse and mistreatment to a supervisor immediately."</p> <p>Client A's record was reviewed on 09/10/13 at 9:26 AM. Client A's ISP (Individual Support Plan) was dated 04/22/13 and indicated client A required 24 hour supervision.</p> <p>Client B's record was reviewed on 09/10/13 at 10:24 AM. Client B's ISP</p>		<p>occur no less than monthly. Additionally, members of the Administrative Team, including the Executive Director and Program Manager, will maintain an increased presence at the facility, performing unscheduled observation of active treatment no less than five times weekly for the next 30 days, no less than three times weekly for an additional 30 days and no less than weekly for an additional 30 days. Team members will incorporate reviews of incident and behavioral documentation into these visits. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Administrative Team</p>				

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	<p>was dated 03/11/13 and indicated client B required 24 hour supervision.</p> <p>Client C's record was reviewed on 09/10/13 at 11:25 AM. Client C's ISP was dated 07/15/13 and indicated client C required 24 hour supervision.</p> <p>An interview was conducted on 09/11/13 at 11:40 AM, with the Clinical Supervisor #1 (CS #1). The CS #1 indicated staff failed to follow the policy/procedure and failed to immediately report allegations of abuse, mistreatment, exploitation and failed to report staff sleeping on the job. The CS #1 indicated staff #2 and staff #7 have both been terminated with the agency. The CS #1 indicated all of the clients in the home required 24 hour supervision and awake staff.</p> <p>This federal tag relates to complaint #IN00135301.</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 2 of 11 BDDS (Bureau of Developmental Disabilities Services) reports regarding allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct an investigation in regard to client neglect for clients A and B.</p> <p>Findings include:</p> <p>On 09/09/13 at 11:29 AM the facility's BDDS Reports, investigations and internal incident/accident reports were reviewed from 06/01/13 through 09/08/13 and indicated the following:</p> <p>07/18/13: A BDDS report indicated, "...At the end of the day approx[imately] 8:00 (pm) [client A] asked to call her grandmother. As staff were monitoring other clients and felt that they could not leave them unattended they asked her to wait until she went home. [Client A] left the supervised break area and went onto the plant floor. When staff could leave the others with another supervisor they went in to find [client A]. After several minutes of searching the inside of the</p>	W000154	<p>CORRECTION: The facility must have evidence that all alleged violations are thoroughly investigated. Specifically, the facility will investigate a medication error that occurred with Client B on 7/29/13 and the facility will obtain investigation records from Client A's former day service regarding an incident of elopement that occurred on 7/18/13: PREVENTION: The new QIDP trained regarding the need to document all investigations, criteria for conducting investigations at the facility 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 and nursing staff 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 Clinical Supervisor will also follow-up with the Nurse Manager</p>	10/24/2013	

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	<p>building staff began to search outside. At 8:30 (pm) [client A] was observed walking out of the woods behind the industries...." There was no investigation available for review of this incident.</p> <p>07/29/13: "[Client B] was given another individual's medication by another staff. [Client B] was taken to [hospital #1] and was seen in the emergency room (ER). The ER physician instructed thata (sic) [client B] stay a few hours for observation...." There was no investigation available for review of this incident.</p> <p>An interview was conducted on 09/11/13 at 11:40 AM, with the Clinical Supervisor #1 (CS #1). The CS #1 indicated all incidents of abuse, neglect and injuries of unknown sources are to be investigated. He indicated the facility failed to conduct investigations for these incidents.</p> <p>This federal tag relates to complaint #IN00135301.</p> <p>9-3-2(a)</p>		<p>no less than weekly to assure that timely investigations occur for significant medical incidents. 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. Additionally, members of the Administrative Team, including the Executive Director and Program Manager, will maintain an increased presence at the facility, performing unscheduled observation of active treatment no less than five times weekly for the next 30 days, no less than three times weekly for an additional 30 days and no less than weekly for an additional 30 days. Team members will incorporate reviews of incident, behavioral and investigation documentation into these visits. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Administrative Team</p>		

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W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview, the facility failed to provide sufficient staff to provide care to meet client needs and to ensure staff not sleep on duty for 7 of 7 clients living in the home (clients A, B, C, D, E, F and G); by failing to provide sufficient staff to monitor clients and keep them safe (client A, B and F).</p> <p>Findings include:</p> <p>On 09/09/13 at 11:29 AM the facility's BDDS Reports and investigations were reviewed from 06/01/13 through 09/08/13 and indicated the following:</p> <p>1. 06/27/13: A BDDS report indicated, "The Executive Director received a report alleging that staff [staff #7] had been sleeping while on duty and had made threatening remarks towards [client A]... [staff #7] has been suspended pending investigation of the allegations.</p>	W000186	CORRECTION:The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Specifically, the facility has added a full time day shift and full time evening shift staff to the schedule and new associates have been hired to fill staffing vacancies. Additionally, when sufficient direct support staff are not available to cover a shift, professional/supervisory staff will provide active treatment services. PREVENTION: The Administrative Team will monitor facility staff schedules to assure adequate direct support staff are assigned to all shifts. Specifically the Program Manager will perform weekly checks of facility labor hours and take corrective action as needed. Additionally, on an ongoing basis, members of the Administrative Team will spot check time and attendance records to assure hours worked match the facility schedule. Additionally, members of the Administrative Team, including the Executive Director	10/24/2013	

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	<p>07/16/13: A Follow-up BDDS report indicated, "...Evidence did however, substantiate that [staff #7] slept while on duty. [Staff #7's] employment with [agency] has been terminated."</p> <p>An Investigative Summary dated 06/27/13 indicated, "Introduction: [Client A]...and [staff #2] reported to [client A's counselor] on 6/27/13 that during the week of 6/24/13 - 6/27/13 [staff #7] was rude to [client A]. [Client A] also reported on an occasion during the week of 6/17/13 - 6/21/13, [staff #7] told her that, 'if you weren't a client, I would have hit you' in response to [client A] almost sitting on [staff #7's] hand. [Client A] also told her counselor that [staff #7] fails to give [client A] spending money each week and also has been witnessed sleeping while working at the house on multiple occasions. [Client A's counselor] said that [staff #2] was present when [client A] made the allegations..."</p> <p>Summary of Interviews: [Client A] said that on the night of 5/23/13, when [staff #7] and [staff #2] picked her up from work, when [client A] was getting into the van, [staff #7] told her not to sit on her hand and then said if [client A] wasn't a client she would hit her. She said she did not report these allegations to [Clinical Supervisor #3] but that she told [staff #2]</p>		<p>and Program Manager, will maintain an increased presence at the facility, performing unscheduled observation of active treatment no less than five times weekly for the next 30 days, no less than three times weekly for an additional 30 days and no less than weekly for an additional 30 days. Team members will compare the actual staffing present at the facility to the schedule matrix during these visits. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONSIBLE PARTIES: QIDP, Residential Manager Direct Support Staff, Administrative Team</p>		

