

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G797	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/29/2012
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NAME OF PROVIDER OR SUPPLIER  AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 9029 S AMERICA RD LA FONTAINE, IN 46940
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W0000	<p>This visit was for a pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00104098.</p> <p>Complaint #IN00104098: SUBSTANTIATED, Federal and state deficiencies related to the allegations are cited at W102, W104, W122, W149, W154, W156, W157, W159, W195, W196, W206, W210, W225, W226 and W249.</p> <p>Dates of Survey: February 20, 21, 22, 23, 24, 27, 28, and 29, 2012.</p> <p>FACILITY NUMBER: 0012563 PROVIDER NUMBER: 15G797 AIM NUMBER: 201018540</p> <p>Surveyors: Susan Eakright, Medical Surveyor III/QMRP-Team Leader David Piotrowski, Federal Surveyor</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/12/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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

TITLE

(X6) DATE

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

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W0102	<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 observation, record review, and interview, the Condition of Participation: Governing Body and Management was not met as the governing body failed to establish oversight over the facility and to ensure the Conditions of Participation: Client Protections, Active Treatment Services, and Health Care Services, were met for 2 of 2 sample clients (clients A and B) and for two additional clients (clients C and D). The governing body failed to ensure the implementation of its abuse and neglect prevention policy, failed to implement effective corrective action to protect clients from abuse, neglect, and/or mistreatment systemically, failed to provide continuous aggressive active treatment services, and failed to provide health care services systemically at the group home.</p> <p>Findings include:</p> <p>Please refer to W122. The governing body failed to meet the Condition of Participation: Client Protections. The facility failed to implement their abuse, neglect, and mistreatment policy and procedure, to prevent peer to peer abuse</p>	W0102	<p><b>W102</b> Condition of Governing Body</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>A variety of measures have been put into place to address cited deficiencies related to Governing Body, which are detailed throughout the agency's Plan of Correction (including W122, W195, W318, and W104). Corrective actions include training staff to prevent peer-to-peer abuse; implementing the agency's revised incident reporting/investigations policy that includes a new investigations format which does not distinguish between peer aggression and abuse; training investigators to address identified problems with investigations; eliminating unapproved restrictions; training staff in how to appropriately restrict what has been approved; replacing original QMRP and Nurse whose performance led to many problems with an experienced QMRP QMRP and nurse; conducting new</p>	03/30/2012			

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	<p>and aggression, failed to thoroughly investigate, failed to report results of investigations within five days, and failed to take effective corrective actions. The facility failed to protect clients A, B, C, and D's individual rights regarding unimpeded access to their personal belongings, money, chemicals, and food for 2 of 2 sample clients (clients A and B) and for two additional clients (clients C and D).</p> <p>Please refer to W195. The governing body failed to meet the Condition of Participation: Active Treatment Services. The facility failed to ensure each client received a continuous active treatment program which included aggressive, consistent implementation of a program of specialized training and related services. Major elements of the active treatment process not present included assessment, restrictive practices, the development of priority needs, development of formal training objectives, personal skill training, program implementation, development of the ISP (Individual Support Plan) document and program monitoring for 4 of 4 clients (clients A, B, C, and D) who lived in the group home.</p> <p>Please refer to W318. The governing body failed to meet the Condition of</p>		<p>assessments; training staff members on proper implementation of treatment; having the nurse who took over healthcare coordination responsibilities spend significant time in the homes and work closely with clients, direct support staff members, and community providers.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>Training staff, implementing a new agency policy, training investigators, eliminating unneeded restrictions, training staff on restrictions still in place, having experienced QMRP and Nurse in place for future admissions; conducting new assessments; improving implementation of treatments; and coordinating more effectively with community health care providers.</p>		

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	<p>Participation: Health Care Services, was not met as the facility failed to provide health care monitoring and oversight of nursing services for 2 of 2 sample clients (clients A and B) and for two additional clients (clients C and D).</p> <p>Please see W104. The governing body failed to ensure implementation of their abuse, neglect, and mistreatment policy and procedure and to provide facility oversight for 36 of 156 BDDS (Bureau of Developmental Disability Services) Reports reviewed from 9/1/11 through 2/20/12. The governing body failed to protect clients A, B, C, and D from peer to peer abuse and aggression; to thoroughly investigate behavioral incidents (client B); to ensure the results of the investigations were reported for five (5) allegations; and to take effective corrective action to reduce the potential for continued peer to peer abuse. The facility failed to ensure routine maintenance repairs were completed in the facility residence for 2 of 2 sample clients (clients A and B) and for two additional clients (clients C and D).</p> <p>This federal tag relates to complaint #IN00104098.</p> <p>9-3-1(a)</p>		<p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>The Group Home Manager supervises staff, including ensuring that their training needs are met. The Behavior Clinician (BC) trains staff on BSPs, including restrictive measures in place. The BC monitors restrictions and reports to the IDT – a new section will be added to the BC monthly report that is distributed to the team that monitors restrictions in place. The IDT oversees the ISP and determines the need for restrictions. Management staff complete home visit forms and will assist in monitoring restrictions and program implementation. The Director supervises staff and reviews home visit forms at regular staff meetings. The IDT meets regularly and reviews incidents, including those that result in abuse investigations. The agency's Incident Oversight Committee – comprised of the Director, an agency Vice President, and a Compliance Officer – reviews all incidents, including those that require investigations. When insufficient corrective action is put in place, the committee follows up with the agency's management staff. The Director supervises management staff and reviews home visit</p>		

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			forms at regular staff meetings.	

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview, and record review, the governing body failed to ensure implementation of their abuse, neglect, and mistreatment policy and procedure and provide facility oversight for 36 of 156 BDDS (Bureau of Developmental Disability Services) Reports reviewed from 9/1/11 through 2/20/12, to protect clients A, B, C, and D from peer to peer abuse and aggression; to thoroughly investigate behavioral incidents (client B); to ensure the results of the investigations were reported (clients A, B, C, and D) for five (5) allegations; and to take effective corrective action to reduce the potential for continued peer to peer abuse. The facility failed to ensure routine maintenance repairs were completed in the facility residence for 2 of 2 sample clients (clients A and B) and for two additional clients (clients C and D).</p> <p>Findings include:</p> <p>1. On 2/20/12 at 11am, and on 2/21/12 at 8am, the facility's BDDS reports were reviewed and indicated the following for</p>	W0104	<p><b>W104</b> Governing Body</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>In order to protect clients from peer abuse, staff were trained that there is no distinction between aggression and abuse and that although the home is in place for extensive support, it cannot just be routine to have peer aggression. They must follow the BSPs, which have measures in place to prevent these abusive acts, including the need to intervene as early as possible when precursor behaviors (e.g., verbal aggression) are occurring. To address problems with investigations, both professional staff who conduct investigations were trained to ensure that they are thorough and have effective corrective action designed to prevent recurrence. Maintenance needs are being addressed, including ordering new carpet.</p>	03/30/2012			

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	<p>client B.</p> <p>-A 1/10/12 BDDS report for an incident on 1/10/12 at 8:30am, indicated client B was verbally aggressive toward staff, picked up a chair and threatened staff. The report indicated staff applied a physical restraint hold and client B said "staff were trying to rape her. But there was another staff there that stated that was not true. Therefore this is an allegation." The report did not indicate if an investigation was completed.</p> <p>-A 11/11/11 BDDS report for an incident on 11/10/11 at 4pm, indicated client B had behaviors of "crying, screaming, cursing, throwing things (sic)." The report indicated a male staff person had "used a mandt (a physical restraint staff used to hold the client) restraint to ensure safety. During the restraint [client B's] sweats came part way down. Staff pulled them up and [client B] stated she was going to say staff raped her." The report indicated after client B calmed, the agency LPN (Licensed Practical Nurse) asked client B "if she said that? [Client B] said yes." The report indicated the "LPN asked [client B] if staff did rape her</p>		<p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>Staff were trained to better understand that it is not acceptable for peer abuse to continue and to implement the BSPs fully in order to prevent it. The investigators received investigations training on revised incident reporting policy that includes an updated investigations form. Maintenance needs have been met, including ordering new carpet.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>The Group Home Manager supervises staff, including ensuring that their training needs are met. An Incident Oversight Committee reviews all incidents, including those that require investigations. When insufficient corrective action is put in place,</p>				

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	<p>and [client B] said no." The report indicated client B was seen by her physician for neck and shoulder pain and indicated "no other injuries noted." No documentation was available for review to determine if the allegation of rape had been investigated, why client B's pants had fallen down, or if the restraint staff implemented caused the discomfort.</p> <p>On 2/21/12 at 11:30am, client B's record was reviewed. Client B's record indicated a physician's visit for "complaints of neck and shoulder pain" sustain in on 11/10/11 when a "restraint" hold was applied by staff at the group home.</p> <p>On 2/22/12 at 11:05am, an interview with the Facility Director (FD) was completed. The FD stated client B's incidents on 1/10/12 and 11/10/11 were behaviors, client B "threatened" to make an allegation of rape against the male staff person who implemented the restraint, and client B "recanted" her threats of the allegations of rape. The FD indicated the facility did not investigate "threats by a client to make an allegation." The FD indicated client B's 11/10/11 incident of</p>		<p>the committee follows up with the agency's management staff. Management staff complete home visit forms and will assist in monitoring program implementation. The Director supervises management staff and reviews home visit forms at regular staff meetings.</p>				

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	<p>her pants falling down during a restraint was not investigated.</p> <p>2. The following incidents were reported to BDDS and investigated by the facility as peer to peer "abuse allegations."                      -On 1/16/12, the facility reported and investigated an allegation of peer to peer abuse wherein client B hit client D on the hand.                      -On 12/21/11, the facility reported and investigated an allegation of peer to peer abuse wherein client C hit client D on top of the head.                      -On 12/14/11, the facility reported and investigated an allegation of peer to peer abuse wherein client C hit client A in the face. Client A sustained reddening to face which required first aid in the form of an ice pack.                      -On 12/6/11, the facility reported and investigated an allegation of peer to peer abuse wherein client B kicked client A while she was on the floor. Client A sustained a golf size lump on her forehead described as red and bruising. Ice had to be applied and neuro-checks were completed multiple times each shift.                      -On 11/24/11, the facility reported and</p>			

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	<p>investigated an allegation of peer to peer abuse wherein client B kicked client A in the nose and the leg, causing client A's nose to bleed and reddened areas to her face.</p> <p>3. The following incidents were reported to BDDS by the facility as peer to peer "aggression resulting in physical contact" between clients A, B, C, and D.</p> <p>-On 2/13/12, the facility reported and investigated an incident of peer to peer aggression wherein client B hit client D in the back of the head.</p> <p>-On 2/12/12, the facility reported and investigated an incident of peer to peer aggression wherein client C bit client A on the hand, necessitating first aid and a visit to the hospital for an x-ray to rule out a fracture.</p> <p>-On 2/8/12, the facility reported and investigated an incident of peer to peer aggression wherein client B ran into client A's room pulling client A's hair and hitting her. Client B also kicked client A in the eye. Client A was assessed to have a golf-ball sized bruise to her left elbow and a small quarter-sized reddened area near her left eye.</p>			

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	<p>-On 2/4/12, the facility reported and investigated an incident of peer to peer aggression wherein client C pushed client D into a wall.</p> <p>-On 2/2/12, the facility reported and investigated an incident of peer to peer aggression wherein client B bit client C in the leg while in the van. Client C sustained redness and broken skin.</p> <p>-On 2/2/12, the facility reported and investigated an incident of peer to peer aggression wherein clients A and C were "involved in altercation where they pushed each other."</p> <p>-On 2/2/12, the facility reported and investigated an incident of peer to peer aggression wherein client A pushed client D and client D "retaliated" by knocking client A to the floor. Client A sustained a bruise to her foot.</p> <p>-On 1/16/12, the facility reported and investigated an incident of peer to peer aggression wherein client B struck client D. The report indicated "Plan to Resolve." "This is the third incident this month of abuse toward [client D] from a peer, how are future incidents like these being prevented? Do plans remain effective and are any new proactive</p>			

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	<p>measures being implemented/explored?"</p> <p>No information was documented.</p> <p>-On 1/10/12, the facility reported and investigated an incident of peer to peer aggression wherein client B kicked client D in the leg.</p> <p>-On 1/6/12, the facility reported and investigated an incident of peer to peer aggression wherein client B "threatened to kill" client A and client A's "mother". Client B threw her cell phone at client A hitting client A in the stomach.</p> <p>-On 12/28/11, the facility reported and investigated an incident of peer to peer aggression wherein client C threw a bottle at client D and later in the day struck client D in the head.</p> <p>-On 12/7/11, the facility reported and investigated an incident of peer to peer aggression wherein client C threw a cup at client A grazing client A's face.</p> <p>-On 11/27/11, the facility reported and investigated an incident of peer to peer aggression wherein client B bit client C on the arm. No injury was indicated on the report.</p> <p>-On 11/4/11, the facility reported and investigated an incident of peer to peer aggression wherein client D kicked client</p>			

