

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
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NAME OF PROVIDER OR SUPPLIER  IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
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W 0000  Bldg. 00	<p>This visit was for a recertification and state licensure survey.</p> <p>Dates of Survey: 4/28, 4/29, 5/2, and 5/6/16.</p> <p>Facility number: 000698 Provider number: 15G163 AIM number: 100248790</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed May 13, 2016 by #09182.</p>	W 0000		
W 0104  Bldg. 00	<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 observation and interview for 2 of 2 sampled clients (#1 and #2) and for 1 additional client (#3), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility maintained the group home's kitchen cabinet and vacuum cleaner.</p>	W 0104	The vacuum cleaner belt had just broken and was fixed that evening. Responsible person: Joyce Parrish, GH Manager. A maintenance request was submitted to replace the cabinet door. It was being fixed. A second request has been submitted to complete the job. Responsible person: Sheila O'Dell, GH Director. To ensure future compliance, as needed a	06/05/2016

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

TITLE

(X6) DATE

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

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	<p>Findings include:</p> <p>During the 4/28/16 observation period between 2:34 PM and 5:45 PM and the 4/29/16 observation period between 4:57 AM and 7:05 AM, at the group home, the carpeted areas of the group home (living room, back sitting room) were not vacuumed as paper and/or other items were on the carpeted areas of the home. In the kitchen, a cabinet door was missing on the bottom of a cabinet where the toaster was kept where clients #1, #2 and #3 lived.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) and administrative staff #1 on 5/2/16 at 1:05 PM indicated the carpet in the group home should be vacuumed daily. Administrative staff #1 indicated she had learned staff was not able to vacuum the floor as the vacuum cleaner was not working. Administrative staff #1 stated the "belt" needed to be replaced. Administrative staff #1 indicated she was aware the door on the cabinet needed to be replaced. Administrative staff #1 and the QIDP indicated the cabinet door was on a maintenance checklist for the maintenance man to fix.</p> <p>9-3-1(a)</p>		<p>maintenance request will be filled out and submitted. Responsible person: Joyce Parrish, GH Manager. To ensure future compliance, at least monthly the home will be inspected to see if any repairs are needed to be done. Responsible person: Stephanie Blackman, QIDP &amp; Sheila O'Dell, GH Director.</p>	

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W 0120  Bldg. 00	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on observation, interview and record review for 1 of 2 sampled clients (#2), the facility failed to ensure the school did not use any restrictive devices/techniques which were not part of a plan and/or failed to ensure the school addressed the client's identified behavior of stripping.</p> <p>Findings include:</p> <p>During the 4/29/16 observation between 7:50 AM and 9:02 AM at the school at 8:45 AM, client #2 sat at a round desk with a male assistant teacher standing next to the client. Client #2 had a type of seatbelt around his waist. As an assistant teacher was reading a book, client #2 attempted to stand at the desk. Client #2 was still strapped in the chair with the belt. The male assistant teacher physically assisted client #2 to sit back down in the chair. Client #2 again attempted to stand and leaned back into the chair attempting to raise his shirt with the male assistant teacher pulling client #2's shirt down. The male assistant teacher attempted to physically assist client #2 to sit down. Client #2 became</p>	W 0120	<p>Client #2 has only been in our services for a short time. We were still learning him and his behaviors. His behavior plan has been revised a few times to address behaviors. His current BSP is revised again to address stripping and to include the restrictive techniques being implemented at the school. Responsible person: Karen Warner, Behaviorist. A team meeting was held on 5/3/16, to discuss client #2's behaviors with our behaviorist. Our GH manager has been in close contact with the school and trying to work through some of the behaviors. The case conference held on 2/4/16, had for several assessment to be completed including behavioral. These were completed and a case conference was held on 5/23/16. The IEP also now addresses the restrictive techniques being used as well as their own BSP for their setting. To ensure future compliance, at least monthly school contact will be made to see if all behaviors identified have been addressed and that any restrictive techniques are part of the plan. Responsible person: Joyce Parrish, GH Manager.</p>	06/05/2016	