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	<p>and her counselor. [Client A] also said that [staff #2] told her counselor. [Client A] also said that [staff #7] sleeps while she is at work. She said that [staff #7] locks herself in the medication room and sleeps. When first interviewed, [client A] said that many people had told her about [staff #7] sleeping but she had not actually seen [staff #7] asleep. When re-interviewed and asked about a specific alleged sleeping incident on 6/20/13, [client A] said that [staff #7] was asleep when she got up and she also said that [staff #7] had slept during her counseling appointments. [Client A] said that the fact that [staff #7] sleeps frequently while she is at work is common knowledge.</p> <p>[Staff #2] said that on 6/20/13, she came into work at 7:00 AM, rang the doorbell and [client #7] opened the door for her and she came in and saw [staff #7] sleeping in a chair by the television. She said she spoke to [staff #7] and [staff #7] responded by saying 'hey'. She said [staff #7] picked something up off the table and then went back to sleep. She said [staff #7] remained asleep through breakfast and was still asleep when she left to transport the individuals to work. [Staff #2] said she did not report this to a supervisor because she did not trust that the situation would be handled. [Staff #2] said that on 6/22/13, [client A] told her</p>			
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	<p>and [staff #1] that on the night of the dance 5/23/13 when [staff #7] and [staff #5] picked her up from work, when [client A] was getting into the van, [staff #7] told her not to sit on her hand and then said if [client A] wasn't a client she would hit her. [Staff #2] said she did not report these allegations to a supervisor but that while assisting [client A] with attending an (sic) counselor's appointment on 6/26/13, she observed [client A] explaining the allegations to the counselor who said she would report them. [Staff #2] said she did not prompt [client A] to make the allegations to her counselor.</p> <p>[Staff #5] said that on the night of 5/23/13, she and [staff #7] picked up [client A] from work. She said as [client A] was getting into the back seat, [staff #7] saw something on the seat and reached back to grab it. She said [client A] acknowledged [staff #7's] hand being on the seat and proceeded to act as if she was going to sit on it. She said [staff #7] did tell [client A] that if she wasn't a client, she would hit her...</p> <p>[Staff #7] said that due to her sleep apnea, she takes measures to stay awake on th (sic) job including vitamin supplements and energy drinks. She said that she does not sleep while on duty and that the only time she locks herself in the medication</p>			

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	<p>room is when she is having a private conversation with [CS #3] or a staff person. [Staff #7] said that on the night of 5/23/13, she and [staff #5] picked up [client A] from work. She said when [client A] was getting on the van she attempted to move an object off the seat so [client A] would not sit on it. She said she told [client A], 'Wow. Don't you see me moving this so you don't sit on this?' [Staff #7] said she has never told [client A] or any other individuals supported by [agency] that she would hit them if they weren't clients...</p> <p>[Client F] said that on the morning of 6/21/13, [staff #7] was sleeping in the living room when [staff #2] arrived at work. He said she remained asleep through breakfast. He said he has seen [staff #7] sleeping while at work on other occasions.</p> <p>[Client E] said that on the morning of 6/21/13, [staff #7] was sleeping in the living room when [staff #2] arrived at work. He said she remained asleep through breakfast. He said he did not know if she had slept at work on other occasions.</p> <p>[Client D] said that on the morning of 6/21/13, [staff #7] was sleeping in the living room when [staff #2] arrived at</p>			

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	<p>work. She said [staff #7] woke up for breakfast and then went back to sleep. [Client D] said she has seen [staff #7] sleeping on other occasions.</p> <p>[Client G] said that on the morning of 6/21/13, [staff #7] was sleeping in the living room when [staff #2] arrived at work. He said [staff #7] woke up for breakfast.</p> <p>[Client B] said that on the morning of 6/21/13, [staff #7] was sleeping in the living room when [staff #2] arrived at work. She said [staff #7] remained asleep through breakfast.</p> <p>[Client C] said that on the morning of 6/21/13, [staff #7] was sleeping in the living room when [staff #2] arrived at work. He said she remained asleep through breakfast. [Client C] said that he has seen [staff #7] sleeping at work frequently...</p> <p>[Staff #1] said that on the first day she worked with [staff #7], [staff #7] slept in the medication room from 9:00 AM - 12:00 PM. She said she did not (sic) report that [staff #7] was sleeping to a supervisor...</p> <p>[Client A's counselor] reported via email that [client A] said [staff #7] has been</p>			

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	<p>witnessed sleeping while working at the house on multiple occasions...she noticed (counselor) that [staff #7] had 'dozed off' in the [counselor] waiting room during [client A's] appointments 'on a few occasions'...</p> <p>Conclusion: ...</p> <ol style="list-style-type: none"> <li>...</li> <li>3. The evidence substantiates that [staff #7] slept while on duty.</li> <li>4. The evidence substantiates that [staff #2] failed to report allegations of abuse and mistreatment to a supervisor immediately...."</li> </ol> <p>Client A's record was reviewed on 09/10/13 at 9:26 AM. Client A's ISP (Individual Support Plan) was dated 04/22/13 and indicated client A required 24 hour supervision.</p> <p>Client B's record was reviewed on 09/10/13 at 10:24 AM. Client B's ISP was dated 03/11/13 and indicated client B required 24 hour supervision.</p> <p>Client C's record was reviewed on 09/10/13 at 11:25 AM. Client C's ISP was dated 07/15/13 and indicated client C required 24 hour supervision.</p> <p>An interview was conducted on 09/11/13 at 11:40 AM, with the Clinical Supervisor</p>			
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	<p>#1 (CS #1). The CS #1 indicated there should be no less than two staff on duty during the clients waking hours and if one staff was sleeping that only left one staff to care for the clients needs.</p> <p>2. 07/09/13: A BDDS report indicated, "On 07/09/13 it was alleged that a staff [staff #2] left [client C] and [client F]...unattended on the van while it was still running. [Staff #2] has been suspended pending a (sic) investigation...."</p> <p>An investigation dated 07/09/13 indicated, "Introduction: On 07/09/13, at 3:40 PM, [staff #5] reported that [staff #2] left [client F] and [client C]...unattended on the...van, while the vehicle was running...</p> <p>Summary of Interviews: [Staff #5] said on 7/9/13, she arrived at [group home address] at 3:00 PM. She said [staff #2] was away in the van until 3:26 PM. [Staff #5] said she was in the house doing some cleaning and [staff #2] came into he (sic) house, clocked out and went outside. She said [staff #2] came back into the house and dropped off the...card and left the house. [Staff #5] said she then opened the door to ask [staff #2] about the location of the can (sic) keys and [staff #2] pointed to the van and drove away.</p>			