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	<p>B and spit on her.</p> <p>-On 10/27/11, the facility reported and investigated an incident of peer to peer aggression wherein client B kicked client A in the face and back.</p> <p>-On 10/24/11, the facility reported and investigated an incident of peer to peer aggression wherein client C hit client D with a remote control.</p> <p>-On 10/9/11, the facility reported and investigated an incident of peer to peer aggression wherein client C hit client D on the side of her head.</p> <p>-On 10/6/11, the facility reported and investigated an incident of peer to peer aggression wherein client C pushed client A to the ground.</p> <p>-On 10/5/11, the facility reported and investigated an incident of peer to peer aggression wherein client C pushed client A into the kitchen counter.</p> <p>-On 9/20/11, the facility reported and investigated an incident of peer to peer aggression wherein client C hit client A in the head and on the left arm.</p> <p>-On 9/17/11, the facility reported and investigated an incident of peer to peer aggression wherein client C bit client B. Medical treatment was provided to client</p>						

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	<p>B for a human bite.</p> <p>-On 9/11/11, the facility reported and investigated an incident of peer to peer aggression wherein client B pushed client D into a corner and hit client D. The facility reported client D was again struck by client B "a short time later."</p> <p>-On 9/10/11, the facility reported and investigated an incident of peer to peer aggression wherein client B struck client D in the mouth.</p> <p>-On 9/8/11, the facility reported and investigated an incident of peer to peer aggression wherein client B knocked client A to the ground and client B began scratching client A's back and kicking her in the hip. Swelling was noted in Client A's hip area which required a follow-up physician appointment.</p> <p>On 2/22/12 at 11:05am, an interview with the Facility Director (FD) was completed. The FD was asked why certain incidents were investigated as peer to peer abuse, while others were reported and investigated as peer to peer aggression. The FD stated "All peer to peer incidents were reported to me and the facility had systemically taken action in response to</p>						

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	<p>these incidents by instituting case conferences in relation to the sentinel events." The FD indicated the individual client case conferences were not started until after December, 2011. The FD indicated revisions were made to clients A, B, C, and D's Behavior Support Plan (BSPs) in response to incidents. The FD stated that he had "trend analysis reports identifying the frequency of aggression caused by each of the clients." When it was pointed out to the FD that the review of allegations and incidents involving peer aggression had continued and had increased in rate, the FD stated "The behavior management intervention techniques employed were able to reduce the seriousness of injuries and most incidents were of a brief duration."</p> <p>4. The following investigation results were not reported to the facility director or designee within five working days. -On 11/28/11, the facility reported an allegation of abuse wherein client C alleged a staff member kicked her on 11/24/11. The summary report identified the client C recanted the allegation, but the report was not signed by the Facility</p>						

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	<p>Director until 12/6/11, six working days after the incident was reported.</p> <p>-On 12/1/11, client D alleged a staff member threatened her by stating he would write her up if she did not do what he said, or if she told anyone he had kissed a co-worker. The summary report was signed by the Facility Director on 12/14/11 nine working days after the incident had been reported.</p> <p>-On 12/6/11, the facility reported an allegation of peer to peer abuse wherein client B kicked client A while she was on the floor. The summary report was signed by the Facility Director on 12/20/11 ten working days after the incident was reported.</p> <p>-On 12/15/11, the facility reported an allegation of abuse wherein client C stated a staff member pushed her down and broke her game system and that she was fearful of another staff member who "hurt her all the time." The Facility Director signed the summary report on 1/5/12 thirteen working days after the incident had been reported.</p> <p>-On 1/17/12 the facility reported and investigated an allegation of abuse wherein client C alleged a staff member</p>			

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	<p>bent her fingers back accidentally while playing around. Other than the QMRP (Qualified Mental Retardation Professional) signature on the summary page, there was no other evidence the results of the investigation had been reported to the Facility Director, or designee.</p> <p>In a follow-up interview with the Facility Director (FD) on 2/22/12 at 11:05 AM, the FD indicated the facility investigations were to be completed within five days. The FD stated he reviewed and signed "all" investigative reports.</p> <p>5. On 2/20/12 at 11am, and on 2/21/12 at 8am, the Facility's BDDS reports were reviewed for corrective action related to allegations of abuse, neglect, mistreatment and exploitation, and the facility investigated five (5) allegations of peer to peer abuse during the time parameter 9/1/11 through 2/20/12 and twenty-four incidents of peer to peer aggression.</p> <p>On 2/22/12 at 11:05am, an interview with the Facility Director (FD) was completed.</p>						

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	<p>The FD was asked why certain incidents were investigated as peer to peer abuse, while others were reported and investigated as peer to peer aggression. The FD stated "all peer to peer incidents were reported to him and the facility had systemically taken action in response to these incidents by instituting case conferences in relation to the sentinel events." The FD indicated the individual client case conferences were not started until after December, 2011. The FD indicated revisions were made to clients A, B, C, and D's Behavior Support Plan (BSPs) in response to incidents. The FD stated that he had "trend analysis reports identifying the frequency of aggression caused by each of the clients." When it was pointed out to the FD that the review of allegations and incidents involving peer aggression had continued and had increased in rate, the FD stated "The behavior management intervention techniques employed were able to reduce the seriousness of injuries and most incidents were of a brief duration."</p> <p>On 2/22/12 at 11:05am, the Behavior Specialist (BS) presented the monthly AWS Behavior Summary reports for</p>						

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	<p>client A as additional evidence to demonstrate how the facility was reviewing and modifying the behavior plan for client A. The BS indicated the record revealed the following recommendations for client A had been made starting in September, 2011, "1. Continue to follow the current behavior support program until IDT consensus indicates otherwise. 2. [Client A] should continue to receive routine and PRN blood work to monitor her medication levels, and overall health. 3. Continue to document all incidents of inappropriate behavior in daily notes, as well as behavioral data tracking forms. 4. Continue to refer [Client A] for follow-up psychiatric consultation for medication review and further recommendations. "</p> <p>When the October, November, December of 2011 and January 2012 behavior summary reports were reviewed and compared, it was noted that all of the recommendations for Client A were exactly the same for five consecutive months starting with the September, 2011 report.</p> <p>The Behavior Specialist presented the monthly AWS Behavior Summary reports for clients B, C, and D as additional evidence to demonstrate how the facility was reviewing and modifying the</p>				

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	<p>behavior plans for clients B, C, and D. The BS indicated the records revealed the following recommendations were the same for clients B, C, and D which indicated starting in September, 2011, "</p> <p>1. Continue to follow the current behavior support program until IDT consensus indicates otherwise. 2. [Client] should continue to receive routine and PRN (as needed) blood work to monitor her Depakote level, and overall health. 3. Continue to document all incidents of inappropriate behavior in daily notes, as well as behavioral data tracking forms. 4. [Client] should receive continued follow-up psychiatric consultation for medication review, and further recommendations when indicated. "</p> <p>When the October, November, December of 2011 and January 2012 behavior summary reports were reviewed and compared, the recommendations for clients B, C, and D were exactly the same for five consecutive months starting with the September, 2011 report.</p> <p>On 2/20/12 at 11:00 AM, the undated facility's policy on abuse "Group Home Abuse and Neglect" was reviewed and indicated "Purpose. To educate and inform staff of the definition, define reporting requirements and stress that</p>						

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	<p>AWS will not tolerate abuse, neglect, of exploitation of any kind...Description, AWS does not tolerate abuse in any form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse." The policy indicated "all" allegations would be investigated. The policy indicated "Results of the investigation must be reported within 5 days. All corrective action will be written and disseminated to the appropriate entities."</p> <p>6. On 2/20/12 at 8:15 AM the following items were noted to be in disrepair in the facility: the security alarm on the front door was not audible; the family room carpeting seam was ripped from the outside wall to the inside wall of a twenty feet (20') area of carpet; there was a dent in the corner of the linen closet door; the refrigerator door did not properly latch closed and opened three times independently; the television entertainment center was missing two lower cabinet doors; four of four blades of the family room ceiling fan had dirt which circulated in the room when the fan was activated; the ceiling above the fan was</p>						

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	<p>covered had dust that had formed a circular pattern; there was a basketball size circular hole in the living room wall; there was a two feet (2 feet) rip in the carpet in the living room near the kitchen threshold entrance; the living room carpet had six dark dirt stains that covered a ten feet area; and one of the five light bulbs above the dining room table was not functioning.</p> <p>On 2/20/12 at 8:30am, an interview with the facility's Licensed Practical Nurse (LPN) was completed. The LPN indicated the Director was in the process of obtaining a new contractor for general maintenance as the previous handyman was no longer working for the facility. The LPN indicated the facility was preparing a list of repairs for the facility. On 2/29/12 at 2pm, no maintenance list was available for review.</p> <p>On 2/20/12 at 5pm, an interview with the Home Manager (HM) on 2/20/12 was completed. The HM indicated a contractor had recently fixed the front door frame that had been damaged during a client's behavioral incident and other</p>						

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	<p>repair requests were in process. The HM stated "Simple things like lights bulbs or dirty fan blades should be cleaned by third shift staff."</p> <p>This federal tag relates to complaint #IN00104098.</p> <p>9-3-1(a)</p>			

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on interview and record review for 2 of 2 sample clients (clients A and B), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement their abuse, neglect, and mistreatment policy and procedure for clients A, B, C, and D, to prevent peer to peer abuse and aggression, failed to thoroughly investigate, report results of investigations, and failed to take effective corrective actions. The facility failed to protect clients A, B, C, and D's individual rights regarding unimpeded access to their personal belongings, money, chemicals, and food.</p> <p>Findings include:</p> <p>Please refer to W149. The facility neglected to implement its policy to protect clients A, B, C, and D from peer to peer abuse and aggression; neglected to thoroughly investigate behavioral incidents (client B); neglected to ensure the results of the investigations were reported to the facility administrator or designee (clients A, B, C, and D) for five (5) allegations of abuse, neglect, and mistreatment; and neglected to take</p>	W0122	<p><b>W122</b> Condition of Client Protections <b>Corrective action for resident(s) found to have been affected</b> A number of measures have been put into place to address cited deficiencies in Client Protections, which are detailed throughout the agency's Plan of Correction (including W149, W124, W125, W126, W129, W154, W156, and W157). Corrective actions include staff training to prevent peer-to-peer abuse; implementing the agency's revised incident reporting/investigations policy that includes a new investigations format which does not distinguish between peer aggression and abuse; investigator training to address identified problems with investigations; the elimination of unapproved restrictions; and the retraining of staff in how to appropriately restrict what has been approved. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> Staff training to prevent peer-to-peer abuse; implementing revised agency policy and new investigations</p>	03/30/2012	

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	<p>effective corrective action to reduce the potential for continued peer to peer abuse for 36 of 156 BDDS (Bureau of Developmental Disability Services) Reports reviewed from 9/1/11 through 2/20/12.</p> <p>Please refer to W124. The facility failed to inform clients and their legally sanctioned representatives about facility restrictive practices of locking up butter knives, forks, chemicals, food, finger nail polish, clothing, and money for 2 of 2 sample clients (clients A and B) and two additional clients (clients C and D).</p> <p>Please refer to W125. The facility failed to allow and encourage independent access to chemicals, food, finger nail polish, and money and for client A to have access to her personal dresser for 2 of 2 sample clients (clients A and B) and two additional clients (clients C and D).</p> <p>Please refer to W126. The facility failed to teach and encourage clients to manage their own money for 2 of 2 sample clients (clients A and B) and two additional clients (clients C and D).</p> <p>Please refer to W129. The facility failed to ensure personal privacy for 1 of 2 sample clients (client A).</p>		<p>format; investigator training; the elimination of unapproved restrictions; and the retraining of staff in how to appropriately restrict what has been approved.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b> The Group Home Manager supervises Direct Support Professional Staff, including ensuring that training needs are met. The Behavior Clinician (BC) trains staff on BSPs, including restrictive measures in place. The BC monitors restrictions and reports to the IDT – a new section will be added to the BC monthly report that is distributed to the team that monitors restrictions in place. The IDT oversees the ISP and determines the need for restrictions. Management staff complete home visit forms and will assist in monitoring restrictions, including whether items are inappropriately locked. The Director supervises staff and reviews home visit forms at regular staff meetings. The IDT meets regularly and reviews incidents, including those that result in abuse investigations. The agency's Incident Oversight Committee – consisting of the Director, a Vice President, and a Compliance Officer – reviews all incidents, including those that require investigations.</p>		

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	<p>Please refer to W154. The facility failed to thoroughly investigate client B's behavioral threats of an allegation of rape and failed to thoroughly investigate client to client abuse and aggression for 31 of 156 BDDS (Bureau of Developmental Disability Services) reports reviewed during the time parameter 9/1/11 through 2/20/12 for clients A, B, C, and D.</p> <p>Please refer to W156. The facility failed to ensure the results of investigations for abuse, neglect, and mistreatment were reported to the facility administrator or the facility designee in accordance with state law within five working days for 4 of 4 clients (clients A, B, C, and D) who lived in the group home.</p> <p>Please refer to W157. The facility failed to take effective corrective action for client B's threats to make allegations of rape and to reduce the potential from injury for twenty-four (24) continued peer to peer aggression and five (5) reports of peer to peer abuse for clients A, B, C, and D for 31 of 156 BDDS (Bureau of Developmental Disability Services) Reports reviewed from 9/1/11 through 2/20/12.</p> <p>This federal tag relates to complaint #IN00104098.</p> <p>9-3-2(a)</p>						