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	<p>more aggressive and started pulling against the male assistant teacher while trying to get over the top of the desk while still in the seatbelt attached to the chair. A second male assistant teacher came to attempt to physically assist client #2 to sit down with no luck. The assistant teacher who was reading the book, then joined the two assistant teachers to assist client #2 to stay at his desk. Client #2 continued to push against the assistant teachers until he was able to get out of the seatbelt and stood on his feet with the three assistant teachers holding the client behind the desk. At which time, one of the assistant teachers indicated client #2 may need to use the bathroom. Client #2's male assistant teacher placed a gait belt around the client and the other students were moved out of the path of client #2. The three male assistant teachers walked client #2 out of the classroom into the hallway to go to the bathroom utilizing the gait belt.</p> <p>Client #2's record was reviewed on 5/2/16 at 11:10 AM. Client #2's 4/12/16 Behavior Support Plan (BSP) indicated client #2 demonstrated property destruction and elopement. Client #2's BSP did not address stripping and/or include the restraints of a seatbelt and/or gait belt.</p>			

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	<p>Client #2's 2/4/16 Multidisciplinary Case Conference Report indicated "[Client #2] will attend a self-contained classroom in a public segregated facility 6.5 hours per day- 5 days a week. IEP (Individual Education Plan) from [name of previous school] is attached. A reevaluation is going to be requested at the ACR (unknown acronym) in March. Diaper is worn. He is working on toileting skills..." Client #2's case conference indicated client #2 would wear a safety vest and seatbelt while being transported on the school bus. Client #2's case conference indicated client #2 would bite his hand when he was mad. Client #2's case conference did not include the use of a seat belt while in the classroom and/or the use of a gait belt. Client #2's school's case conference did not address the client's stripping behavior and/or include a behavior plan for the school.</p> <p>Interview with teacher #1 on 4/29/16 at 9:15 AM stated client #2 was having a "hard time" transitioning to the school. Teacher #1 stated client #2 "tears up everything on walls." Teacher #1 stated the client would "strip and run through the school naked." Teacher #1 indicated she had chased the client naked through the school on 2 different occasions. Teacher #1 stated "A 17 year old running naked through a school is not good."</p>			

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	<p>Teacher #1 stated the seatbelt was being used for client #2's "seizures and to prevent stripping." Teacher #1 stated the gait belt was being used to "slow him down." Teacher #1 indicated client #2 would run versus walking. Teacher #1 indicated the group home staff would come to the school to assist them with client #2 when he was having a lot of behaviors. Teacher #1 stated the school had client #2's behavior plan from the group home, but it did not work for the "school's environment." Teacher #1 indicated they could not let client #2 run and then redirect him back to his seat. Teacher #1 indicated she had other kids in her classroom to think about as she had some clients in wheelchairs. Teacher #1 indicated the school did not have a behavior plan for client #2. Teacher #1 indicated the school was still evaluating client #2 and was in the process of developing a plan.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 5/2/16 at 10:45 AM indicated the school was having a difficult time dealing with client #2. The QIDP indicated the facility staff had been to the school on several different occasions to assist in dealing with the client's behavior. The QIDP indicated the school had client #2's BSP to use and was aware the teacher did</p>			

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W 0125 Bldg. 00	<p>not think it could be implemented at the school. The QIDP indicated she was not aware a gait belt was being used with the client. The QIDP indicated the use of a gait belt and/or seatbelt was not part of the client's BSP. The QIDP indicated the school was still evaluating client #2's behavior and would be developing their own behavior plan. The QIDP indicated client #2's stripping behavior at the school had not been addressed. The QIDP indicated the school's staff and the client's interdisciplinary team at the group home and the behavior specialist were having a meeting at the school on 5/3/16 to discuss the client's behaviors at school.</p> <p>9-3-1(a)</p> <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2), the facility failed to ensure the clients' rights in regard to how the clients would get their rights back to eliminate the use of window, bedroom doors and exterior door alarms.</p>	W 0125	Client #1 & 2 both have elopement addressed in their BSP. To allow them the freedom to move about the home independently and to be alone in their bedrooms, alarms have been place on the windows and doors. This is in their HRC approved BSP. Responsible	06/05/2016