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	<p>She said she (staff #5) closed the door and got dinner out and then left the house for evening transport. She said she saw that the van was running and that [client C] and [client F]...were in the van unattended. She said she was unaware that [client C] and [client F] had been picked up...</p> <p>[Client C] said that on the afternoon of 7/9/13, [staff #2] left him and [client F] on the van at [group home] after she picked them up from day service. He said that [staff #2] seemed upset but that she did not say anything when she left them on the van. He said the van was parked in front of the house and that he did not see [staff #5] when [staff #2] went into the house.</p> <p>[Client F] said that on the afternoon of 7/9/13, [staff #2] left him and [client C] on the van at [group home]. He said that [staff #2] did not say anything to them when she left. He said [staff #2] parked the van in front of the house and that he did not see [staff #5] when [staff #2] went into the house...</p> <p>[Staff #2] said that she was asked to pick up [client C] from day service before 3:00 PM and picked up [client F] as well. She said she arrived back at [group home] at approximately 3:30 PM. She said when</p>			

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	<p>she pulled up, the door was open and [staff #5] was standing in the doorway. She said she told [client F] and [client C] to stay in the van and that she told [staff #5] that [client C] and [client F] were waiting in the van. She said she left the van running so the air conditioner would stay on because it was hot outside. She said that she went into the house, dropped of the...card and left for the day. She said when she got into her vehicle, [staff #5] was sitting in the van.</p> <p>Factual Findings: Time and Attendance Records for [group home] indicate that on 7/9/13, [staff #2] worked from 6:57 AM - 3:29 PM and [staff #5] worked from 3:19 PM - 11:00 PM...[Staff #2] signed the [agency] Driver Safety Code on 4/2/13 agreeing that 'I understand that consumers at no time are to be left unsupervised in any [agency] vehicle.' Conclusion: 1. The evidence substantiates that [staff #2] left [client F] and [client C]...unattended on the [group home] van, while the vehicle was running, on the afternoon of 7/9/13...Recommendations: 1. Term [staff #2] for leaving 2 individuals unattended in a running van."</p> <p>An interview was conducted on 09/11/13 at 11:40 AM, with the Clinical Supervisor #1 (CS #1). The CS #1 indicated clients C and F both required 24 hour</p>			

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	<p>supervision and there should be enough staff on duty to provide supervisor.</p> <p>3. 08/13/13: A BDDS report indicated, "[Client A]...told staff that she did not feel well because she took too much medication the previous night. Staff took [client A's] vital signs, which were within normal limits and called the supervisor. While staff was speaking to the supervisor, [client A] called 911. EMS (Emergency Medical Services) arrived and transported her to the [hospital #1] Emergency Department (ED). Tests indicated that [client A] had elevated liver enzymes and she was admitted to the hospital. An investigation was initiated and [client A] said that the medication room was unlocked and the keys to the medication cabinet were not being held by staff. [Staff #1] was the only employee on duty at the time of the incident and she has been suspended pending investigation. A review of the service site's medication indicated [client A] took the following medications prescribed to her: 16 Tylenol ES (Extra Strength) 500 mg (milligram) tabs (tablets) (pain), 5 Mylicon 80 mg tabs (gas relief) and 3 Hydroxyzine 25 mg tabs (anxiety/nausea/vomiting)...Her liver function had not improved on the morning of 08/14/13 and [client A] is being prepared for transfer to the [hospital</p>			

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	<p>#2]...."</p> <p>08/20/13: A Follow-up BDDS report to the 08/13/13 incident indicated, "[Client A] remains hospitalized at [hospital #2] and is being treated for liver failure. Evidence gathered through investigation substantiated that Direct Support Staff (DSS) [staff #1] failed to lock the medication room and left the keys to the medication room accessible to [client A], enabling her to access the medication. Staff [staff #1] remained suspended throughout the investigation and terminated of her employment has been approved. Staff have been retrained regarding the need to keep medications secured at all times and carry the keys at all times...."</p> <p>08/22/13: A BDDS report indicated, "...On 08/15/13 at 4:00 PM ResCare nurse, [name] visited [client A] and spoke with [client A's] nurse and hospital case manager. [name] was told that [client A's] condition was critical and guarded. [Client A] was on a ventilator but breathing on her own. Her LFTs (Liver Function Tests) were elevated...[Client A's] [aunt], at this time, stated that any communication regarding [client A's] condition would have to go through her and ResCare was not given access to the password to see [client A] in the hospital.</p>						

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	<p>On 08/16/13, QIDP (Qualified Intellectual Disabilities Professional) [name] and ResCare nurse, [name] attempted to visit [client A]. [Aunt] stated she would call them with an update and [QIDP] and [nurse] were asked to leave the hospital. From 08/17-08/22 ResCare staff included nursing, QIDP and Clinical Supervisor made daily attempts to corresponded (sic) with [client A's] aunt for updates on her condition. On 08/19/13, [client A's] aunt stated that [client A] would most likely need a liver transplant and her condition remained critical. On 08/23/13, [aunt] contacted PM (Program Manager) [name] and stated that [client A] had passed away at approximately 3:30 on 08/22/13. [Aunt] stated that [client A] had died from liver and kidney failure...."</p> <p>An Investigative Summary dated 08/13/13 indicated, "[Client A]...told [staff #8] on 08/13/13 at approximately 6:00 am that she did not feel well because she took too much medication the previous night. Staff took [client A's] vital signs, which were within normal limits. [Client A] took the phone an went upstairs and called 911. EMS (Emergency Medical Services) arrived and transported her to the [hospital #1] Emergency Department. [Client A] told EMS that she overdosed on Tylenol. Tests indicated that [client A] had elevated liver enzymes and she</p>			

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	<p>was admitted to the hospital. An investigation was initiated and [client A] said that the medication room was unlocked and she went in and got what she wanted. [Staff #1] was the only employee on duty at the time of the incident. A review of the service site's medication indicated [client A] took the following medications prescribed to her: 16 Tylenol ES 500 mg tabs, 6 Mylicon 80 mg tabs and 3 Hydroxyzine 25 mg tabs. Additional information indicated that a lock on one of the medication cabinets containing some of [client A's] PRN (as needed) medications was not functioning properly.</p> <p>On the morning of 8/14/13 her liver function had not improved and [client A] was prepared to transfer to the [hospital #2].</p> <p>[Staff #1] was suspended on 8/13/13 pending investigation of the allegations...</p> <p>Summary of Interviews:</p> <p>[Client G] said...he did see the medication room door open...</p> <p>[Client E] said...he did see the medication room door open...</p> <p>[Client C] said...the door to the medication room was open.</p>			