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W0124	<p>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>Based on observation, interview, and record review, for 2 of 2 sample clients (clients A and B) and two additional clients (clients C and D), the facility failed to inform clients and their legally sanctioned representatives about facility restrictive practices of locking up butter knives, forks, chemicals, food, finger nail polish, clothing, and money.</p> <p>Findings include:</p> <p>1. On 2/20/12 at 6:12am, GHT (Group Home Trainer) #6 went to the medication area inside the laundry room with client C to complete medication administration. At 6:12am, GHT #6 retrieved her keys from her pocket, unlocked a lower cabinet, and removed wet wipes to wipe off the medication cart. Inside the locked lower cabinet were the laundry detergent, hand soap, Pine-Sol cleaner, toilet bowl</p>	W0124	<p><b>W124</b></p> <p>Consent for restrictions</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>In place were unapproved restrictions that lacked consent. All unapproved restrictions have been removed. The IDT met and decided to keep a sharps restriction in place. Consents are being obtained for these restrictions.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes</b></p>	03/30/2012			

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	<p>cleaner, and bleach. GHT #6 stated the cabinet was "kept locked" and "only" staff had access to the keys. At 6:12am, GHT #6 showed a locked upper cabinet that held nail polish belonging to clients A, B, C, and D. At 6:12am, GHT #6 stated the items were kept "locked" because of client behaviors.</p> <p>2. On 2/20/12 at 6:30 AM, Group Home Trainer (GHT) #6 retrieved a knife from inside a locked kitchen cabinet and indicated knives were kept inside to secure them. GHT #6 indicated and showed the locked cabinet held knives, butter knives, and forks and indicated the cabinet was kept locked. Observation inside the cabinet at that time showed there was a money lock box and a three holed paper punch kept with the sharp objects inside the locked cabinet. GHT #6 stated client A and B's bedroom closets were "also kept locked because of the client histories of harming themselves with their clothing."</p> <p>On 2/20/12 at 7:25 AM, client A was making toast for breakfast. Client A used a spoon to spread butter on her toast and</p>		<p><b>facility put in place to ensure no recurrence</b></p> <p>Written consent will be obtained for all clients' restrictions. HRC procedures have changed and now require guardian approval with signature prior to consideration. Staff training will take place on the need to only restrict items specifically listed in an individual's BSP.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>Behavior Clinician is responsible for all restrictions and HRC applications. Any new restriction requires HRC approval, which now requires verification of signed consent prior to consideration. Additionally, at a minimum, BSPs (which include the restrictions) are renewed on an annual basis and submitted for HRC approval.</p>		

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	<p>no knife was offered or encouraged.</p> <p>From 7:25am until 8am, clients A, B, C, and D were observed to make toast and spread the butter with a spoon. No knife was offered or the use of a knife taught for clients A, B, C, and D by the facility staff.</p> <p>On 2/20/12 at 7:45am, client A's bedroom closet in her room was locked. At 8am, GHT #2 opened client A's bedroom closet with a key she carried on a ring. In the locked closet were client A's clothing, stuffed animals, a fire truck, a belt, and a dresser. GHT #2 stated client A's closet was kept locked and "only" staff had keys because she could hurt herself with her clothing.</p> <p>On 2/20/12 at 8:10am, client B's bedroom closet was locked with a pad lock. Client B indicated the facility staff had the keys to her locked closet. At 8:10am, client B and GHT #1 indicated client B's clothing, clothes hangers, and her shoes were kept inside the locked closet.</p> <p>3. On 2/20/12 at 6:30am, two of two closets inside the living room were locked</p>			

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	<p>and GHT #6 indicated clients A, B, C, and D did not have access to the locked cabinet in the kitchen or the two living room closets. GHT #6 indicated the emergency food supply was in one locked living room closet and she was unsure of what was in the other closet.</p> <p>On 2/20/12 at 4:55 PM, two second shift GHTs #7 and #8 were asked to identify what was kept inside the two locked living room closets. GHT #7 stated "It was extra food." GHT #7 was asked to open the doors. GHT #7 and GHT #8 tried to open the doors with a key, but were unsuccessful. GHT #7 attempted to open the doors but was not able to. GHT #2 suggested another key be tried, but even with another key that attempt to open the door was also unsuccessful.</p> <p>On 2/21/12 at 10:30am, client A's record was reviewed. No documentation was available for review that client A or her legally sanctioned representatives (family and Healthcare Representative) had been informed of restrictions regarding limited access to: a butter knife; fork; her money; household supplies for cleaning; and</p>						

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	<p>finger nail polish since client A's admission on 5/9/11.</p> <p>On 2/21/12 at 11:30am, client B's record was reviewed. Client B was admitted to the facility 5/18/11. Client B's record indicated her mother was her guardian. Client B had an 8/13/2010 "Consent of Current BSP (Behavior Support Plan) and "Restrictions" which included Sharps, Footwear, Acrylic nails, belts, and a padlock on the basement door for safety. Client B and her legally sanctioned representative did not sign the form on 8/13/2010 and no update was available for review after admission to the new facility.</p> <p>In a phone interview with the Qualified Mental Retardation Professional (QMRP) on 2/21/12 at 12:20 PM, the QMRP indicated the facility had no documentation that client A or B or their legally sanctioned representatives had been informed of the facility practices to restrict access. The QMRP stated there was no policy regarding restrictions and stated clients A, B, and D "all required restrictions" related to sharps. The QMRP</p>			

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	<p>explained that client C had no documented information available for review for sharp objects and indicated the lack of information regarding the sharps restrictions was an oversight.</p> <p>On 2/22/12 at 12:10 PM, an interview with the facility's Behavior Specialist (BS) was completed. The BS indicated restrictions were identified as a separate addendum to the Behavior Support Plan (BSP). The BS presented an addendum dated 4/8/11, thirty-one days before client A's admission to the facility. The addendum indicated "Due to her history of SIB (Self Injurious Behavior) and physical aggression sharps such as knives, forks scissors, etc. will be kept locked. [Client A] will have supervised access when needed for food preparation or engaging in craft activities." The BS indicated client A's addendum did not include restrictions related to money, clothing, food, cleaning supplies or finger nail polish. The BS indicated client B's record indicated an 8/13/10 verbal consent for locked items and client B was admitted on 5/18/11. The BS indicated no updated record of notification for the</p>			

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	restrictions was available for review.  9-3-2(a)				

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W0125	<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 sample clients (clients A and B) and two additional clients (clients C and D), the facility failed to allow and encourage independent access to chemicals, food, finger nail polish, and money and for client A to have access to her personal dresser.</p> <p>Findings include:</p> <p>On 2/20/12 at 6:12am, GHT (Group Home Trainer) #6 went to the medication area inside the laundry room with client C to complete medication administration. At 6:12am, GHT #6 retrieved her keys from her pocket, unlocked a lower cabinet, and removed wet wipes to wipe off the medication cart. Inside the locked lower cabinet were the laundry detergent, hand soap, Pine-Sol cleaner, toilet bowl cleaner, and bleach. GHT #6 stated the cabinet was "kept locked" and "only" staff</p>	W0125	<p><b>W125</b> Access to chemicals, food, finger nail polish, money, and clothing <b>Corrective action for resident(s) found to have been affected</b> In place were unapproved restrictions. All unapproved restrictions have been removed. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> Staff training will take place on what restrictions are in place and the need to only restrict items specifically listed in an individual's BSP. <b>How corrective actions will be monitored to ensure no recurrence</b> The Behavior Clinician monitors restrictions and reports to the IDT. The IDT determines the need for restrictions. A new section will be added to the BC monthly report that is distributed to the team that monitors restrictions in place. Management staff complete home visit forms and will assist in</p>	03/30/2012

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	<p>had access to the keys. At 6:12am, GHT #6 showed a locked upper cabinet that held nail polish belonging to clients A, B, C, and D. At 6:12am, GHT #6 stated the items were kept "locked" because of client behaviors.</p> <p>On 2/20/12 at 6:30 AM, Group Home Trainer (GHT) #6 retrieved a knife from inside a locked kitchen cabinet and indicated the cabinet was kept locked. GHT #6 opened the locked cabinet and indicated there was a money lock box and a three holed paper punch kept with the sharp objects inside the locked cabinet. GHT #6 stated client A and B's bedroom closets were "also kept locked because of the client histories of harming themselves with their clothing."</p> <p>On 2/20/12 at 6:30am, two of two closets inside the facility living room were locked and GHT #6 indicated clients A, B, C, and D did not have access to the locked cabinet in the kitchen or the two living room closets. GHT #6 indicated the emergency food supply was in one locked living room closet and she was unsure of what was in the other closet.</p>		<p>monitoring restrictions, including whether items are inappropriately locked. The Director supervises management staff and reviews home visit forms at regular staff meetings.</p>				

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	<p>On 2/20/12 at 7:45am, client A's bedroom closet in her room was locked. At 8am, GHT #2 opened client A's bedroom closet with a key she carried on a ring. In the locked closet were client A's clothing, stuffed animals, a fire truck, a belt, and a dresser. GHT #2 stated client A's closet was kept locked and "only" staff had keys because she could hurt herself with her clothing. At 8am, client A's television sat on the floor in her bedroom.</p> <p>On 2/20/12 at 8:10am, client B's bedroom closet was locked with a pad lock. Client B indicated the facility staff had the keys to her locked closet. At 8:10am, client B and GHT #1 indicated client B's clothing, clothes hangers, and her shoes were kept inside the secured closet.</p> <p>On 2/20/12 at 4:55 PM, two second shift GHTs #7 and #8 were asked to identify what was kept inside the two locked living room closets. GHT #7 stated "it was extra food." GHT #7 was asked to open the doors. GHT #7 and GHT #8 tried to open the doors with a key, but was unsuccessful. GHT #7 attempted to</p>			

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	<p>open the doors but was not able to. GHT #2 suggested another key be tried, but even with another key that attempt to open the door was also unsuccessful.</p> <p>On 2/21/12 at 10:30am, client A's record was reviewed. No documentation was available for review that client A had been assessed for the restriction regarding limited access to: a butter knife; fork; her money; household supplies for cleaning; finger nail polish, or her personal dresser since client A's admission on 5/9/11.</p> <p>On 2/21/12 at 11:30am, client B's record was reviewed. Client B was admitted to the facility 5/11/11. Client B had a 8/13/2010 "Consent of Current BSP (Behavior Support Plan) and "Restrictions" which included Sharps, Footwear, Acrylic nails, belts, and a padlock on the basement door for safety. The group home was not observed to have a basement on 2/20/12 at 6am.</p> <p>In a phone interview with the Qualified Mental Retardation Professional (QMRP) on 2/21/12 at 12:20 PM, the QMRP indicated the facility had no</p>			

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	<p>documentation that client A or B had been assessed of the facility practices to restrict access. The QMRP stated there was no policy regarding restrictions and stated clients A, B, and D "all required restrictions" related to sharps. The QMRP indicated clients A, B, C, and D were not to be restricted from access to money, cleaning supplies, nail polish, or food.</p> <p>On 2/22/12 at 12:10 PM, an interview with the facility's Behavior Specialist (BS) was completed. The BS indicated restrictions were identified as a separate addendum to the Behavior Support Plan (BSP). The BS presented an addendum dated 4/8/11, thirty-one days before client A's admission to the facility. The addendum indicated "Due to her history of SIB (Self Injurious Behavior) and physical aggression sharps such as knives, forks scissors, etc. will be kept locked. [Client A] will have supervised access when needed for food preparation or engaging in craft activities." The BS indicated client A's addendum did not include restrictions related to money, clothing, food, cleaning supplies, finger nail polish, or her personal dresser. At</p>			

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	<p>12:10pm, the BS indicated and provided client B's record which indicated an 8/13/10 verbal consent for locked items and client B was admitted on 5/18/11. The BS indicated client B's restrictions did not include money, cleaning supplies, nail polish, or food.</p> <p>9-3-2(a)</p>				

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W0126	<p><b>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS</b> The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on observation, interview, and record review, for 2 of 2 sample clients (clients A and B) and two additional clients (clients C and D), the facility failed to teach and encourage clients to manage their own money.</p> <p>Findings include:</p> <p>On 2/20/12 at 8:28 AM, clients A and D approached a Group Home Trainer (GHT) #6 and wanted to know how much money they had. GHT #6 told the clients they had to "wait until we get the key." On 2/20/12 at 8:37 AM, client A stated to GHT #1, "I want my money." GHT #1 responded, "As soon as med (medication) pass is done, so I can get the key." At 8:50 AM, client D entered the kitchen and the GHT #6 working with client D unlocked the kitchen cabinet, took out the lock box, opened it, and took out a change purse for client D. Client D then counted her change and stated the amount "57 cents." GHT #6 responded, "You don't have enough for a pop, maybe a granola bar."</p> <p>On 2/20/12 at 8:37am, client C then approached the GHT to count her money and client C stated she had "22 cents." The GHT reminded client C she had still had some money from her family that amounted to \$1.18. The GHT also mentioned to</p>	W0126	<p><b>W126</b> Teaching money management to clients</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>Client access to money was restricted by being locked up. This is no longer the case. They receive their money and have control of it themselves. All clients were given the option to have their own private locked area for money, and two of the four opted for this. They have the key (extra key is agency office), so they maintain full access. IDTs met and are implementing new money management goals for each client.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p>	03/30/2012			