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	<p>Findings include:</p> <p>During the 4/28/16 observation period between 2:34 PM and 5:45 PM and the 4/29/16 observation period between 4:57 AM and 7:05 AM, at the group home, door alarms were on each exit door to the group home and would sound when others entered and/or exited the group home. Door alarms were also on interior doors of clients #1 and #2's bedrooms. Each time client #1 and/or client #2 entered or exited their bedrooms the alarms would sound. Window alarms were also on clients #1 and #2's windows located in the clients' bedrooms.</p> <p>Client #2's record was reviewed on 5/2/16 at 11:10 AM. Client #2's 4/12/16 Behavior Support Plan (BSP) indicated "...Door alarms: There are alarms on the bedroom doors and exterior doors to alert staff a door has been opened. This in no manner prevents [client #2] from entering rooms or exiting the home." The BSP indicated "...Alarms: [Client #2] has not responded to verbal redirection upon elopement. The team agrees the risk of restriction of alerting staff of an exit does not outweigh the risks of elopement..." Client #2's 4/12/16 BSP did not indicate what client #2 had to do to get his right of freedom of movement back.</p>		<p>person: Karen Warner, Behaviorist. Client #1 &amp; 2 both have had their BSP revised to address when they what they would have to do to get the alarms removed. Responsible person: Karen Warner, Behaviorist. To ensure future compliance, at least quarterly the team will review the BSP to make sure that a plan of reduction is in place for any restrictions. Responsible person: Karen Warner, Behaviorist, Stephanie Blackman, QIDP &amp; Joyce Parrish GH Manager.</p>	

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W 0192  Bldg. 00	<p>Client #1's record was reviewed on 5/2/16 at 12:15 PM. Client #1's 2/29/16 BSP indicated client #1 demonstrated Outbursts, "Inappropriate Urination" and elopement. Client #1's BSP indicated "...Alarms have been installed on all bedroom and exit doors to alert staff when doors are open. This is a means to prevent elopement...." Client #1's BSP also indicated alarms were also on the windows. Client #1's 2/29/16 BSP did not indicate what client #1 would have to do to get his right of freedom of movement back.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) and administrative staff #1 on 5/2/16 at 1:05 PM indicated clients #1 and #2's BSPs did not indicate what the clients would have to do to get the alarms removed and the right to freedom of movement back.</p> <p>9-3-2(a)</p> <p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on observation, interview and record review for 1 of 2 sampled clients</p>	W 0192	All staff are trained in Med core A & B and pill passing upon hire	06/05/2016	

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	<p>(#1), the facility failed to ensure facility staff were adequately trained on how to administer a client's medications.</p> <p>Findings include:</p> <p>During the 4/29/16 observation period between 4:57 AM and 7:05 AM, at the group home, client #1 was administered the following medications:</p> <ul style="list-style-type: none"> <li>-Calcium (supplement) 500 milligrams chewable tablet</li> <li>-Divalproex Sodium (behavior) 125 milligrams 12 capsules</li> <li>-Diazepam (behavior) 2 milligrams</li> <li>-Citalopram (behavior) 10 milligrams</li> <li>-Vitamin D 3 (supplement)</li> <li>-Fluphenazine (behavior) 5 milligrams</li> <li>-Clonidine (behavior) 0.1 milligram</li> <li>-Montelukast Sodium (asthma/allergy-anti-inflammatory) 5 milligrams chewable (2 tablets).</li> </ul> <p>Staff #4 handed client #1 three different medication cups separately and asked the client to chew the medications up. Client #1 made gagging sounds on 2 different occasions when the client was attempting to chew the client's 12 Divalproex capsules. Client #1 spit out 2 of the Divalproex capsules. Staff #4 re-administered 2 of the capsules to client #1 who again attempted to chew the</p>		<p>and at least annually there after. Responsible person: Sherri DiMarco, RN. All staff including #4 will be retrained in pill passing, in specific on how to pass Client #1's medications. Responsible person: Stephanie Blackman, QIDP &amp; Joyce Parrish, GH Manager. All of the capsules are sprinkles and are to be opened up and removed from the capsules. Client #2 may chew the pills that are chewable and then follow with water. The nurse has gone through his medications as well as the pharmacist that all the capsules can be opened. Responsible person: Sherri DiMarco, RN &amp; Joyce Parrish, GH Manager. All staff will have a med passing reliability completed to ensure competency. Staff #4 will have an additional med passing reliability completed. Responsible person: Joyce Parrish, GH Manager &amp; Stephanie Blackman, QIDP. To ensure future compliance, at monthly a med passing reliability will be completed on going. Responsible person: Joyce Parrish, GH Manager &amp; Stephanie Blackman, QIDP.</p>		