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	<p>[Staff #1] said that on 8/12/13, she worked at [group home] from 3:00 PM - 11:00 PM. She said [staff #9] was present until about 5:30 PM and [CS #2] and [QIDP] brought back [client A] about 4:45 PM and they were there for awhile. She said [QIDP] and [CS #2] left without even seeing that [client A] was back in the house. She said no one was helping her with the work.</p> <p>The visitors log provides evidence that [CS #2] was present in the home until 6:29 PM. [CS #2] states that she did check in with [client A] prior to leaving the home.</p> <p>The visitors log also provides evidence that [QIDP] was present in the home until 5:45 PM and she also stated that she did check in with [client A] prior to leaving the home.</p> <p>[Staff #9] stated that he left the home around 6:30 PM that evening and assisted with preparing dinner.</p> <p>[Staff #1] said the medication keys at [group home] are kept in one of the drawers in the medication room and the keys to the medication room door are in the desk in the medication room. She said she has never seen anyone lock the medication room. She said on the</p>			

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	<p>weekends she and [staff #3] have locked it a few times. She said nobody ever goes in there except when they call the individuals to take their meds...</p> <p>When asked, 'when you received medication training in orientation, what were you told about the medication keys?' [Staff #1] said, 'Keep them on you at all times and away from the clients.'...[Staff #1] said that [QIDP] told her that on the morning of 8/12/13, [client A] had snapped out, hit one of the other clients and took off walking. [Staff #1] also stated that [QIDP] told (sic) that she [QIDP] had to call the police and that they took [client A] to the hospital to get checked out and then took her to the psych ward. [Staff #1] said that when [client A] returned from her psych evaluation, she wouldn't speak to anyone when she came home for an hour or two. She said [client A] sat outside with [staff #9] as he tried to get her to speak. [Staff #1] said [client A] finally grabbed her by the arm and made her walk around the neighborhood. She said [client A] opened up to her and told her how she felt. [Client A] said she felt mistreated and no one paid attention to her and she was tired of [agency]. [Staff #1] said that on 8/12/13, I guess [client A] just went down there (med room) on her own and did whatever she needed to do. [Staff #1]</p>			

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	<p>stated that she had just left the med room to assist one of [client A's] roommates with a shower and when she was turning the corner to return to the med room, [client A] was walking back up stairs. I thought she had just come from the laundry room and she was just doing her laundry. [Staff #1] said the lock is broken on one of the med cabinets where [client A's] along with two other client's medication is kept. Nobody ever locks the med room. The cabinets are always left open when I come in on my shift to pass meds. Even though the med room door is never locked, none of the clients enter the room unless the staff is down there....</p> <p>[QIDP] stated that the cabinet was locked everyday. It was just that the key would get stuck...A work order was submitted to repair the lock on 08/08/13.</p> <p>[Maintenance] went to the home on 08/13/13 and stated, 'when I arrived the key was stuck in the lock...</p> <p>[Staff #9] said he witnessed that the lock was broken on the left upper cabinet when he administered meds on 08/09/13. He said when he placed the key in the lock it would just pin and not lock. He said he mentioned it to his [QIDP] and she said a work order had been submitted. [Staff</p>			

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	<p>#9] said that [client A's] PRN and overflow medications were located in this cabinet.</p> <p>[Client A] said she obtained the medication that she took on 8/12/13 from the lower medication cabinet according to a statement from [PD #2]. [Client A] did not respond to questions about whether or not the cabinet was locked. When re-interviewed, [client A] said she waited until the staff on duty was assisting [client B] with a bath and she opened the medication room door. She said she got the medication cabinet keys out of a drawer, unlocked the bottom cabinet and took the medication.</p> <p>When asked why only one staff (sic) on duty at [group home], [QIDP] said, normally there would be a split shift, but due to lack of staff...there was only one staff on duty...</p> <p>[LPN] (Licensed Practical Nurse) said Dr [PCP] (Primary Care Physician) made no recommendations regarding [client A's] elevated liver levels drawn on 4/20/12 and 10/25/12. She said she did not personally follow-up with Dr [PCP] but the results were in her chart when [client A] had her physical examination on 5/9/13. She said she did not discuss the lab results with [NM] (Nurse Manager)...</p>			

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	<p>Factual Findings: ...on the morning of 8/12/12, [client A] was standing by the front door and without apparent antecedent, began hitting [client C]. When staff intervened, [client A] ran out the door and into the street. Staff followed and called 911 when [client A] was no longer in line of sight, per the elopement protocols in her Behavior Support Plan (BSP). Staff and police located [client A] approximately one mile from the service site. She remained agitated and the police transported her to the ER (Emergency Room) at [hospital] for a psychiatric evaluation. [Client A] was evaluated and released with a recommendation to meet with her counselor as scheduled on 8/13/13...On the record of visit for [client A] psychiatric evaluation, it states under Results/Findings of Examinations: Calm, regrettable, safe to return home; identifies coping skills.</p> <p>A review of [group home's] medication indicated the following medications prescribed to [client A] were missing from the bubble packs and were Not initialed as given: 16 Tylenol ES 500 mg tabs, 6 Mylicon 80 mg tabs and 3 Hydroxyzine 25 mg tabs...</p> <p>On the morning of 8/13/13, [client A]</p>			
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	<p>called 911 and was transported to [hospital] via ambulance where she was admitted at 7:16 AM with elevated liver enzymes.</p> <p>[Hospital], Lab Orders and results. Original note by [MD] (Medical Doctor) filed at 08/13/13 at 8:47 AM. History/Chief Complaint states: abdominal pain since 0500, Drug Overdose, took 10 Tylenol last noc (night) because she was upset and her stomach was hurting. Patient was evaluated by provider at 7:25 AM...overdose of Tylenol last night at 20:00...Last night she states she took 10 Tylenol (325 mg) because she was upset and her stomach hurt. She states the med room was unlocked at her group home so she went in and got what she wanted.</p> <p>According to [group home] staffing matrix [staff #1] worked by herself at [group home] from approximately 6:30 PM - 11:07 AM (sic). (08/12/13).</p> <p>According to [group home] staffing matrix [staff #8] worked by herself at [group home] from 11:08 PM on 08/12/13 - 07:06 Am on 08/13/13.</p> <p>A work order was entered into the work order tracking sheet on 8/8/13 stating, 'need med cabinet to lock - top cabinet' at</p>			