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	<p>client C the Home Manager (HM) was holding her money in the office safe for a jersey client C wanted to purchase. After clients C and D retrieved their change, their change purses were placed back into the lock box, the lock box was placed in the kitchen cabinet and the door was secured with a key by the GHT. On 2/20/12 at 8:55 AM, GHT #6 indicated clients didn't carry money and indicated the clients lost and had thrown away money in the past.</p> <p>An interview with GHT #7 on 2/20/12 at 4:30 PM, was completed and GHT #7 indicated the facility kept petty cash distribution in the lock box for community activities. GHT #7 indicated client B received money on Tuesdays and the receipts for client expenditures were kept in the lock box that was secured in the kitchen cabinet.</p> <p>An interview with the Home Manager (HM) on 2/20/12 at 5:00 PM, was completed and the HM indicated the lock box was used primarily for safeguarding petty cash, but indicated receipts from client transactions were also secured in the lock box for accounting purposes. The HM stated "keeping client money secure was important as there had been incidents in the past where clients had stolen each other's money."</p> <p>Record review for client A was completed on 2/21/12 at 10:30 AM. Client A's record indicated an Individual Support Plan dated 4/1/11 completed 31 days prior to Client A's admission on 5/9/11. Three money management objectives were suggested: "[Client A] will identify coins at</p>		<p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>Restriction eliminated with optional safeguard in place that allows money to be locked privately with client maintaining full access to their money. New money management goals are being implemented for each client.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>Group Home Manager works with clients and provides them with their personal money. The Behavior Clinician monitors restrictions and reports to the IDT. The QMRP works with the IDT to develop, implement, and monitor ISP goals. The IDT oversees the ISP and determines the need for restrictions. A new section will be added to the BC monthly report that is distributed to the team that monitors restrictions in place. Management staff complete home visit forms and will assist in monitoring restrictions, including whether items - such as money - are inappropriately locked. The Director supervises staff and reviews home visit forms at</p>				

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	<p>day services weekly; [Client A] will purchase an item with petty cash independently once per week; [Client A] will turn in receipts to staff in order to prepare a budget once per week." The plan was absent of information related to Client A's capabilities to hold and handle her own money or whether there was a need to restrict access. A risk assessment plan also dated 4/1/11 and conducted prior to Client A's admission did not address Client A's capabilities or limitations with respect to money management. Client A's 5/25/11 "Group Home Individual Support Plan Assessment" indicated "Section 2 - Money Usage and Management" the following for client A were rated as independent: "Knows purpose of money; Carries own money; Exchanges money for a purchase; Knows value of money." Client A was rated as needing verbal prompts for "Makes purchases based on need/resources" and was rated as needing help on "Budgets money for week."</p> <p>Client B's record was reviewed on 2/21/12 at 11:30am. Client B was admitted on 5/18/11 to the facility. Client B's 7/11/11 ISP and updated on 9/22/11 indicated goals/objectives implemented on 5/7/11 to make a purchase while in the community of an item of her choice and to turn in a receipt from her purchase. Client B's "Residential Monthly Report" hand written reports for 5/11 and 6/11 indicated client B did not have money to complete the objectives. Client B's 5/25/11 "Group Home Individual Support Plan Assessment" indicated client B had the skill to carry her own money, knows the purpose of money, exchanges money for a purchase, makes purchases based on need, budgets her own money for the week, and "regularly" understands individual values of coins and currency.</p>		regular staff meetings.				

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W0129	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy.</p> <p>Based on observation and interview, for 1 of 2 sample clients (client A) who lived in the facility, the facility failed to ensure personal privacy.</p> <p>Findings include:</p> <p>On 2/20/12 from 6am until 8:37am, observation and interviews were completed at the group home. At 7:10 AM, client A entered the kitchen to make breakfast. Client A bent over, her pants fell down, and client A's bottom was exposed. From 6am until 8:37am, Group Home Trainer (GHT) #2 and GHT #6 assisted client A with breakfast and did not prompt client A to adjust her pants. At 7:15am, client A was observed to expose her bottom three (3) additional times. At 7:15am, client A raised her arms to retrieve items from a kitchen cabinet and her bottom was exposed again. GHT #2 and GHT #6 did not redirect client A to change her pants or</p>	W0129	<p><b>W129</b></p> <p>Personal Privacy – client pants falling down because it was locked up</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>The clothes did not need to be restricted, so lock was removed. Staff assisted client in sorting through clothing to ensure that they fit. Additional clothing was purchased. Staff were trained to remind clients to cover themselves appropriately when their privacy is compromised.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes</b></p>	03/30/2012			

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	<p>wear a belt.</p> <p>In an interview with the Team Leader (TL) on 2/20/12 at 8:00 AM, the TL indicated client A had a belt. The TL stated the belt "was locked in [client A's] closet." At 8:10am, client A and GHT #2 were inside client A's bedroom. GHT #2 retrieved her keys from her pocket, unlocked client A's closet, and stated "Yes, there is a belt." GHT #2 pointed to a black belt inside client A's closet and relocked the closet door. Client A was not prompted or offered the opportunity to wear her belt.</p> <p>On 2/20/12 at 10:54 AM, at the facility owned day service site client A was observed with two other female clients and two male clients in the large room. Client A's bottom fold was exposed when she sat in a chair. No staff intervention was provided to get Client A to adjust her clothing and client A's pants were still not fastened with a belt.</p> <p>An interview was conducted on 2/21/12 at 10:30am with the House Manager (HM). The HM indicated client A should have</p>		<p><b>facility put in place to ensure no recurrence</b></p> <p>Restrictions removed, clothing purchased, and training conducted.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>Group Home Manager supervises staff and ensures appropriate training. The Behavior Clinician monitors restrictions and reports to the IDT. The IDT determines the need for restrictions. A new section will be added to the BC monthly report that is distributed to the team that monitors restrictions in place. Management staff complete home visit forms and will assist in monitoring restrictions, including whether items - such as clothing - are inappropriately locked. The Director supervises staff and reviews home review forms at regular staff meetings.</p>		

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	<p>been prompted to wear a belt.</p> <p>9-3-2(a)</p>			

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on interview and record review, for 36 of 156 BDDS (Bureau of Developmental Disability Services) Reports reviewed from 9/1/11 through 2/20/12, the facility neglected to implement its policy to protect clients A, B, C, and D from peer to peer abuse and aggression; neglected to thoroughly investigate behavioral incidents (client B); neglected to ensure the results of the investigations were reported to the facility administrator or designee (clients A, B, C, and D) for five (5) allegations of abuse, neglect, and mistreatment; and neglected to take effective corrective action to reduce the potential for continued peer to peer abuse.</p> <p>Findings include:</p> <p>On 2/20/12 at 11:00 AM, the undated facility's policy on abuse "Group Home Abuse and Neglect" was reviewed and indicated "Purpose. To educate and inform staff of the definition, define</p>	W0149	<p><b>W149</b></p> <p>Prevention of peer-to-peer abuse and thorough investigations</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>Staff have been retrained on the need to prevent peer-to-peer abuse. Both professional staff members responsible to conduct investigations received training from the agency Compliance Officer on conducting thorough investigations. This included the timeline that all investigations must be signed by the Director within 5 days, that there is no difference between client abuse and client aggression, and that effective follow-up action is needed in each instance in order to prevent recurrence.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address</p>	03/30/2012			

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	<p>reporting requirements and stress that AWS will not tolerate abuse, neglect, of exploitation of any kind...Description, AWS does not tolerate abuse in any form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse." The policy indicated "all" allegations would be investigated. The policy indicated "Results of the investigation must be reported within 5 days. All corrective action will be written and disseminated to the appropriate entities."</p> <p>1. On 2/20/12 at 11am, and on 2/21/12 at 8am, the facility's BDDS reports were reviewed and indicated the following for client B.</p> <p>-A 1/10/12 BDDS report for an incident on 1/10/12 at 8:30am, indicated client B was verbally aggressive toward staff, picked up a chair and threatened staff. The report indicated staff applied a physical restraint hold and client B said "staff were trying to rape her. But there was another staff there that stated that was not true. Therefore this is an allegation." The report did not indicate if an investigation was completed.</p>		<p>the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>Training for Direct Support Staff to prevent client abuse &amp; Management staff to investigate thoroughly. Additionally, a revised agency policy on incident reports went into effect this month. The agency IR policy includes investigations procedures, which were revised. Training on these revisions occurred with the two professional staff responsible for investigations.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>All Direct Support Staff are supervised by the Group Home Manager who is responsible for ensuring training needs are met. All appropriate incidents will be investigated. This will be reported within 5 days to the Director. The IDT reviews all incidents. An Incident Oversight Committee – consisting of the Director, an agency Vice President, and an agency Compliance Officer – also reviews all incidents and ensures</p>				

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	<p>-A 11/11/11 BDDS report for an incident on 11/10/11 at 4pm, indicated client B had "behaviors" of "crying, screaming, cursing, throwing things (sic)." The report indicated a male staff person had "used a mandt restraint (a restraint used by staff to physically hold the client) to ensure safety. During the restraint [client B's] sweats came part way down. Staff pulled them up and [client B] stated she was going to say staff raped her." The report indicated after client B calmed, the agency LPN (Licensed Practical Nurse) asked client B "if she said that? [Client B] said yes." The report indicated the "LPN asked [client B] if staff did rape her and [client B] said no." The report indicated client B was seen by her personal physician for neck and shoulder pain and indicated "no other injuries noted." No documentation was available for review to determine if the allegation of rape was investigated, why client B's pants had fallen down, or if the restraint staff implemented caused the discomfort.</p> <p>On 2/21/12 at 11:30am, client B's record was reviewed. Client B's record indicated a physician's visit for "complaints of neck</p>		that all investigations are thorough and completed in the correct timeframe. Corrective action is implemented as needed.		

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	<p>and shoulder pain" sustained in on 11/10/11 when a "restraint" hold applied by staff at the group home.</p> <p>On 2/22/12 at 11:05am, an interview with the Facility Director (FD) was completed. The FD stated client B's incidents on 1/10/12 and 11/10/11 were behaviors, client B "threatened" to make an allegation of rape against the male staff person who implemented the restraint, and client B "recanted" her threats of the allegations of rape. The FD indicated the facility did not investigate "threats by a client to make an allegation." The FD indicated client B's 11/10/11 incident of her pants falling down during a restraint were not investigated.</p> <p>2. The following incidents were reported to BDDS and investigated by the facility as peer to peer "abuse allegations." -On 1/16/12, the facility reported and investigated an allegation of peer to peer abuse wherein client B hit client D on the hand. -On 12/21/11, the facility reported and investigated an allegation of peer to peer abuse wherein client C hit client D on top</p>						

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	<p>of the head.</p> <p>-On 12/14/11, the facility reported and investigated an allegation of peer to peer abuse wherein client C hit client A in the face. Client A sustained reddening to face which required first aid in the form of an ice pack.</p> <p>-On 12/6/11, the facility reported and investigated an allegation of peer to peer abuse wherein client B kicked client A while she was on the floor. Client A sustained a golf size lump on her forehead described as red and bruising. Ice had to be applied and neuro-checks were completed multiple times each shift.</p> <p>-On 11/24/11, the facility reported and investigated an allegation of peer to peer abuse wherein client B kicked client A in the nose and the leg, causing client A's nose to bleed and an reddened areas to her face.</p> <p>3. The following incidents were reported by the facility to BDDS as peer to peer "aggression resulting in physical contact" between clients A, B, C, and D.</p> <p>-On 2/13/12, the facility reported and investigated an incident of peer to peer aggression wherein client B hit client D in</p>						

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	<p>the back of the head.</p> <p>-On 2/12/12, the facility reported and investigated an incident of peer to peer aggression wherein client C bit client A on the hand, necessitating first aid and a visit to the hospital for an x-ray to rule out a fracture.</p> <p>-On 2/8/12, the facility reported and investigated an incident of peer to peer aggression wherein client B ran into client A's room pulling client A's hair and hitting her. Client B also kicked client A in the eye. Client A was assessed to have a golf-ball sized bruise to her left elbow and a small quarter-sized reddened area near her left eye.</p> <p>-On 2/4/12, the facility reported and investigated an incident of peer to peer aggression wherein client C pushed client D into a wall.</p> <p>-On 2/2/12, the facility reported and investigated an incident of peer to peer aggression wherein client B bit client C in the leg while in the van. Client C sustained redness and broken skin.</p> <p>-On 2/2/12, the facility reported and investigated an incident of peer to peer aggression wherein clients A and C were "involved in altercation where they</p>			

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	<p>pushed each other."</p> <p>-On 2/2/12, the facility reported and investigated an incident of peer to peer aggression wherein client A pushed client D and client D "retaliated" by knocking client A to the floor. Client A sustained a bruise to her foot.</p> <p>-On 1/16/12, the facility reported and investigated an incident of peer to peer aggression wherein client B struck client D. The report indicated "Plan to Resolve." "This is the third incident this month of abuse toward [client D] from a peer, how are future incidents like these being prevented? Do plans remain effective and are any new proactive measures being implemented/explored?" No information was documented.</p> <p>-On 1/10/12, the facility reported and investigated an incident of peer to peer aggression wherein client B kicked client D in the leg.</p> <p>-On 1/6/12, the facility reported and investigated an incident of peer to peer aggression wherein client B "threatened to kill" client A and client A's "mother". Client B threw her cell phone at client A hitting client A in the stomach.</p> <p>-On 12/28/11, the facility reported and</p>						