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	<p>capsules. Client #1 made gagging sounds again and again spit out the two capsules. Staff #4 re-administered 2 more capsules to client #1 and asked the client to chew the capsules with physical assistant from staff #4 to try and keep client #1 from spitting out the capsules.</p> <p>Client #1's April Medication Administration Record (MAR) was reviewed on 4/29/16 at 6:30 AM. Client #1's April MAR indicated client #1's Calcium and Montelukast were the only 2 medications that were to be chewed. Client #1's April MAR did not indicate client #1 was to take his medications in a food (pudding/applesauce).</p> <p>Client #1's record was reviewed on 5/2/16 at 12:15 PM. Client #1's 11/18/15 Chronological Medical Information Sheet indicated the client saw his psychiatrist on 11/18/15. The 11/18/15 entry indicated "... (5) Depakote sprinkle 125 mg (milligrams) Cap (capsules)... Open capsules &amp; (and) sprinkle over food,...."</p> <p>Client #1's 10/27/15 Prescribed Medication Orders (within the client's physical examination form) and/or record did not indicate client #1 was to chew all his medications when administering.</p> <p>Interview with staff #4 on 4/29/16 at 5:50</p>			

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W 0227 Bldg. 00	<p>AM stated when asked why client #1 chews his pills, staff #4 stated "He always has." Staff #4 indicated client #1 was to chew the Divalproex capsules. Staff #4 indicated she did not open the capsules and/or use food with administering client #1's medications.</p> <p>Interview with administrative staff #1 and the Qualified Intellectual Disabilities Professional (QIDP) on 5/2/16 at 1:05 PM indicated client #1 should not chew all his medications up. The QIDP and administrative staff indicated the Divalproex capsules should be opened up and sprinkled over food. The QIDP and administrative staff #1 stated client #1's chewing up the other pills/medicine "may be his choice."</p> <p>9-3-3(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on interview and record review for 1 of 2 sampled clients (#2), the facility failed to address the client's identified behavioral need in regard to physical aggression.</p>	W 0227	Client #2 has only been in our services for a short time. We were still learning him and his behaviors. His behavior plan has been revised on 3-29, 4-12 & on 5-10 to address behaviors. Some of these	06/05/2016