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	<p>[group home], requested by [QIDP]...</p> <p>[Client A] received a CMP (Comprehensive Metabolic Panel) on 4/20/13 which included liver function tests...The abnormal (elevated) results were verified with a second test. Dr. [PCP] signed that he reviewed the results on 4/24/12. [Client A] received a CMP on 10/25/12 Liver function tests were elevated. The abnormal results were verified with a second test. Dr [PCP] signed that he reviewed the results on 10/31/12...</p> <p>Conclusion:</p> <ol style="list-style-type: none"> <li>1. The evidence substantiates that [staff #1] (alleged perpetrator) failed to secure the medications at [group home] on the evening of 8/12/13, which provided [client A] an opportunity to access medication without staff supervision.</li> <li>2. The evidence substantiates that [client A] accessed her medications without supervision on the evening of 8/12/13.</li> <li>3. The evidence substantiates that the actions of [staff #1] resulted in [client A] ingesting a toxic level of medication.</li> <li>4. The evidence substantiates that [QIDP] failed to assure that staff were held accountable for keeping the [group home]</li> </ol>			

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	<p>medication area secure at all times.</p> <p>5. The evidence substantiates that [QIDP] failed to provide sufficient protective measures when she discovered that the lock a a medication cabinet at [group home] was not functioning properly.</p> <p>6. The evidence substantiates that [QIDP] failed to assure that the staffing level at [group home] was sufficient on 8/12/13."</p> <p>Client A's record was reviewed on 09/10/13 at 9:26 AM. Client A's record included the following dated documents:</p> <p>04/23/13: The ISP indicated client A's diagnoses included but were not limited to: Mild Mental Retardation, Schizoaffective Disorder and Bipolar Disorder.</p> <p>07/18/13: Record of Visit form indicated client A was seen by her Dr for nausea and vomiting and medication was prescribed as needed for the nausea/vomiting and recommened she follow a low fat diet due to his of gallbladder surgery.</p> <p>07/23/13: The BSP indicated client A's Target Behaviors and Goals included: Verbal Aggression, Physical Aggression, Non-Compliance, AWOL (Absent With</p>			

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	<p>Out Leave), Sexual Inappropriateness/Boundaries, Suicidal Attempts and Attention Seeking.</p> <p>07/23/13: Counselor's Record of Visit indicated client A was seen for individual therapy and had a follow-up appointment scheduled for 07/30/13.</p> <p>08/2013: MAR (Medication Administration Record) August 2013 indicated client A's medications included but were not limited to: Tylenol ES 500 mg tablets; Hydroxyzine 25 mg capsules and Mylicon 80 mg tablets.</p> <p>08/06/13: Record of Visit form indicated client A was seen by her psychiatrist. No medication changes indicated and she was to continue her current medications.</p> <p>08/08/13: Record of Visit form indicated client A was seen by her Internal Medicine Dr (doctor) for vomiting, nausea and sore throat. The form indicated her diagnosis for the visit was: 1. (sore throat) R/O (rule/out) strep. 2. vomiting/abd (abdominal) pains. A throat culture was obtained, she was given a prescription and was to be referred for stomach issues.</p> <p>08/12/13: Record of Visit form indicated client A was seen by the therapist for</p>			

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	<p>verbal/physical aggression; elopement; and she was brought in by the police. The therapist indicated client A was "calm, regretful, safe to return home" and they identified coping skills.</p> <p>Recommendations: "therapy tomorrow at 11 AM."</p> <p>08/13/13: [Hospital] reports indicated client A was brought into the Emergency Room at 7:16 AM. The ER History and Physical indicated, "...overdose of Tylenol last night at 20:00. Pt (patient) sts (states) she took ten Tylenol last night because 'she was upset.' Pt sts (states) lower abd (abdominal) pain which radiates low back since 0500. Pain is constant and moderate. Pt also c/o (complains of) nausea and non-bloody emesis since 0500..."</p> <p>The record indicated client A's Acetaminophen level (Tylenol) was 54 (reference range 10-30) and her liver enzymes were elevated as follows: AST (Aspartate Amino Transfer) was 799 (reference range 14-36); ALT (Alanine Amino Transter) was 719 (range 9-52); Alkaline Phosphatase 169 (range 38-126); Bilirubin, Total 3.3 (range 0.2-1.2) and Bilirubin Direct 2.4 (range 0.0-0.5). Client A's liver enzyme values continue to increase and on 08/14/13 at 8:10 AM the values were as follows: AST 7687; ALT 5554; Alkaline Phosphatase 171;</p>			

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	<p>Bilirubin, Total 6.8 and Bilirubin Direct was low at 3.4 (normal 3.5-5.0). Lab values on 08/14/13 at 9:31 AM indicated the following: ALT 5598; AST 7747; Alkaline Phosphatase 175 and Bilirubin, Total 6.7.</p> <p>08/14/13: Hospital Discharge Summary indicated, "...She has been complaining of abdominal pain since June. She states it is worse in her RUQ (right upper quadrant). She has a previous cholecystectomy (removal of gall bladder). She states she took 10 tables of Tylenol (325 mg) because she was upset and her stomach hurt. She states the med room was unlocked at her group home so she went in and got what she wanted. Pt today with liver failure her ALT/AST in the thousands...will arrange transfer to [hospital #2] might need liver transplant, for liver failure...Plan: I discussed her condition with her care team and have decided that [hospital #2] is better equipped to manage her hepatic failure and should be able to give her every consideration for liver transplant if she might become a candidate..."</p> <p>08/23/13: Nurse's Medical Notes indicated the LPN had been notified client A died at [Hospital #2] on 08/22/13.</p> <p>An interview was conducted on 09/11/13</p>				

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	<p>at 11:40 AM, with the Clinical Supervisor #1 (CS #1). The CS #1 indicated there should not have been only one staff in the house. He indicated there should have been no less than two staff when clients are awake.</p> <p>This federal tag relates to complaint #IN00135301.</p> <p>9-3-3(a)</p>				

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 3 sampled clients (client B), to conduct a reassessment of her safety due to recent falls.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 09/09/13 from 3:45 PM until 6:00 PM. During the observation time client B was observed to ambulate independently throughout the home.</p> <p>Client B's records were reviewed on 09/10/13 at 10:24 AM. There were 3 reports for client B regarding falls which occurred on the following dates:</p> <p>06/04/13: An Incident/Accident Report indicated client B fell in the laundry room.</p> <p>06/18/13: A Record of Visit document indicated client B was seen by the physician who indicated client B had a second fall recently.</p>	W000210	<p>CORRECTION: Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Specifically, the team will assure that a Physical Therapy assessment for Client B is completed. Additionally, the nurse has reviewed all facility medical records and additional PT assessments have been scheduled based on the results of the record review. PREVENTION: Professional staff will be retrained regarding assessment requirements for individuals with compromised mobility. The QIDP, Residential Manager and facility Medical Coach will be provided with a tracking system to assure that all required assessments are completed within 30 days of admission. Members of the Administrative and/or Health Services Teams will review assessment data during and after the initial assessment period to assure assessments occur as needed and required. Additionally, the Clinical Supervisor and Executive</p>	10/24/2013