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	<p>investigated an incident of peer to peer aggression wherein client C threw a bottle at client D and later in the day struck client D in the head.</p> <p>-On 12/7/11, the facility reported and investigated an incident of peer to peer aggression wherein client C threw a cup at client A grazing client A's face.</p> <p>-On 11/27/11, the facility reported and investigated an incident of peer to peer aggression wherein client B bit client C on the arm. No documented information was available for review to determine if client C was injured.</p> <p>-On 11/4/11, the facility reported and investigated an incident of peer to peer aggression wherein client D kicked client B and spit on her.</p> <p>-On 10/27/11, the facility reported and investigated an incident of peer to peer aggression wherein client B kicked client A in the face and back.</p> <p>-On 10/24/11, the facility reported and investigated an incident of peer to peer aggression wherein client C hit client D with a remote control.</p> <p>-On 10/9/11, the facility reported and investigated an incident of peer to peer aggression wherein client C hit client D</p>			

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	<p>on the side of her head.</p> <p>-On 10/6/11, the facility reported and investigated an incident of peer to peer aggression wherein client C pushed client A to the ground.</p> <p>-On 10/5/11, the facility reported and investigated an incident of peer to peer aggression wherein client C pushed client A into the kitchen counter.</p> <p>-On 9/20/11, the facility reported and investigated an incident of peer to peer aggression wherein client C hit client A in the head and on the left arm.</p> <p>-On 9/17/11, the facility reported and investigated an incident of peer to peer aggression wherein client C bit client B. Medical treatment was provided to client B for a human bite.</p> <p>-On 9/11/11, the facility reported and investigated an incident of peer to peer aggression wherein client B pushed client D into a corner and hit client D. The facility reported client D was again struck by client B "a short time later."</p> <p>-On 9/10/11, the facility reported and investigated an incident of peer to peer aggression wherein client B struck client D in the mouth.</p> <p>-On 9/8/11, the facility reported and</p>						

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	<p>investigated an incident of peer to peer aggression wherein client B knocked client A to the ground and client B began scratching client A's back and kicking her in the hip. Swelling was noted in Client A's hip area which required a follow-up physician appointment.</p> <p>On 2/22/12 at 11:05am, an interview with the Facility Director (FD) was completed. The FD was asked why certain incidents were investigated as peer to peer abuse, while others were reported and investigated as peer to peer aggression. The FD stated "All peer to peer incidents were reported to me and the facility had systemically taken action in response to these incidents by instituting case conferences in relation to the sentinel events." The FD indicated the individual client case conferences were not started until after December, 2011. The FD indicated revisions were made to clients A, B, C, and D's Behavior Support Plan (BSPs) in response to incidents. The FD stated that he had "trend analysis reports identifying the frequency of aggression caused by each of the clients." When it was pointed out to the FD that the review</p>			

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	<p>of allegations and incidents involving peer aggression had continued and had increased in rate, the FD stated "The behavior management intervention techniques employed were able to reduce the seriousness of injuries and most incidents were of a brief duration."</p> <p>4. The following investigation results were not reported to the facility director or designee within five working days.</p> <p>-On 11/28/11, the facility reported an allegation of abuse wherein client C alleged a staff member kicked her on 11/24/11. The summary report identified the client C recanted the allegation, but the report was not signed by the Facility Director until 12/6/11, six working days after the incident was reported.</p> <p>-On 12/1/11, client D alleged a staff member threatened her by stating he would write her up if she did not do what he said, or if she told anyone he had kissed a co-worker. The summary report was signed by the Facility Director on 12/14/11 nine working days after the incident had been reported.</p> <p>-On 12/6/11, the facility reported an allegation of peer to peer abuse wherein</p>						

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	<p>client B kicked client A while she was on the floor. The summary report was signed by the Facility Director on 12/20/11 ten working days after the incident was reported.</p> <p>-On 12/15/11, the facility reported an allegation of abuse wherein client C stated a staff member pushed her down and broke her game system and that she was fearful of another staff member who "hurt her all the time." The Facility Director signed the summary report on 1/5/12 thirteen working days after the incident had been reported.</p> <p>-On 1/17/12 the facility reported and investigated an allegation of abuse wherein client C alleged a staff member bent her fingers back accidentally while playing around. Other than the QMRP (Qualified Mental Retardation Professional) signature on the summary page, there was no other evidence the results of the investigation had been reported to the Facility Director, or designee.</p> <p>In a follow-up interview with the Facility Director (FD) on 2/22/12 at 11:05 AM, the FD indicated the facility</p>				

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	<p>investigations were to be completed within five days. The FD stated he reviewed and signed "all" investigative reports.</p> <p>5. On 2/20/12 at 11am, and on 2/21/12 at 8am, the Facility's BDDS reports were reviewed for corrective action related to allegations of abuse, neglect, mistreatment and exploitation, and the facility investigated five (5) allegations of peer to peer abuse during the time parameter 9/1/11 through 2/20/12 and twenty-four incidents of peer to peer aggression.</p> <p>On 2/22/12 at 11:05am, an interview with the Facility Director (FD) was completed. The FD was asked why certain incidents were investigated as peer to peer abuse, while others were reported and investigated as peer to peer aggression. The FD stated "All peer to peer incidents were reported to him and the facility had systemically taken action in response to these incidents by instituting case conferences in relation to the sentinel events." The FD indicated the individual client case conferences were not started until after December, 2011. The FD</p>						

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	<p>indicated revisions were made to clients A, B, C, and D's Behavior Support Plan (BSPs) in response to incidents. The FD stated that he had "trend analysis reports identifying the frequency of aggression caused by each of the clients." When it was pointed out to the FD that the review of allegations and incidents involving peer aggression had continued and had increased in rate, the FD stated "The behavior management intervention techniques employed were able to reduce the seriousness of injuries and most incidents were of a brief duration."</p> <p>On 2/22/12 at 11:05am, the Behavior Specialist (BS) presented the monthly AWS Behavior Summary reports for client A as additional evidence to demonstrate how the facility was reviewing and modifying the behavior plan for client A. Client A's plan indicated the following recommendations had been made starting in September, 2011, "1. Continue to follow the current behavior support program until IDT consensus indicates otherwise. 2. [Client A] should continue to receive routine and PRN blood work to monitor her medication levels, and overall health. 3. Continue to document all incidents of inappropriate behavior in daily notes, as</p>						

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	<p>well as behavioral data tracking forms. 4. Continue to refer [Client A] for follow-up psychiatric consultation for medication review and further recommendations. "</p> <p>When the October, November, December of 2011 and January 2012 behavior summary reports were reviewed and compared, it was noted that all of the recommendations for Client A were exactly the same for five consecutive months starting with the September, 2011 report.</p> <p>The Behavior Specialist presented the monthly AWS Behavior Summary reports for clients B, C, and D as additional evidence to demonstrate how the facility was reviewing and modifying the behavior plans for clients B, C, and D. The BS indicated client B, C, and D's plans were had the same recommendations made starting in September, 2011, " 1. Continue to follow the current behavior support program until IDT consensus indicates otherwise. 2. [Client] should continue to receive routine and PRN blood work to monitor her Depakote level, and overall health. 3. Continue to document all incidents of inappropriate behavior in daily notes, as well as behavioral data tracking forms. 4. [Client] should receive continued follow-up psychiatric consultation for</p>			

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	<p>medication review, and further recommendations when indicated. "</p> <p>When the October, November, December of 2011 and January 2012 behavior summary reports were reviewed and compared, the recommendations for clients B, C, and D were exactly the same for five consecutive months starting with the September, 2011 report.</p> <p>This federal tag relates to complaint #IN00104098.</p> <p>9-3-2(a)</p>				

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review the facility failed to thoroughly investigate client B's behavioral threats of an allegation of rape and failed to thoroughly investigate client to client abuse and aggression (clients A, B, C and D).</p> <p>Findings include:</p> <p>1. On 2/20/12 at 11am, and on 2/21/12 at 8am, the facility's BDDS (Bureau of Developmental Disability Services) reports were reviewed from 9/1/2011 through 2/20/2012 and indicated the following for client B.</p> <p>-A 1/10/12 BDDS report for an incident on 1/10/12 at 8:30am, indicated client B was verbally aggressive toward staff, picked up a chair and threatened staff. The report indicated staff applied a physical restraint hold and client B said "staff were trying to rape her. But there was another staff there that stated that was not true. Therefore this is an allegation." The report did not indicate if an</p>	W0154	<p><b>W154</b></p> <p>Thorough Investigations, including client-to-client abuse</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>Both professional staff members responsible to conduct investigations received training from the agency Compliance Officer on conducting thorough investigations. This included that all threats to make an allegation of rape or any variation of rape allegation must be investigated. The training also covered use of a new investigation form that does not differentiate between client "aggression" and client "abuse" – all are now considered investigations of client abuse.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p>	03/30/2012			

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	<p>investigation was completed.</p> <p>-A 11/11/11 BDDS report for an incident on 11/10/11 at 4pm, indicated client B had "behaviors" of "crying, screaming, cursing, throwing things (sic)." The report indicated a male staff person had "used a mandt restraint to ensure safety. During the restraint [client B's] sweats came part way down. Staff pulled them up and [client B] stated she was going to say staff raped her." The report indicated after client B calmed, the agency LPN (Licensed Practical Nurse) asked client B "if she said that? [client B] said yes." The report indicated the "LPN asked [client B] if staff did rape her and [client B] said no." The report indicated client B was seen by her personal physician for neck and shoulder pain and indicated "no other injuries noted." No documentation was available for review to determine if the allegation of rape was investigated, why client B's pants had fallen down, or if the restraint staff implemented caused the discomfort.</p> <p>On 2/21/12 at 11:30am, client B's record was reviewed. Client B's record indicated</p>		<p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>Agency policy on incident reports was revised and went into effect this month. The agency IR policy includes investigations policy and procedures, which were revised. Training on these revisions occurred with the two professional staff responsible for investigations. The training included instruction to investigate all variations of rape allegations, including threats. It also included all peer aggressive incidents will be investigated as abuse and will include substantiation.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>All appropriate incidents will be investigated. This will be reported within 5 days to the Director. The IDT reviews all incidents. An Incident Oversight Committee – consisting of the Director, an agency Vice President, and an agency Compliance Officer – also reviews all incidents and ensures that all investigations are completed as needed.</p>	

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	<p>a physician's visit for "complaints of neck and shoulder pain" sustained on 11/10/11 when a "restraint" hold was applied by staff at the group home.</p> <p>On 2/22/12 at 11:05am, an interview with the Facility Director (FD) was completed. The FD stated client B's incidents on 1/10/12 and 11/10/11 were behaviors, client B "threatened" to make an allegation of rape against the male staff person who implemented the restraint, and client B "recanted" her threats of the allegations of rape. The FD indicated the facility did not investigate "threats by a client to make an allegation." The FD indicated client B's 11/10/11 incident of her pants falling down during a restraint was not investigated.</p> <p>2. The following incidents were reported to BDDS and investigated by the facility as peer to peer "abuse allegations (between clients living in the group home):" -On 1/16/12, the facility reported and investigated an allegation of peer to peer abuse wherein client B hit client D on the hand.</p>				

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	<p>-On 12/21/11, the facility reported and investigated an allegation of peer to peer abuse wherein client C hit client D on top of the head.</p> <p>-On 12/14/11, the facility reported and investigated an allegation of peer to peer abuse wherein client C hit client A in the face. Client A sustained reddening to face which required first aid in the form of an ice pack.</p> <p>-On 12/6/11, the facility reported and investigated an allegation of peer to peer abuse wherein client B kicked client A while she was on the floor. Client A sustained a golf size lump on her forehead described as red and bruising. Ice had to be applied and neuro-checks were completed multiple times each shift.</p> <p>-On 11/24/11, the facility reported and investigated an allegation of peer to peer abuse wherein client B kicked client A in the nose and the leg, causing client A's nose to bleed and an reddened areas to her face.</p> <p>The following BDDS incidents were reported by the facility as peer to peer "aggression resulting in physical contact" between clients A, B, C, and D.</p>						

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	<p>-On 2/13/12, the facility reported and investigated an incident of peer to peer aggression wherein client B hit client D in the back of the head.</p> <p>-On 2/12/12, the facility reported and investigated an incident of peer to peer aggression wherein client C bit client A on the hand, necessitating first aid and a visit to the hospital for an x-ray to rule out a fracture.</p> <p>-On 2/8/12, the facility reported and investigated an incident of peer to peer aggression wherein client B ran into client A's room pulling client A's hair and hitting her. Client B also kicked client A in the eye. Client A was assessed to have a golf-ball sized bruise to her left elbow and a small quarter-sized reddened area near her left eye.</p> <p>-On 2/4/12, the facility reported and investigated an incident of peer to peer aggression wherein client C pushed client D into a wall.</p> <p>-On 2/2/12, the facility reported and investigated an incident of peer to peer aggression wherein client B bit client C in the leg while in the van. Client C sustained redness and broken skin.</p> <p>-On 2/2/12, the facility reported and</p>						

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	<p>investigated an incident of peer to peer aggression wherein clients A and C were "involved in altercation where they pushed each other."</p> <p>-On 2/2/12, the facility reported and investigated an incident of peer to peer aggression wherein client A pushed client D and client D "retaliated" by knocking client A to the floor. Client A sustained a bruise to her foot.</p> <p>-On 1/16/12, the facility reported and investigated an incident of peer to peer aggression wherein client B struck client D. The report indicated "Plan to Resolve" "This is the third incident this month of abuse toward [client D] from a peer, how are future incidents like these being prevented? Do plans remain effective and are any new proactive measures being implemented/explored?" No information was documented.</p> <p>-On 1/10/12, the facility reported and investigated an incident of peer to peer aggression wherein client B kicked client D in the leg.</p> <p>-On 1/6/12, the facility reported and investigated an incident of peer to peer aggression wherein client B "threatened to kill" client A and client A's "mother".</p>			