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	<p>Findings include:</p> <p>Client #2's record was reviewed on 5/2/16 at 11:10 AM. Client #2's Behavior Data Sheets indicated the following (not all inclusive):</p> <p>-4/21/16 Client #2 was "being aggressive towards staff members."</p> <p>-4/22/16 at 9:12 AM, client #2 "was grabbing at staff clothes (sic) then pushed her out of chair onto floor...."</p> <p>-4/22/16 at 10:17 AM, client #2 "grabbed staff in the face causing her to bleed on her nose."</p> <p>-4/22/16 at 11:15 AM, client #2 "grabbed staff's hoody off and ripped her hair out."</p> <p>-4/22/16 at 12:15 PM, client #2 hit staff with a shower rod.</p> <p>-4/22/16 at 2:16 PM, client #2 was "ripping at staff's clothes."</p> <p>-4/22/16 at 6:35 PM, client #2 tried to "grab at staff's neck."</p> <p>-4/27/16 Client #2 "grabbed staff's breast. Pulling on them (staff) when being redirected out of office (sic)...."</p> <p>Client #2's 4/7/16 Medication Team Review sheet indicated client #2 saw his psychiatrist. The sheet indicated "...still very destruction &amp; (and) some agg. (aggression)...."</p>		<p>documented behaviors had to do with him grabbing at the items that staff were wearing (glasses, necklaces, etc.) verses aggression towards staff. His current BSP is revised again on 5-23 to make aggressive behaviors a targeted behavior, which was a newer behaviors that started at the end of April. Responsible person: Karen Warner, Behaviorist. All staff were trained in the changes to the BSP. Responsible person: Stephanie Blackman, QIDP and Joyce Parrish, GH Manger. To ensure future compliance, monthly the behaviorist will review and analyze the data. Responsible person: Karen Warner, Behaviorist. To ensure future compliance, at least quarterly the team will review the BSP to make sure that a plan of reduction is in place for any restrictions. Responsible person: Karen Warner, Behaviorist, Stephanie Blackman, QIDP &amp; Joyce Parrish GH Manager.</p>	

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W 0240 Bldg. 00	<p>Client #2's 4/12/16 Behavior Support Plan (BSP) indicated client #2 demonstrated property destruction and elopement. Client #2's BSP did not address the client's physical aggression toward others.</p> <p>Interview with administrative staff #1 and the Qualified Intellectual Disabilities Professional (QIDP) on 5/2/16 at 1:05 PM indicated they were tracking client #2's physical aggression. The QIDP stated the facility staff were to use a "blocking cushion" (foam cushion to hold up to block hits) which had been approved by the facility's Human Rights Committee until the client's interdisciplinary team developed a plan/objective to deal with client #2's physical aggression.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 1 of 2 sampled clients (#2), the client's Behavior Support Plan (BSP) did not specifically indicate what</p>	W 0240	Client #2 has only been in our services for a short time. We were still learning him and his behaviors and doing behavioral assessments to know the	06/05/2016

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	<p>facility staff were to do when the client eloped from the group home and/or indicate what facility staff were to do when the client demonstrated property destruction.</p> <p>Findings include:</p> <p>During the 4/29/16 observation period between 4:57 AM and 7:05 AM, at the group home at 6:15 AM, client #2 went back to his bedroom. Staff #3 went to get client #2. Client #2 walked out of his bedroom with staff #3 following the client. Client #2 got to the dining room area and then took off running toward the front door of the group home. Client #2 opened the door and eloped from the group home with the alarm sounding as he opened the door. Staff #3 looked toward the back of the house (where staff #4 was with client #1 in his bedroom) and then turned and ran out the front door chasing client #1. Staff #3 ran after client #2 to the garage area of the group home. The garage door was up. Staff #3 grabbed client #2 in a one arm restraint and turned the client around to walk back to the group home with the alarm sounding as the front door was still open. Staff #4, who was at the back of the house, was still not aware client #2 had eloped and staff #3 had left the group home.</p>		<p>functions of his behaviors to properly address them. His behavior plan has been revised on 3-29, 4-12 &amp; on 5-10 to address behaviors. His current BSP is revised again on 5-23 to indicate more on what the staff were to do with client demonstrated property destruction and elopement. Responsible person: Karen Warner, Behaviorist. All staff were trained in the changes to the BSP. Responsible person: Stephanie Blackman, QIDP and Joyce Parrish, GH Manger. To ensure future compliance, monthly the behaviorist will review and analyze the data. Responsible person: Karen Warner, Behaviorist. To ensure future compliance, at least quarterly the team will review the BSP to make sure that the all targeted behaviors had a reactive strategies for staff to follow. Responsible person: Karen Warner, Behaviorist, Stephanie Blackman, QIDP &amp; Joyce Parrish GH Manager.</p>		