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	<p>08/05/13: A BDDS (Bureau of Developmental Disabilities Services) report indicated client B had a "...purple bruise under her right eye the size of a half dollar...also had a right swollen knee the size of a tennis ball and redness towards her right shin...seen by the Emergency room physician..." An investigation dated 08/05/13 indicated client B had "...sustained the injury from a fall out of bed...."</p> <p>Client B's record contained a Fall Risk Plan dated 05/16/13 and indicated client B was at risk for falls due to osteoporosis. The record contained a PT evaluation dated 03/31/10. The record did not contain any documentation for a reassessment for PT.</p> <p>On 09/11/13 at 10:25 AM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client B needed to be reassessed by PT.</p> <p>9-3-4(a)</p>		<p>Director will review incident documentation and make recommendation for assessments and other corrective action as needed. The Clinical Supervisor will follow-up with the QIDP and facility nurse to assure appropriate follow-through occurs. Additionally, members of the Administrative Team, including the Executive Director and Program Manager, will maintain an increased presence at the facility, performing unscheduled observation of active treatment no less than five times weekly for the next 30 days, no less than three times weekly for an additional 30 days and no less than weekly for an additional 30 days. Team members will incorporate audits of assessment documentation into these visits. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Health Services Team, Administrative Team</p>		

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W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on record review and interview, the Condition of Participation of Health Care Services is not met as the facility failed for 3 of 3 sampled clients (clients A, B and C), to ensure they received health care services for their medical needs and for 4 additional clients (clients D, E, F and G) to ensure medications are secure.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Please refer to W331. The facility nursing services failed for 3 of 3 sampled clients (clients A, B and C), by not ensuring the clients received re-evaluations (client B), physician follow-ups (client C), and failed to document medication counts after an overdose of medication (client A).</li> <li>Please refer to W368. The facility nursing services failed for 1 of 3 sample clients (client B), who take medications prescribed by the physician, to administer medications as ordered.</li> <li>Please refer to W382. The facility nursing services failed for 7 of 7 clients (clients A, B, C, D, E, F and G) who lived in the group home, the facility failed to</li> </ol>	W000318	<p>CORRECTION: The facility must ensure that specific health care services requirements are met. Specifically: The facility nurse has been replaced. Medication will be counted no less than once per shift. In addition to regularly scheduled counts, any time a breach in security occurs that results in or has the potential to result in a medication error, the facility nurse will oversee a count of all medications in the home. The team will assure that a Physical Therapy assessment for Client B is completed. Additionally, the nurse has reviewed all facility medical records and additional PT assessments have been scheduled based on the results of the record review. Client C has received an annual physical examination. A review of facility records indicated all other clients have received a physical examination within the past 12 months. The Health Services Team will conduct a thorough audit of facility medical records to assure that all other recommended medical follow-up has occurred. A new supervisory team is in place at the facility. All staff have been retrained on the agency's medication administration procedures as well as the need to keep medication</p>	10/24/2013

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	<p>maintain proper medication security.</p> <p>This federal tag relates to complaint #IN00135301.</p> <p>9-3-6(a)</p>		<p>secure at all times. Additional staff have been placed on the day and evening shifts to eliminate distractions that could result in medication errors and to provide enhanced supervision of all clients. PREVENTION: The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to visual evaluations, occur within required time frames. Members of the Administrative Team will incorporate medical chart reviews into the formal audit process, which will occur no less than quarterly to assure appropriate medical follow-up takes place as required. Additionally the Nurse Manager will monitor the facility's tracking system and will participate in Administrative Team audits. The Administrative Team will monitor facility staff schedules to assure adequate direct support staff are assigned to all shifts. Specifically the Program Manager will perform weekly checks of facility labor hours and take corrective action as needed. Additionally, on an ongoing basis, members of the Administrative Team will spot check time and attendance records to assure hours worked match the facility schedule. Members of the Administrative Team, including the Executive Director and Program Manager, will maintain an increased presence at the</p>	

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			<p>facility, performing unscheduled observation of active treatment no less than five times weekly for the next 30 days, no less than three times weekly for an additional 30 days and no less than weekly for an additional 30 days to assure that medications are administered per physician's orders and are secured properly. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Administrative Team</p>	

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W000322	<p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client C) to have an annual physical examination.</p> <p>Findings include:</p> <p>Client C's records were reviewed on 09/10/13 at 11:25 AM. Client C's record did not contain a physical examination after 08/01/12.</p> <p>On 09/11/13 at 10:25 AM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client C had not had a physical examination since 08/01/12.</p> <p>9-3-6(a)</p>	W000322	<p>CORRECTION:The facility must provide or obtain preventive and general medical care. Specifically, Client C has received an annual physical examination. A review of facility records indicated all other clients have received a physical examination within the past 12 months. PREVENTION:The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to visual evaluations, occur within required time frames. Members of the Administrative Team will incorporate medical chart reviews into the formal audit process, which will occur no less than quarterly to assure appropriate medical follow-up takes place as required. Additionally the Nurse Manager will monitor the facility's tracking system and will participate in Administrative Team audits. Additionally, members of the Administrative Team, including the Executive Director and Program Manager, will maintain an increased presence at the facility, performing unscheduled observation of active treatment no less than five times weekly for the next 30 days, no less than three times weekly for an additional 30 days and no</p>	10/24/2013	

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			less than weekly for an additional 30 days. Team members will incorporate audits of medical records into these visits. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Administrative Team	

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed for 3 of 3 sampled clients (clients A, B and C), by not ensuring the clients received re-evaluations, physician follow-ups, and failed to document medication counts after an overdose of medication.</p> <p>Findings include:</p> <p>1. Client A's records were reviewed on 09/10/13 at 9:26 AM. A BDDS (Bureau of Developmental Disabilities Services) report dated 08/13/13 indicated, "[Client A]...told staff that she did not feel well because she took too much medication the previous night. Staff took [client A's] vital signs, which were within normal limits and called the supervisor. While staff was speaking to the supervisor, [client A] called 911. EMS (Emergency Medical Services) arrived and transported her to the [hospital #1] Emergency Department (ED). Tests indicated that [client A] had elevated liver enzymes and she was admitted to the hospital. An investigation was initiated and [client A] said that the medication room was unlocked and the keys to the medication cabinet were not being held by staff.</p>	W000331	<p>CORRECTION: The facility must provide clients with nursing services in accordance with their needs. Specifically: The facility nurse has been replaced. Medication will be counted no less than once per shift. In addition to regularly scheduled counts, any time a breach in security occurs that results in or has the potential to result in a medication error, the facility nurse will oversee a count of all medications in the home. The team will assure that a Physical Therapy assessment for Client B is completed. Additionally, the nurse has reviewed all facility medical records and additional PT assessments have been scheduled based on the results of the record review. Client C has received an annual physical examination. A review of facility records indicated all other clients have received a physical examination within the past 12 months. The Health Services Team will conduct a thorough audit of facility medical records to assure that all other recommended medical follow-up has occurred. PREVENTION: The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to visual evaluations,</p>	10/24/2013			