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	<p>Client B threw her cell phone at client A hitting client A in the stomach.</p> <p>-On 12/28/11, the facility reported and investigated an incident of peer to peer aggression wherein client C threw a bottle at client D and later in the day struck client D in the head.</p> <p>-On 12/7/11, the facility reported and investigated an incident of peer to peer aggression wherein client C threw a cup at client A grazing client A's face.</p> <p>-On 11/27/11, the facility reported and investigated an incident of peer to peer aggression wherein client B bit client C on the arm. No documentation was available for review to determine if client C was injured.</p> <p>-On 11/4/11, the facility reported and investigated an incident of peer to peer aggression wherein client D kicked client B and spit on her.</p> <p>-On 10/27/11, the facility reported and investigated an incident of peer to peer aggression wherein client B kicked client A in the face and back.</p> <p>-On 10/24/11, the facility reported and investigated an incident of peer to peer aggression wherein client C hit client D with a remote control.</p>			

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	<p>-On 10/9/11, the facility reported and investigated an incident of peer to peer aggression wherein client C hit client D on the side of her head.</p> <p>-On 10/6/11, the facility reported and investigated an incident of peer to peer aggression wherein client C pushed client A to the ground.</p> <p>-On 10/5/11, the facility reported and investigated an incident of peer to peer aggression wherein client C pushed client A into the kitchen counter.</p> <p>-On 9/20/11, the facility reported and investigated an incident of peer to peer aggression wherein client C hit client A in the head and on the left arm.</p> <p>-On 9/17/11, the facility reported and investigated an incident of peer to peer aggression wherein client C bit client B. Medical treatment was provided to client B for a human bite.</p> <p>-On 9/11/11, the facility reported and investigated an incident of peer to peer aggression wherein client B pushed client D into a corner and hit client D. The facility reported client D was again struck by client B "a short time later."</p> <p>-On 9/10/11, the facility reported and investigated an incident of peer to peer</p>						

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	<p>aggression wherein client B struck client D in the mouth.</p> <p>-On 9/8/11, the facility reported and investigated an incident of peer to peer aggression wherein client B knocked client A to the ground and client B began scratching client A's back and kicking her in the hip. Swelling was noted in Client A's hip area which required a follow-up physician appointment.</p> <p>On 2/22/12 at 11:05am, an interview with the Facility Director (FD) was completed. The FD was asked why certain incidents were investigated as peer to peer abuse, while others were reported and investigated as peer to peer aggression. The FD stated "All peer to peer incidents were reported to me and the facility had systemically taken action in response to these incidents by instituting case conferences in relation to the sentinel events." The FD indicated the individual client case conferences were not started until after December, 2011. The FD indicated revisions were made to clients A, B, C, and D's Behavior Support Plan (BSPs) in response to incidents. The FD stated clients A, B, C, and D's case</p>			

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	<p>conferences review of incidents "recently" began in 2/2012. The FD stated that he had "trend analysis reports identifying the frequency of aggression caused by each of the clients." When it was pointed out to the FD that the review of allegations and incidents involving peer aggression had continued and had increased in rate, the FD stated "The behavior management intervention techniques employed were able to reduce the seriousness of injuries and most incidents were of a brief duration." The FD indicated the incidents were investigated and did not respond when asked if the investigations were thorough.</p> <p>This federal tag relates to complaint #IN00104098.</p> <p>9-3-2(a)</p>						

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W0156	<p>483.420(d)(4) <b>STAFF TREATMENT OF CLIENTS</b> The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on interview and record review, the facility failed to ensure the results of investigations for abuse, neglect, and mistreatment were reported to the facility administrator or the facility designee in accordance with state law within five working days for 4 of 4 clients (clients A, B, C, and D) who lived in the group home.</p> <p>Findings include:</p> <p>On 2/20/12 at 11:00 AM, the facility allegations of abuse, neglect and mistreatment were reviewed from the time parameter 9/7/11 through 2/20/12 were reviewed. The following were BDDS (Bureau of Developmental Disability Services) reports and indicated a lack of reproducible evidence to demonstrate the results of the facility's investigations were reported in accordance to state law and to the facility's administrator or administrator's designee within five working days.</p> <p>-On 11/28/11, the facility reported and investigated an allegation of abuse wherein Client #3 alleged a staff member kicked her on 11/24/11. The summary report identified the client recanted the allegation, but the report was not signed by the Facility Director until 12/6/11, six working days after the incident was reported.</p>	W0156	<p><b>W156</b></p> <p>Investigations signed by administrator within 5 days</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>Both professional staff members responsible to conduct investigations received training from the agency Compliance Officer on conducting thorough investigations. This included the timeline that all investigations must be signed by the Director within 5 days.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes</b></p>	03/30/2012			

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	<p>-On 12/1/11, Client #4 alleged a staff member threatened her by stating he would write her up if she did not do what he said, or if she told anyone he had kissed a co-worker. The summary report was signed by the Facility Director on 12/14/11 nine working days after the incident had been reported.</p> <p>-On 12/6/11, the facility reported and investigated an allegation of peer to peer abuse wherein Client #2 kicked Client #1 while she was on the floor. The summary report was signed by the Facility Director on 12/20/11 ten working days after the incident was reported.</p> <p>-On 12/15/11, the facility reported and investigated an allegation of abuse wherein Client #3 stated a staff member pushed her down and broke her game system and that she was fearful of another staff member who "hurt her all the time." The Facility Director signed the summary report on 1/5/12 thirteen working days after the incident had been reported.</p> <p>-On 1/17/12 the facility reported and investigated an allegation of abuse wherein Client #3 alleged a staff member bent her fingers back accidentally while playing around. Other than the QMRP signature on the summary page, and no documentation was available for review that the results of the investigation had been reported to the Facility Director, or designee.</p> <p>On 2/20/12 at 12:10pm, an interview with the facility's Behavior Specialist (BS) was completed. The BS stated he had participated in several incident reviews and to the best of his knowledge the Director "always" signed the reports.</p>		<p><b>facility put in place to ensure no recurrence</b></p> <p>Training conducted that included all investigations must be signed by the Director within 5 days.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>All appropriate incidents will be investigated. This will be reported within 5 days to the Director. The IDT reviews all incidents. An Incident Oversight Committee – consisting of the Director, an agency Vice President, and an agency Compliance Officer – also reviews all incidents and ensures that all investigations are completed in the correct timeframe. Corrective action is implemented as needed.</p>				

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	<p>On 2/22/12 at 11:05am, an interview with the Facility Director was completed. The FD indicated the facility investigations were to be completed within five days. The FD indicated he reviewed and signed all investigative reports.</p> <p>This federal tag relates to complaint #IN00104098.</p> <p>9-3-2(a)</p>			

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on interview and record review, for 31 of 156 BDDS (Bureau of Developmental Disability Services) Reports reviewed from 9/1/11 through 2/20/12, the facility failed to take effective corrective action for client B's threats to make allegations of rape and to reduce the potential for twenty-four (24) continued incidents of peer to peer aggression and five (5) reports of peer to peer abuse for clients A, B, C, and D.</p> <p>Findings include:</p> <p>1. On 2/20/12 at 11am, and on 2/21/12 at 8am, the Facility's BDDS reports were reviewed and indicated the following for client B.</p> <p>-A 1/10/12 BDDS report for an incident on 1/10/12 at 8:30am, indicated client B was verbally aggressive toward staff, picked up a chair and threatened staff. The report indicated staff applied a physical restraint hold and client B said "staff were trying to rape her. But there</p>	W0157	<p><b>W157</b></p> <p>Appropriate Corrective Action taken</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>Both professional staff members responsible to conduct investigations received training from the agency Compliance Officer on conducting thorough investigations. This included that all threats to make an allegation of rape or any variation of rape allegation must be investigated and that appropriate corrective action is needed to prevent recurrence of the issue under investigation.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p>	03/30/2012			

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	<p>was another staff there that stated that was not true. Therefore this is an allegation." The report did not indicate if an corrective action was completed.</p> <p>-A 11/11/11 BDDS report for an incident on 11/10/11 at 4pm, indicated client B had behaviors of "crying, screaming, cursing, throwing things (sic)." The report indicated a male staff person had "used a mandt (a physical hold staff apply to a client) restraint to ensure safety. During the restraint [client B's] sweats came part way down. Staff pulled them up and [client B] stated she was going to say staff raped her." The report indicated after client B calmed, the agency LPN (Licensed Practical Nurse) asked client B "if she said that? [Client B] said yes." The report indicated the "LPN asked [client B] if staff did rape her and [client B] said no." The report indicated client B was seen by her physician for neck and shoulder pain and indicated "no other injuries noted." No corrective action was available for review.</p> <p>On 2/21/12 at 11:30am, client B's record was reviewed. Client B's record indicated a physician's visit for "complaints of neck</p>		<p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>Training conducted on thorough investigations.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>All threats to allege rape or any variation of rape allegation will be investigated. This will be reported within 5 days to the Director. The IDT reviews all incidents. An Incident Oversight Committee – consisting of the Director, an agency Vice President, and an agency Compliance Officer – also reviews all incidents and ensures that all investigations are completed as needed.</p>		

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	<p>and shoulder pain" sustained in on 11/10/11 when a "restraint" hold applied by staff at the group home and no corrective action was available for review.</p> <p>On 2/22/12 at 11:05am, an interview with the Facility Director (FD) was completed. The FD stated client B's incidents on 1/10/12 and 11/10/11 were behaviors, client B "threatened" to make an allegation of rape against the male staff person who implemented the restraint, and client B "recanted" her threats of the allegations of rape. The FD indicated the facility did not investigate and no corrective action was taken for "threats by a client to make an allegation." The FD indicated client B's 11/10/11 incident of her pants falling down during a restraint were not investigated and no corrective action was available for review.</p> <p>2. The following incidents were reported to BDDS and investigated by the facility as peer to peer "abuse allegations" and no corrective action was available for review. -On 1/16/12, the facility reported and investigated an allegation of peer to peer abuse wherein client B hit client D on the</p>						

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	<p>hand. No corrective action was available for review.</p> <p>-On 12/21/11, the facility reported and investigated an allegation of peer to peer abuse wherein client C hit client D on top of the head. No corrective action was available for review.</p> <p>-On 12/14/11, the facility reported and investigated an allegation of peer to peer abuse wherein client C hit client A in the face. Client A sustained reddening to face which required first aid in the form of an ice pack. No corrective action was available for review.</p> <p>-On 12/6/11, the facility reported and investigated an allegation of peer to peer abuse wherein client B kicked client A while she was on the floor. Client A sustained a golf size lump on her forehead described as red and bruising. Ice had to be applied and neuro-checks were completed multiple times each shift. No corrective action was available for review.</p> <p>-On 11/24/11, the facility reported and investigated an allegation of peer to peer abuse wherein client B kicked client A in the nose and the leg, causing client A's nose to bleed and an reddened areas to her face. No corrective action was available</p>			

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	<p>for review.</p> <p>The following BDDS incidents were reported by the facility as peer to peer "aggression resulting in physical contact" between clients A, B, C, and D and no corrective action was available for review.</p> <p>-On 2/13/12, the facility reported and investigated an incident of peer to peer aggression wherein client B hit client D in the back of the head. No corrective action was available for review.</p> <p>-On 2/12/12, the facility reported and investigated an incident of peer to peer aggression wherein client C bit client A on the hand, necessitating first aid and a visit to the hospital for an x-ray to rule out a fracture. No corrective action was available for review.</p> <p>-On 2/8/12, the facility reported and investigated an incident of peer to peer aggression wherein client B ran into client A's room pulling client A's hair and hitting her. Client B also kicked client A in the eye. Client A was assessed to have a golf-ball sized bruise to her left elbow and a small quarter-sized reddened area near her left eye. No corrective action was available for review.</p>			
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	<p>-On 2/4/12, the facility reported and investigated an incident of peer to peer aggression wherein client C pushed client D into a wall. No corrective action was available for review.</p> <p>-On 2/2/12, the facility reported and investigated an incident of peer to peer aggression wherein client B bit client C in the leg while in the van. Client C sustained redness and broken skin. No corrective action was available for review.</p> <p>-On 2/2/12, the facility reported and investigated an incident of peer to peer aggression wherein clients A and C were "involved in altercation where they pushed each other." No corrective action was available for review.</p> <p>-On 2/2/12, the facility reported and investigated an incident of peer to peer aggression wherein client A pushed client D and client D "retaliated" by knocking client A to the floor. Client A sustained a bruise to her foot. No corrective action was available for review.</p> <p>-On 1/16/12, the facility reported and investigated an incident of peer to peer aggression wherein client B struck client D. The report indicated "Plan to Resolve" a note indicated "this is the third incident</p>			

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	<p>this month of abuse toward [client D] from a peer, how are future incidents like these being prevented? Do plans remain effective and are any new proactive measures being implemented/explored?"</p> <p>No information was documented. No corrective action was available for review.</p> <p>-On 1/10/12, the facility reported and investigated an incident of peer to peer aggression wherein client B kicked client D in the leg. No corrective action was available for review.</p> <p>-On 1/6/12, the facility reported and investigated an incident of peer to peer aggression wherein client B "threatened to kill" client A and client A's "mother". Client B threw her cell phone at client A hitting client A in the stomach. No corrective action was available for review.</p> <p>-On 12/28/11, the facility reported and investigated an incident of peer to peer aggression wherein client C threw a bottle at client D and later in the day struck client D in the head. No corrective action was available for review.</p> <p>-On 12/7/11, the facility reported and investigated an incident of peer to peer aggression wherein client C threw a cup at client A grazing client A's face. No</p>						