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	<p>Client #2's record was reviewed on 5/2/16 at 11:10 AM. Client #2's Behavior Data Sheets indicated the following (not all inclusive):</p> <p>-4/27/16 Client #2 eloped out of the house and staff "chased" the client to redirect back to the group home.</p> <p>-4/27/16 at 7:15 PM, client #2 eloped out of the front door of the group home.</p> <p>-4/22/16 at 5:15 PM, client #2 "plowed through staff. Staff found (client #2 at garbage can again."</p> <p>-4/22/16 at 12:15 PM, client #2 "ripped shower curtain rod off hitting staff (with) it."</p> <p>-4/22/16 at 2:16 PM, "[Client #2] got on bed trying to rip curtain down and light...."</p> <p>-4/22/16 at 2:05 PM, client #2 "ran out of house to van then into the street. Almost got hit by a car going 50 mph (miles per hour). Ran down the street. Retrieved him brought him back inside the bedroom (with) staff. Called [QIDP] for advice on keeping him safe. Took [client #2] for a 1 1/2 hr (hour) ride until next staff came into (sic) assist."</p> <p>-4/22/16 at 11:30 AM, client #2 "plowed through (staff) knocking her down and ran out southeast front door to try and get in cars."</p> <p>-4/22/16 at 12:30 PM, client #2 tore up</p>			

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	<p>sensory items.</p> <p>-4/22/16 at 10:30 AM. client #2 "...run over staff to elope out of house down the street."</p> <p>-4/22/16 at 10:00 AM, client #2 broke the staff's glasses.</p> <p>-4/21/16 at 5:15 PM, client #3 "ran out south front door attempting to get into people's cars."</p> <p>-4/21/16 at 1:15 PM, client #2 "Broke hoyer lift." The note indicated client #2 was suspended for the day at school.</p> <p>-4/21/16 at 6:15 AM, client #2 broke staff's eyeglasses.</p> <p>-4/20/16 "[Client #2] had just got home from school. He came in front west door and ran out the front south west door...I (staff #2) went out front west door and cut him off in the front yard."</p> <p>-4/18/16 at 3:15 PM, facility staff "chased (client #2) out front southeast door."</p> <p>-4/15/16 at 5:45 PM, client #2 eloped from the group home.</p> <p>-4/9/16 at 5:00 PM, client #2 "ripped off fire/smoke detector." Client #2 was redirected to sit down.</p> <p>-4/9/16 at 4:30 PM, client #2 eloped from the group home and "...got into neighbor's car."</p> <p>-4/2/16 at 5:15 PM, client #2 "ripped panel off wall."</p> <p>-4/1/16 at 3:40 PM, client #2 "pulled out drawer in kitchen."</p>			

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	<p>Client #2's 4/12/16 Behavior Support Plan (BSP) indicated client #2 demonstrated the behaviors of Property Destruction and elopement. The 4/12/16 BSP indicated the following proactive strategies for elopement (not all inclusive):</p> <p>"1. Post stop signs on areas that are off limits to [client #2]. When he approaches an area with a sign, point to it and say 'off limits' and redirect.</p> <p>2. Avoid any emotional reaction or rushing toward him in response to his behavior. Give strong emotional reactions to preferred behavior.</p> <p>3. Do not discuss [client #2's] problem in front of him.</p> <p>4. When [client #2] needs to be redirected (for example, if standing on a table), say his name to get his attention then give a one step firm command...6. Keep items [client #2] may be interested in but that are not acceptable for he (sic) to have (due to property misuse) out of sight...." Client #2's 4/12/16 BSP indicated in regard to "Reactive Intervention: 1. If [client #2] is in an area he should not be, first point out the stop sign (if posted), then as needed, use a pivot turn and physical escort toward</p>			