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	<p>[Staff #1] was the only employee on duty at the time of the incident and she has been suspended pending investigation. A review of the service site's medication indicated [client A] took the following medications prescribed to her: 16 Tylenol ES (Extra Strength) 500 mg (milligram) tabs (tablets) (pain), 5 Mylicon 80 mg tabs (gas relief) and 3 Hydroxyzine 25 mg tabs (anxiety/nausea/vomiting)...Her liver function had not improved on the morning of 08/14/13 and [client A] is being prepared for transfer to the [hospital #2]...."</p> <p>On 09/11/13 at 10:25 AM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated a count on the clients' medications had been conducted. She indicated there was no documentation to indicated when the count was conducted or the findings.</p> <p>2. Client B's records were reviewed on 09/10/13 at 10:24 AM. There were 3 reports for client B regarding falls which occurred on the following dates:</p> <p>06/04/13: An Incident/Accident Report indicated client B fell in the laundry room.</p> <p>06/18/13: A Record of Visit document indicated client B was seen by the</p>		<p>occur within required time frames. Members of the Administrative Team will incorporate medical chart reviews into the formal audit process, which will occur no less than quarterly to assure appropriate medical follow-up takes place as required. Additionally the Nurse Manager will monitor the facility's tracking system and will participate in Administrative Team audits. Additionally, members of the Administrative Team, including the Executive Director and Program Manager, will maintain an increased presence at the facility, performing unscheduled observation of active treatment no less than five times weekly for the next 30 days, no less than three times weekly for an additional 30 days and no less than weekly for an additional 30 days. Team members will incorporate audits of medical records into these visits. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Administrative Team</p>				

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	<p>physician who indicated client B had a second fall recently.</p> <p>08/05/13: A BDDS report indicated client B had a "...purple bruise under her right eye the size of a half dollar...also had a right swollen knee the size of a tennis ball and redness towards her right shin...seen by the Emergency room physician...." An investigation dated 08/05/13 indicated client B had "...sustained the injury from a fall out of bed...."</p> <p>Client B's record contained a Fall Risk Plan dated 05/16/13 and indicated client B was at risk for falls. The record contained a PT evaluation dated 03/31/10. The record did not contain any documentation for a reassessment for PT.</p> <p>On 09/11/13 at 10:25 AM an interview with the LPN was conducted. The LPN indicated client B needed to be reassessed by PT.</p> <p>3. Client C's records were reviewed on 09/10/13 at 11:25 AM. Client C's record contained a physical examination dated 08/01/12. The physical indicated client C was to return annually for an examination.</p> <p>On 09/11/13 at 10:25 AM an interview with the LPN was conducted. The LPN</p>			

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	<p>indicated client C had not had a physical examination since 08/01/12.</p> <p>This federal tag relates to complaint #IN00135301.</p> <p>9-3-6(a)</p>			

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sample clients (client B), who take medications prescribed by the physician, to administer medications as ordered.</p> <p>Findings include:</p> <p>On 09/09/13 at 11:29 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports and internal incident/accident reports was completed and included the following medication error:</p> <p>07/29/13: "[Client B] was given another individuals medication by another staff. [Client B] was taken to [hospital #1] and was seen in the emergency room (ER). The ER physician instructed thata (sic) [client B] stay a few hours for observation...."</p> <p>Client B's record was reviewed on 09/10/13 at 10:24 AM. Client B's record contained ER discharge information which indicated the following: "Your diagnosis was Accidental Drug Ingestion." The information sheet</p>	W000368	<p>CORRECTION: The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Specifically, a new supervisory team is in place at the facility. All staff have been retrained on the agency's medication administration procedures. Additional staff have been placed on the day and evening shifts to eliminate distractions that could result in medication errors and to provide enhanced supervision of all clients. PREVENTION: The Administrative Team will monitor facility staff schedules to assure adequate direct support staff are assigned to all shifts. Specifically the Program Manager will perform weekly checks of facility labor hours and take corrective action as needed. Additionally, on an ongoing basis, members of the Administrative Team will spot check time and attendance records to assure hours worked match the facility schedule, Members of the Administrative Team, including the Executive Director and Program Manager, will maintain an increased presence at the facility, performing unscheduled observation of active treatment no less than five times weekly for</p>	10/24/2013	

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	<p>indicated client B's treatment included cardiac monitoring, saline lock IV (intravenous) and she was given activated charcoal-sorbitol to treat the overdose.</p> <p>On 09/11/13 at 10:25 AM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated medications that are not given as prescribed are considered medication errors as staff are not following the physician's orders.</p> <p>This federal tag relates to complaint #IN00135301.</p> <p>9-3-6(a)</p>		<p>the next 30 days, no less than three times weekly for an additional 30 days and no less than weekly for an additional 30 days to assure that medications are administered per physician's orders. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Administrative Team</p>		

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W000382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>Based on record review, and interview, for 7 of 7 clients (clients A, B, C, D, E, F and G) who lived in the group home, the facility failed to maintain proper medication security.</p> <p>Findings include:</p> <p>08/13/13: A BDDS report indicated, "[Client A]...told staff that she did not feel well because she took too much medication the previous night. Staff took [client A's] vital signs, which were within normal limits and called the supervisor. While staff was speaking to the supervisor, [client A] called 911. EMS (Emergency Medical Services) arrived and transported her to the [hospital #1] Emergency Department (ED). Tests indicated that [client A] had elevated liver enzymes and she was admitted to the hospital. An investigation was initiated and [client A] said that the medication room was unlocked and the keys to the medication cabinet were not being held by staff. [Staff #1] was they only employee on duty at the time of the incident and she has been suspended pending investigation. A review of the service</p>	W000382	<p>CORRECTION:The facility must keep all drugs and biologicals locked except when being prepared for administration. Specifically, a new supervisory team is in place at the facility. All staff have been retrained regarding the need to keep medication secure at all times. Additional staff have been placed on the day and evening shifts to eliminate distractions and to provide enhanced supervision of all clients. PREVENTION:The Administrative Team will monitor facility staff schedules to assure adequate direct support staff are assigned to all shifts. Specifically the Program Manager will perform weekly checks of facility labor hours and take corrective action as needed. Additionally, on an ongoing basis, members of the Administrative Team will spot check time and attendance records to assure hours worked match the facility schedule. Members of the Administrative Team, including the Executive Director and Program Manager, will maintain an increased presence at the facility, performing unscheduled observation of active treatment no less than five times weekly for the next 30 days, no less than three times weekly for an additional 30</p>	10/24/2013			