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	<p>corrective action was available for review.</p> <p>-On 11/27/11, the facility reported and investigated an incident of peer to peer aggression wherein client B bit client C on the arm. No corrective action was available for review.</p> <p>-On 11/4/11, the facility reported and investigated an incident of peer to peer aggression wherein client D kicked client B and spit on her. No corrective action was available for review.</p> <p>-On 10/27/11, the facility reported and investigated an incident of peer to peer aggression wherein client B kicked client A in the face and back. No corrective action was available for review.</p> <p>-On 10/24/11, the facility reported and investigated an incident of peer to peer aggression wherein client C hit client D with a remote control. No corrective action was available for review.</p> <p>-On 10/9/11, the facility reported and investigated an incident of peer to peer aggression wherein client C hit client D on the side of her head. No corrective action was available for review.</p> <p>-On 10/6/11, the facility reported and investigated an incident of peer to peer aggression wherein client C pushed client</p>						

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	<p>A to the ground. No corrective action was available for review.</p> <p>-On 10/5/11, the facility reported and investigated an incident of peer to peer aggression wherein client C pushed client A into the kitchen counter. No corrective action was available for review.</p> <p>-On 9/20/11, the facility reported and investigated an incident of peer to peer aggression wherein client C hit client A in the head and on the left arm. No corrective action was available for review.</p> <p>-On 9/17/11, the facility reported and investigated an incident of peer to peer aggression wherein client C bit client B. Medical treatment was provided to client B for a human bite. No corrective action was available for review.</p> <p>-On 9/11/11, the facility reported and investigated an incident of peer to peer aggression wherein client B pushed client D into a corner and hit client D. The facility reported client D was again struck by client B "a short time later." No corrective action was available for review.</p> <p>-On 9/10/11, the facility reported and investigated an incident of peer to peer aggression wherein client B struck client D in the mouth. No corrective action</p>						

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	<p>was available for review.</p> <p>-On 9/8/11, the facility reported and investigated an incident of peer to peer aggression wherein client B knocked client A to the ground and client B began scratching client A's back and kicking her in the hip. Swelling was noted in Client A's hip area which required a follow-up physician appointment. No corrective action was available for review.</p> <p>On 2/22/12 at 11:05am, an interview with the Facility Director (FD) was completed. The FD was asked why certain incidents were investigated as peer to peer abuse, while others were reported and investigated as peer to peer aggression. The FD stated "All peer to peer incidents were reported to me and the facility had systemically taken action in response to these incidents by instituting case conferences in relation to the sentinel events." The FD indicated the individual client case conferences were not started until after December, 2011. The FD indicated no corrective action was available for review. The FD indicated revisions were made to clients A, B, C, and D's Behavior Support Plan (BSPs) in</p>				

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	<p>response to incidents. The FD stated that he had "trend analysis reports identifying the frequency of aggression caused by each of the clients." When it was pointed out to the FD that the review of allegations and incidents involving peer aggression had continued and had increased in rate, the FD stated "The behavior management intervention techniques employed were able to reduce the seriousness of injuries and most incidents were of a brief duration." No corrective action was available for review.</p> <p>On 2/22/12 at 11:05am, the Behavior Specialist (BS) presented the monthly Behavior Summary reports for client A as additional evidence to demonstrate how the facility was reviewing and modifying the behavior plan for client A. It was revealed for client A the following recommendations had been made starting in September, 2011, "1. Continue to follow the current behavior support program until IDT consensus indicates otherwise. 2. [Client A] should continue to receive routine and PRN blood work to monitor her medication levels, and overall health. 3. Continue to document all incidents of inappropriate behavior in daily notes, as well as behavioral data tracking forms. 4. Continue to refer</p>			

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	<p>[Client A] for follow-up psychiatric consultation for medication review and further recommendations. "</p> <p>When the October, November, December of 2011 and January 2012 behavior summary reports were reviewed and compared, it was noted that all of the recommendations for Client A were exactly the same for five consecutive months starting with the September, 2011 report.</p> <p>The Behavior Specialist presented the monthly Behavior Summary reports for clients B, C, and D indicated how the facility was reviewing and modifying the behavior plans for clients B, C, and D. The BS and client B, C, and D's records indicated the same recommendations had been made starting in September, 2011, "</p> <p>1. Continue to follow the current behavior support program until IDT consensus indicates otherwise. 2. [Client] should continue to receive routine and PRN blood work to monitor her Depakote level, and overall health. 3. Continue to document all incidents of inappropriate behavior in daily notes, as well as behavioral data tracking forms. 4. [Client] should receive continued follow-up psychiatric consultation for medication review, and further recommendations when indicated. "</p>						

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	<p>When the October, November, December of 2011 and January 2012 behavior summary reports were reviewed and compared, the recommendations for clients B, C, and D were exactly the same for five consecutive months starting with the September, 2011 report.</p> <p>This federal tag relates to complaint #IN00104098.</p> <p>9-3-2(a)</p>				

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W0159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on observation, interview and record review the facility's Qualified Mental Retardation Professional (QMRP) failed to provide oversight to integrate, coordinate, and monitor the development of the following: clients A, B, C, and D's individual program plans within 30 days of client admissions, assessments, and comprehensive functional assessments were completed; The QMRP failed to ensure that implementation of restrictive practices were implementation after clients, their representatives, and the facility's HRC (Human Rights Committee) had given consent; The QMRP failed to develop a priority of each each clients' training need; and failed to ensure training objectives were implemented for 2 of 2 sample clients (clients A and B) and for two additional clients (clients C and D).</p> <p>Findings include:</p> <p>Please refer to W196. The facility failed to ensure that each client received a continuous active treatment program which included aggressive, consistent implementation of a program of specialized training and related services. Major elements of the active treatment process not present included assessment, restrictive practices, the development of priority needs, development of</p>	W0159	<p><b>W159</b></p> <p>QMRP failed to integrate and coordinate active treatment program for new admissions.</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>The group home's original QMRP implemented basic ISPs prior to client admission, but did not coordinate ongoing active treatment sufficiently with the individuals' IDTs. Due to performance issues such as these, that QMRP no longer works for the agency. A highly experienced QMRP now works in the home, coordinates ongoing IDT activity across individuals, and has revised all ISP goals in coordination with the IDTs.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address</p>	03/30/2012			

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	<p>formal training objectives, personal skill training, program implementation, development of the ISP (Individual Support Plan) document and program monitoring for 2 of 2 sample clients (clients A and B) and 2 additional clients (clients C and D).</p> <p>Please refer to W206. The facility failed to have an ISP (Individual Support Plan) completed by the interdisciplinary team for 2 of 2 sample clients (clients A and B) and one additional client (client D).</p> <p>Please refer to W210. The facility failed to perform a comprehensive functional assessment (CFA) which included audio and vision assessments within 30 days of their admission for 2 of 2 sample clients (clients A and B) who were new admissions to the facility.</p> <p>Please refer to W225. The facility failed to perform a comprehensive functional assessment (CFA) which included client A and B's vocational assessments for 2 of 2 sample clients (clients A and B).</p> <p>Please refer to W226. The facility failed to develop an ISP (Individual Support Plan) within 30 days of admission to the facility for 2 of 2 sample clients (clients A and B) and for one additional client (client D).</p> <p>Please refer to W249. The facility failed to ensure a choking management plan was implemented (client A), to use formal and informal opportunities to teach and implement ISP</p>		<p>the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>A new QMRP was hired who has significant experience implementing ISPs and coordinating IDT activity. New ISPs have been implemented across clients based on IDT consensus. The QMRP will ensure that all new admissions include appropriate assessments and that IDT activity and ISP goals are developed within the required 30-day timeframe. Program plan implementation will include documentation of the need and approval for any restrictions, including guardian consent and IDT as well as HRC approval.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>The QMRP coordinates the activity of the IDT, which is responsible for development of ISPs. For all new admissions, the QMRP is responsible to ensure that the 30-day requirement is met for all appropriate assessments and for the development of the ISP. Other</p>		

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	<p>(Individual Support Plan) objectives and skill acquisition when opportunities existed for coping skills and medication administration for 2 of 2 sample clients (clients A and B) and for two additional clients (C and D).</p> <p>Please refer to W263. The facility's specially constituted committee (HRC) failed to ensure the BSPs were consented to by client B and her legally sanctioned representatives for 1 of 2 sample clients (client B) with restrictive practices in her Behavior Support Plan (BSP).</p> <p>Please refer to W264. The facility's HRC (Human Rights Committee) failed to approve facility practices for blanket restrictions of money, knives, forks, cleaning supplies, food, clothing, or nail polish for 2 of 2 sample clients (clients A and B) and for two additional clients (clients C and D).</p> <p>On 2/29/12 at 2pm, an interview with the Facility Director (FD) was completed. The FD indicated goals/objectives should be implemented daily during formal and informal opportunities. The FD indicated the QMRP should have completed the monthly summaries from 5/2011 through 2/2012. The FD indicated he was aware the QMRP did not complete reviews of clients A, B, C, and D's active treatment objectives from 5/2011 through 9/2011. The FD indicated the QMRP should have completed CFAs and ISPs for clients A, B, and D within 30 days after admission. The FD stated the facility owned day service site was a "place for clients to go" during the day and clients were to work on goals/objectives and community integration. The FD stated clients A, B, C, and D had the skills to work and no documented evidence was available for review that clients A,</p>		<p>management staff, including the Nurse, the Behavior Clinician, and the Group Home Manager, take part in the process and will assist with appropriate appointments, assessments, and staff training as needed. The Director supervises the management staff and will monitor implementation of all plans during regularly scheduled meetings or more often, as necessary. A checklist will be used by the Director to monitor the status and appropriate scheduling of all required assessments for all new admissions.</p>	

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	<p>B, C, or D had been referred for assessment for a community job or for shelter work. The FD stated he was "aware the files are a mess and missing" assessments, ISPs, and consents. The FD stated "It's getting better, we'll fix it."</p> <p>This federal tag relates to complaint #IN00104098.</p> <p>9-3-3(a)</p>				

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W0195	<p><b>483.440</b> <b>ACTIVE TREATMENT SERVICES</b> The facility must ensure that specific active treatment services requirements are met.</p> <p>Based on observation, record review, and interview, for 4 of 4 clients (clients A, B, C, and D), the facility failed to meet the Condition of Participation: Active Treatment Services by failing to ensure that each client received a continuous active treatment program which included aggressive, consistent implementation of a program of specialized training and related services. Major elements of the active treatment process not present included assessment, restrictive practices, the development of priority needs, development of formal training objectives, personal skill training, program implementation, development of the ISP (Individual Support Plan) document and program monitoring.</p> <p>Findings include:</p> <p>Please refer to W196. The facility failed to ensure that each client received a continuous active treatment program which included aggressive, consistent implementation of a program of specialized training and related services. Major elements of the active treatment process not present included assessment, restrictive practices, the development of priority needs, development of formal training objectives, personal skill training, program implementation, development of the ISP (Individual Support Plan) document and program monitoring for 2 of 2 sample clients (clients A and B) and 2 additional clients (clients C and D).</p>	W0195	<p><b>W195</b>  Condition of Active Treatment</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>The group home's original QMRP implemented basic ISPs prior to client admission that were based on pre-admission IDT meetings that went undocumented. The QMRP did not sufficiently coordinate with the individuals' IDTs to update and implement plans based on assessment within 30 days. Due to performance issues such as these, that QMRP no longer works for the agency. A highly experienced QMRP now works in the home, coordinates and documents ongoing IDT activity across individuals, and has revised all ISP goals in coordination with the IDTs. As detailed throughout the agency's Plan of Correction (W196, W206, W210, W225, W226, W249, W263, W264), new assessments have been conducted, restrictive practices have been eliminated except where needed, and staff members have been trained on</p>	03/30/2012			

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	<p>Please see W159. The facility's Qualified Mental Retardation Professional (QMRP) failed to provide oversight to integrate, coordinate, and monitor the development of the following: clients A, B, C, and D's individual program plans within 30 days of client admissions, assessments, and comprehensive functional assessments were completed; The QMRP failed to ensure that implementation of restrictive practices were implemented after clients, their representatives, and the facility's HRC (Human Rights Committee) had given consent; The QMRP failed to develop a priority of each each clients' training need; and failed to ensure training objectives were implemented for 2 of 2 sample clients (clients A and B) and for two additional clients (clients C and D).</p> <p>Please refer to W206. The facility failed to have an ISP (Individual Support Plan) completed by the interdisciplinary team for 2 of 2 sample clients (clients A and B) and one additional client (client D).</p> <p>Please refer to W210. The facility failed to perform a comprehensive functional assessment (CFA) which included audio and vision assessments within 30 days of their admission for 2 of 2 sample clients (clients A and B) who were new admissions to the facility.</p> <p>Please refer to W225. The facility failed to perform a comprehensive functional assessment (CFA) which included client A and B's vocational</p>		<p>proper implementation of treatment.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>A new QMRP was hired who has significant experience implementing ISPs and coordinating IDT activity. New ISPs have been implemented across clients based on IDT consensus. The QMRP will ensure that all new admissions include appropriate assessments and that IDT activity and ISP goals are developed within the required 30-day timeframe. Program plan implementation will include documentation of the need and approval for any restrictions, including guardian consent and IDT as well as HRC approval.</p> <p><b>How corrective actions will be monitored to ensure no</b></p>		