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	<p>where he should go. [Client #2] is strong and the pivot turn/guide will be needed for all redirections. Staff must self monitor so that he is not pulled, shoved or otherwise roughly mishandled...2. When in the community, link/hook arms to prevent elopement toward things of interest." Client #2's BSP defined in detail the "Pivot turn," "physical guide," and "Physical Transport" techniques. Client #2's BSP did not include any additional measures/supports to indicate specifically how facility staff were to react to/deal with when client #2 demonstrated property destruction and/or eloped from the group home.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) and administrative staff #1 on 5/2/16 at 1:05 PM indicated client #2 would elope from the group home and would demonstrate physical aggression. The QIDP indicated facility staff should follow client #2 when he eloped. The QIDP and administrative staff #1 stated this BSP was a "preliminary plan." The QIDP and administrative staff #1 indicated the facility's behavior specialist was still in the process of developing a formal behavior plan for the client as the client moved into the group home on 1/29/16, and the behavior plan would have reactive strategies in regard to the client's</p>			

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W 0368 Bldg. 00	<p>elopement and property destruction behaviors.</p> <p>9-3-4(a)</p> <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. Based on observation, interview and record review for 1 of 15 medications administered, the facility failed to administer a medication as ordered by the client's physician for client #1.</p> <p>Findings include:</p> <p>During the 4/29/16 observation period between 4:57 AM and 7:05 AM, at the group home, client #1 was administered the following medications:</p> <ul style="list-style-type: none"> <li>-Calcium (supplement) 500 milligrams chewable tablet</li> <li>-Divalproex Sodium (behavior) 125 milligrams 12 capsules</li> <li>-Diazepam (behavior) 2 milligrams</li> <li>-Citalopram (behavior) 10 milligrams</li> <li>-Vitamin D 3 (supplement)</li> <li>-Fluphenazine (behavior) 5 milligrams</li> <li>-Clonidine (behavior) 0.1 milligram</li> <li>-Montelukast Sodium</li> </ul>	W 0368	<p>All staff are trained in Med core A &amp; B and pill passing upon hire and at least annually there after. Responsible person: Sherri DiMarco, RN. All staff including #4 will be retrained in pill passing, in specific on how to pass Client #1's medications. Responsible person: Stephanie Blackman, QIDP &amp; Joyce Parrish, GH Manager. All of the capsules are sprinkles and are to be opened up and removed from the capsules. Client #2 may chew the pills that are chewable and then follow with water. The nurse has gone through his medications as well as the pharmacist that all the capsules can be opened. Responsible person: Sherri DiMarco, RN &amp; Joyce Parrish, GH Manager. All staff will have a med passing reliability completed to ensure competency. Staff #4 will have an additional med passing reliability completed. Responsible person: Joyce Parrish, GH Manager &amp; Stephanie Blackman, QIDP. To</p>	06/05/2016

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	<p>(asthma/allergy-anti-inflammatory) 5 milligrams chewable (2 tablets).</p> <p>Staff #4 handed client #1 three different medication cups separately and asked the client to chew the medications up without any water or food. Client #1 made gagging sounds on 2 different occasions when the client was attempting to chew the client's 12 Divalproex capsules. Client #1 spit out 2 of the Divalproex capsules. Staff #4 re-administered 2 of the capsules to client #1 who again attempted to chew the capsules. Client #1 made gagging sounds again and again spit out the two capsules. Staff #4 re-administered 2 more capsules to client #1 and asked the client to chew the capsules with physical assistant from staff #4 to try and keep client #1 from spitting out the capsules.</p> <p>Client #1's April Medication Administration Record (MAR) was reviewed on 4/29/16 at 6:30 AM. Client #1's April MAR indicated client #1's Calcium and Montelukast were the only 2 medications that were to be chewed.</p> <p>Client #1's record was reviewed on 5/2/16 at 12:15 PM. Client #1's 11/18/15 Chronological Medical Information Sheet indicated the client saw his psychiatrist on 11/18/15. The 11/18/15 entry</p>		<p>ensure future compliance, at monthly a med passing reliability will be completed on going. Responsible person: Joyce Parrish, GH Manager &amp; Stephanie Blackman, QIDP.</p>		