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	<p>site's medication indicated [client A] took the following medications prescribed to her: 16 Tylenol ES (Extra Strength) 500 mg (milligram) tabs (tablets) (pain), 5 Mylicon 80 mg tabs (gas relief) and 3 Hydroxyzine 25 mg tabs (anxiety/nausea/vomiting)...Her liver function had not improved on the morning of 08/14/13 and [client A] is being prepared for transfer to the [hospital #2]...."</p> <p>08/20/13: A Follow-up BDDS report to the 08/13/13 incident indicated, "[Client A] remains hospitalized at [hospital #2] and is being treated for liver failure. Evidence gathered through investigation substantiated that Direct Support Staff (DSS) [staff #1] failed to lock the medication room and left the keys to the medication room accessible to [client A], enabling her to access the medication. Staff [staff #1] remained suspended throughout the investigation and terminated of her employment has been approved. Staff have been retrained regarding the need to keep medications secured at all times and carry the keys at all times...."</p> <p>On 09/10/13 at 9:30 AM, the facility's 09/07/07 policy on "Medication Administration" was reviewed. The policy indicated the agency's training</p>		<p>days and no less than weekly for an additional 30 days to assure that medications are secured properly. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONSIBLE PARTIES:QIDP, Residential Manager, Direct Support Staff, Health Services Team, Administrative Team</p>				

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	<p>curriculum was Core A and Core B. The policy indicated medications should properly be secured, "in the locked cabinet...."</p> <p>On 09/10/13 at 10:30 AM and interview was conducted with the LPN (Licensed Practical Nurse). The LPN indicated the facility followed Core A/Core B policy and procedures for administering medications. The LPN indicated the medications were to be locked except when staff were with the medications during administration.</p> <p>This federal tag relates to complaint #IN00135301.</p> <p>9-3-6(a)</p>			

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (client C), who wore glasses, and used a walker for ambulation the the facility failed to ensure client C used his adaptive equipment.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on On 09/09/12 from 3:45 PM until 6:00 PM. Client C arrived home from day service at 5:00 PM and used a walker to ambulate into the house. Client C placed the walker by the hall doorway where it stayed the remainder of the observation. Client C was not prompted to use his walker when he ambulated around the home. Client C was not wearing his eyeglasses nor were any verbal prompts made to client C regarding his eyeglasses.</p> <p>Client C's record was reviewed on 09/10/13 at 11:25 AM. Client C's vision examination dated 08/20/13 indicated</p>	W000436	<p>CORRECTION: The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Specifically, the team will develop learning objectives to train Client C toward appropriate use of his walker. Additionally, Client C's eyeglasses have been repaired. PREVENTION: Facility professional staff will be expected to observe no less than two morning and two evening active treatment sessions per week to assess direct support staff interaction with clients and to provide hands on coaching and training toward proper implementation of learning objectives including but not limited to adaptive equipment goals. Additionally, members of the Administrative Team, including the Executive Director and Program Manager, will maintain an increased presence at the facility, performing</p>	10/24/2013

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	<p>client C was prescribed eyeglasses and was to use them for "constant wear." Client C's Fall Risk Plan dated 05/13/13 indicated client C was to use his walker for ambulation.</p> <p>09/11/13 at 10:30 AM an interview was conducted with the LPN (Licensed Practical Nurse). The LPN indicated client C was at risk for falls and he should be using his walker for all ambulation as his risk plan indicated.</p> <p>On 09/11/13 at 11:40 AM an interview was conducted with the Clinical Supervisor #2 (CS). The CS #2 indicated client C's glasses had been broken for a month an they were waiting on them to be repaired.</p> <p>9-3-7(a)</p>		<p>unscheduled observation of active treatment no less than five times weekly for the next 30 days, no less than three times weekly for an additional 30 days and no less than weekly for an additional 30 days to assure that clients are utilizing adaptive equipment as recommended and that appropriate training supports are in place.. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONSIBLE PARTIES:QIDP, Residential Manager, Direct Support Staff, Health Services Team, Administrative Team</p>	

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W000460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 3 sample clients (clients B and C) who were on a modified diet to follow diet orders.</p> <p>Findings include:</p> <p>On 09/09/13 from 3:45 PM until 6:00 PM observations at the group home were completed. At 5:50 PM client B's food was placed onto his plate by staff #3 and client C's food was placed onto his plate by staff #4. Client B and C's food included lettuce salad and toasted garlic bread.</p> <p>Client B's records were reviewed on 09/10/13 at 10:24 AM. Client B's record contained a dietary Quarterly Nutritional Review dated 06/24/13. The review indicated client B was on a mechanical soft diet and was a choking risk.</p> <p>Client C's records were reviewed on 09/10/13 at 11:25 AM. Client C's record contained a dietary Quarterly Nutritional Review dated 06/24/13. The review indicated client C was on a mechanical soft diet and was a choking risk.</p>	W000460	<p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Specifically, staff have been retrained on Client B and Client C's dining plans, and their diet is being prepared and served as prescribed. Comprehensive High Risk Plans for all clients assessed as at risk for choking will be revised to include specific guidance for staff toward proper preparation of modified diets PREVENTION:Professional staff will be retrained regarding the need to provide ongoing supervision during meal preparation and during family style dining to assure foods are prepared and served in an appropriate texture. Additionally, members of the Administrative Team, including the Executive Director and Program Manager, will maintain an increased presence at the facility, performing unscheduled observation of active treatment no less than five times weekly for the next 30 days, no less than three times weekly for an additional 30 days and no less than weekly for an additional 30 days to assure clients' dietary needs are supported. After three months the administrative team will evaluate</p>	10/24/2013

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	An interview was conducted on 09/11/13 at 11:40 AM, with the Clinical Supervisor #1 (CS #1). The CS #1 indicated clients B and C mechanical soft diets should not have been given the lettuce salad and garlic bread.  9-3-8(a)		the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONSIBLE PARTIES:QIDP, Residential Manager, Direct Support Staff, Health Services Team, Administrative Team	