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W 0454 Bldg. 00	<p>indicated "...(5) Depakote sprinkle 125 mg (milligrams) Cap (capsules)...Open capsules &amp; (and) sprinkle over food,...."</p> <p>Interview with staff #4 on 4/29/16 at 5:50 AM stated when asked why client #1 chews his pills, staff #4 stated "He always has." Staff #4 indicated client #1 was to chew the Divalproex capsules. Staff #4 indicated she did not open the capsules and/or used food with administering client #1's medications.</p> <p>Interview with administrative staff #1 and the Qualified Intellectual Disabilities Professional (QIDP) on 5/2/16 at 1:05 PM indicated client #1 should not chew all his medications up. The QIDP and administrative staff indicated the Divalproex capsules should be opened up and sprinkled over food.</p> <p>9-3-6(a)</p> <p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation and interview for 1 of 2 sampled clients (#1), the facility failed to ensure the staff cleaned/sanitized the medication</p>	W 0454	All staff are trained on pill passing & infection control upon hire and annually there after. Responsible person: Sherri DiMarco, RN. All staff will be trained to assure that	06/05/2016

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	<p>cart/washed their hands after contact with saliva.</p> <p>Findings include:</p> <p>During the 4/29/16 observation period between 4:57 AM and 7:05 AM, at the group home, client #1 was administered the following medications:</p> <ul style="list-style-type: none"> <li>-Calcium (supplement) 500 milligrams chewable tablet</li> <li>-Divalproex Sodium (behavior) 125 milligrams 12 capsules</li> <li>-Diazepam (behavior) 2 milligrams</li> <li>-Citalopram (behavior) 10 milligrams</li> <li>-Vitamin D 3 (supplement)</li> <li>-Fluphenazine (behavior) 5 milligrams</li> <li>-Clonidine (behavior) 0.1 milligram</li> <li>-Montelukast Sodium (asthma/allergy-anti-inflammatory) 5 milligrams chewable (2 tablets).</li> </ul> <p>Staff #4 handed client #1 three different medication cups separately and asked the client to chew the medications up. Client #1 made gagging sounds and saliva fell all over the top of the medication cart, staff #4's hands, and some of the client's medication cards which laid on the top of the medication cart. Client #1 spit out the Divalproex medications. When staff #4 went to administer the client's Divalproex again client #1 attempted to</p>		<p>proper hygiene and sanitary practices done to avoid sources and transmission of infections. Responsible person: Stephanie Blackman, QIDP and Joyce Parrish, GH Manager. Staff are wipe down/sanitize the med cart and to wash their hands prior to each client's medication pass. Responsible person: Stephanie Blackman, QIDP and Joyce Parrish, GH Manager. To ensure future compliance, reliabilities will be completed during med pass times to assure that the med cart is wipe down and hands were thoroughly washed. Responsible person: Stephanie Blackman, QIDP and Joyce Parrish, GH Manager.</p>	

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	<p>chew the Divalproex capsules and began gagging and drooling again. Client #1 spit out 2 of the Divalproex capsules as staff #4 tried to get client #1 to put the capsules back into his mouth. Staff #4's hands were at the client's mouth with a paper towel which was saturated from the client's saliva. Client #1 continued to drop saliva on top of the medication cart and staff #4's hands with the saturated paper towel. Staff #4 administered (punched out) another 2 capsules of client #1's Divalproex without going to wash her hands. Once staff #4 got client #1 to take the medication, staff #1 put away the medication packs which were wet and locked the medication cart. Staff #4 went into the kitchen and got a handful of paper towels Staff #4 wiped client #1's saliva off the top of the medication cart with the dry paper towels. Staff #4 did not use a cleaning agent to clean up client #1's saliva to prevent the spread of possible infection. Staff #4 then went into the kitchen to wash her hands and administered client #2's morning medication on the top of the unsanitized medication cart.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) and administrative staff #1 on 5/2/16 at 1:05 PM stated client #1 "drooled." The QIDP and administrative staff #1 indicated</p>				

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	<p>facility staff should have used the alcohol on the medication cart to clean the top of the medication cart where client #1 dropped saliva. The QIDP and administrative staff #1 indicated the staff should have washed her hands prior to administering client #1's Divalproex again.</p> <p>9-3-7(a)</p>				