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	<p>assessments for 2 of 2 sample clients (clients A and B).</p> <p>Please refer to W226. The facility failed to develop an ISP (Individual Support Plan) within 30 days of admission to the facility for 2 of 2 sample clients (clients A and B) and for one additional client (client D).</p> <p>Please refer to W249. The facility failed to ensure a choking management plan was implemented (client A), to use formal and informal opportunities to teach and implement ISP (Individual Support Plan) objectives and skill acquisition when opportunities existed for coping skills and medication administration for 2 of 2 sample clients (clients A and B) and for two additional clients (C and D).</p> <p>Please refer to W263. The facility's specially constituted committee (HRC) failed to ensure the BSP was consented to by client B and her legally sanctioned representatives for 1 of 2 sample clients (client B) with restrictive practices in her Behavior Support Plan (BSP).</p> <p>Please refer to W264. The facility's HRC (Human Rights Committee) failed to ensure approval for blanket restrictions for money, knives, forks, cleaning supplies, food, clothing, or nail polish for 2 of 2 sample clients (clients A and B) and for two additional clients (clients C and D).</p> <p>This federal tag relates to complaint #IN00104098.</p>		<p><b>recurrence</b></p> <p>The QMRP coordinates the activity of the IDT, which is responsible for development of ISPs. For all new admissions, the QMPR is responsible to ensure that the 30-day requirement is met for all appropriate assessments and for the development of the ISP. Other management staff, including the Nurse, the Behavior Clinician, and the Group Home Manager, take part in the process and will assist with appropriate appointments, assessments, and staff training as needed. The Director supervises the management staff and will monitor implementation of all plans during regularly scheduled meetings or more often, as necessary. A checklist will be used by the Director to monitor the status and appropriate scheduling of all required assessments for all new admissions.</p>				

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W0196	<p>483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward:</p> <p>(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and</p> <p>(ii) The prevention or deceleration of regression or loss of current optimal functional status.</p> <p>Based on observation, record review, and interview, for 2 of 2 sample clients (clients A and B) and 2 additional clients (clients C and D), the facility failed to ensure each client received a continuous active treatment program which included aggressive, consistent implementation of a program of specialized training and related services. Major elements of the active treatment process not present included assessment, restrictive practices, the development of priority needs, development of formal training objectives, personal skill training, program implementation, development of the ISP (Individual Support Plan) document and program monitoring.</p> <p>Findings include:</p> <p>1. For client A: On 2/20/12 from 6am until 8:37am, observation and interview were completed at the group home. At 6:12am, GHT (Group Home Trainer) #6 went</p>	W0196	<p><b>W196</b> Active Treatment</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>The group home's original QMRP implemented basic ISPs prior to client admission, but did not coordinate ongoing active treatment sufficiently with the individuals' IDTs. Due to performance issues such as these, that QMRP no longer works for the agency. A highly experienced QMRP now works in the home, coordinates ongoing IDT activity across individuals, and has revised all ISP goals in coordination with the IDTs. As detailed throughout the agency's</p>	03/30/2012			

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	<p>to the medication area inside the laundry room to complete medication administration. At 6:12am, GHT #6 retrieved her keys from her pocket, unlocked a lower cabinet, and removed wet wipes to wipe off the medication cart. Inside the locked lower cabinet were the laundry detergent, hand soap, Pine-Sol cleaner, toilet bowl cleaner, and bleach. GHT #6 stated the cabinet was "kept locked" and "only" staff had access to the keys. At 6:12am, GHT #6 showed a locked upper cabinet that held nail polish belonging to clients A, B, C, and D. At 6:12am, GHT #6 stated the items were kept "locked" because of client behaviors.</p> <p>On 2/20/12 from 6am until 8:37am, observation and interviews were completed at the group home. At 7:10 AM, client A entered the kitchen to make breakfast. Client A bent over, her pants fell down, and client A's bottom was exposed. From 6am until 8:37am, Group Home Trainer (GHT) #2 and GHT #6 assisted client A with breakfast and client A was not prompted to adjust her pants. At 7:15am, client A was observed to expose her bottom three (3) additional times. At 7:15am, client A raised her arms to retrieve items from a kitchen cabinet and her bottom was exposed again. GHT #2 and GHT #6 did not redirect client A for her personal privacy.</p> <p>On 2/20/12 at 6:30 AM facility Group Home Trainer (GHT) #6 retrieved a knife from inside a locked kitchen cabinet and indicated knives were kept inside secured. GHT #6 indicated and showed the locked cabinet held knives, butter knives, and forks and indicated the cabinet was</p>		<p>Plan of Correction, new assessments have been conducted, restrictive practices have been eliminated except where needed, and staff have been trained on proper implementation of treatment.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>A new QMRP was hired who has significant experience implementing ISPs and coordinating IDT activity. New ISPs have been implemented across clients based on IDT consensus. The QMRP will ensure that all new admissions include appropriate assessments and that IDT activity and ISP goals are developed within the required 30-day timeframe. Program plan implementation will include documentation of the need and approval for any restrictions, including guardian consent and IDT as well as HRC approval.</p>				

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	<p>kept locked. Inside the cabinet at that time showed there was a money lock box and a three holed paper punch kept with the sharp objects inside the locked cabinet. GHT #6 stated client A's bedroom closets were "also kept locked because of the client histories of harming themselves with their clothing."</p> <p>On 2/20/12 at 6:30am, two of two closets inside the facility living room were locked and GHT #6 indicated client A did not have access to the locked cabinet in the kitchen or the two living room closets. GHT #6 indicated the emergency food supply was in one locked living room closet and she was unsure of what was in the other closet.</p> <p>On 2/20/12 at 7AM, client A was observed preparing breakfast. Client A made oatmeal and toast. Client A independently prepared her oatmeal by pouring the oat contents from a container into a bowl, placing water in a bowl and then placing the bowl in a microwave. Client A also placed two pieces of bread in a toaster and when completed, client A used a tablespoon to spread butter on the toast. Client A ate the oatmeal with the same tablespoon she used to spread butter on her toast and client A consumed the whole pieces of toast by biting off small pieces with her teeth. No youth spoon was observed used or encouraged.</p> <p>On 2/20/12 at 7:25 AM, client A was observed making toast for breakfast. Client A used a spoon to spread butter on her toast and no knife was offered or encouraged. From 7:25am until 8am,</p>		<p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>The QMRP coordinates the activity of the IDT, which is responsible for development of ISPs. For all new admissions, the QMPR is responsible to ensure that the 30-day requirement is met for all appropriate assessments and for the development of the ISP. Other management staff, including the Nurse, the Behavior Clinician, and the Group Home Manager, take part in the process and will assist with appropriate appointments, assessments, and staff training as needed. The Director supervises the management staff and will monitor implementation of all plans during regularly scheduled meetings or more often, as necessary. A checklist will be used by the Director to monitor the status and appropriate scheduling of all required assessments for all new admissions.</p>		

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	<p>client A was observed to make toast and spread the butter with a spoon. No knife was offered or the use of a knife taught for client A by the facility staff.</p> <p>On 2/20/12 at 7:45am, client A's bedroom closet in her room was noted to be locked. At 8am, GHT #2 opened client A's bedroom closet with a key she carried on a ring. In the locked closet were client A's clothing, stuffed animals, a fire truck, a belt, and a dresser. GHT #2 stated client A's closet was kept locked and "only" staff had keys because she could hurt herself with her clothing. Client A was not offered her belt for her pants to prevent her pants falling down and her bottom exposed.</p> <p>In an interview with the Team Leader (TL) on 2/20/12 at 8:00 AM, the TL indicated client A had a belt. The TL stated the belt "was locked in [client A's] closet." At 8:10am, client A and GHT #2 were inside client A's bedroom. GHT #2 retrieved her keys from her pocket, unlocked client A's closet, and stated "Yes, there is a belt." GHT #2 pointed to a black belt inside client A's closet and relocked the closet door. Client A was not prompted or offered the opportunity to wear her belt.</p> <p>On 2/20/12 at 8:28 AM, clients A's approached a Group Home Trainer (GHT) #1 and wanted to know how much money she had. The GHT client A to "wait until we get the key." On 2/20/12 at 8:37 AM, client A stated to another GHT #1, "I want my money." GHT #1 responded, "As soon</p>			

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	<p>as meds pass is done, so I can get the key."</p> <p>On 2/20/12 at 4:55 PM, two second shift GHTs #7 and #8 were asked to identify what was kept inside the two locked living room closets. GHT #7 stated "it was extra food." GHT #7 was asked to open the doors. GHT #7 and GHT #8 tried to open the doors with a key, but was unsuccessful. GHT #7 attempted to open the doors but was not able to. GHT #2 suggested another key be tried, but even with another key that attempt to open the door was also unsuccessful.</p> <p>On 2/20/12 from 10:30am until 1:30pm, client A arrived at the facility owned day program. During observations client A sat at a table and client A was asked to participate in a money concepts activity using cardboard money. Client A ate lunch at the day program and departed from the facility at 1:30 PM, three hours from entering the facility and no other activity was observed.</p> <p>On 2/20/12 at 10:54 AM, at the facility owned day service site client A was observed with two other female clients and two male clients in the large room. Client A's bottom fold was exposed when she sat in a chair. No staff intervention was provided to get Client A to adjust her clothing and client A's pants were still not fastened with a belt.</p> <p>On 2/20/12 at 4:55 PM, two second shift GHTs #7 and #8) were asked to identify what was kept behind the locked doors in the family room. GHT #7 stated it was extra food. To ascertain the contents, the GHTs were asked to open the doors.</p>						

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	<p>GHT #8 tried to open the doors with a key, but was unsuccessful. GHT #7 also attempted to open the doors but was not able to do so. A third GHT #2 suggested another key be tried, but even with another key that attempt to open the door was also unsuccessful. GHT #2, #7, and #8 indicated facility food was kept in one locked living room closet and they were unsure of the contents of the second locked closet.</p> <p>On 2/20/12 at 5:00 PM, the HM (House Manager) was interviewed and indicated a lock box for money was used primarily for safeguarding petty cash, but did acknowledge receipts from client transactions were also secured in the lock box for accounting purposes. The HM also stated "keeping client money secure" was important as there had been incidents in the past where clients had stolen each other's money.</p> <p>On 2/21/12 at 10:30am, client A's record was reviewed. Client A's record indicated she was discharged from a state hospital to the AWS facility on 5/9/11 and indicated the following: -Client A's record indicated a 4/1/11 Individual Support Plan completed 38 days prior to client A's admission on 5/9/11. Three money management objectives were suggested: "[client A] will identify coins at day services weekly; [client A] will purchase an item with petty cash independently once per week; [client A] will turn in receipts to staff in order to prepare a budget once per week. The plan was absent of information related to client A's capabilities to hold and handle her own money or whether there was a need to restrict</p>						

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	<p>access. A risk assessment plan also dated 4/1/11 and completed prior to client A's admission did not address client A's capabilities or limitations with respect to money management.</p> <p>-Client A's 5/25/11 "Group Home Individual Support Plan Assessment" indicated "Section 2 - Money Usage and Management" the following for client A were rated as independent: "Knows purpose of money; Carries own money; Exchanges money for a purchase; Knows value of money." Client A was rated as needing verbal prompts for "Makes purchases based on need/resources" and was rated as needing help on "Budgets money for week."</p> <p>-Client A's record had no documentation that client A or her legally sanctioned representatives had been informed of restrictions regarding limited access to: a butter knife; fork; her money; household supplies for cleaning; finger nail polish since client A's admission on 5/9/11.</p> <p>-Client A's 6/8/11 "Choking Management Plan" indicated instructions for staff encouraging them to use a "youth sized spoon, to cut food into small bite sized pieces," and staff to encourage client A to "take smaller bites." None of those three strategies were implemented at the breakfast meal observed on 2/20/12.</p> <p>-Client A's 7/12/11 Individual Support Plan (ISP) indicated it was completed 64 days after client A's admission had seven training objectives identified. Other than the projected training objective</p>			

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	<p>documentation, the ISP template was blank. It was also determined by documents in the master record the facility completed or updated three assessments within 30 days of admission: Nutritional on 5/9/11; Choking Risk Assessment on 5/10/11; Vision exam on 5/24/11.</p> <p>-Client A's record did not indicate documentation that a comprehensive assessment (CFA) had been completed to identify client A's functional abilities. Client A's CFA did not have documents available for review in the following areas: psychology; sensorimotor development; affective development; speech and language development; auditory functioning; vocational skills. No references to previous assessments could be found</p> <p>-Client A's 7/12/11 ISP did not include training objectives related to vocational aspirations or employment goals.</p> <p>-Client A's record had no documentation evident that client A or her legally sanctioned representatives had ever been informed of any restrictions regarding limited access to: a butter knife; fork; her money; household supplies for cleaning; finger nail polish since client A's admission on 5/9/11.</p> <p>On 2/21/12 at 12:10pm, the Home Manager (HM) was asked if an ISP had been completed within thirty days of client A's admission, the HM indicated she would look into the matter. The HM returned with a copy of client A's 9/22/11 ISP. Though this document had all the template</p>			

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	<p>information completed, it was dated 135 days after client A's admission. The HM indicated that ISP was the most current ISP.</p> <p>An interview with the Facility Director (FD) was completed on 2/22/12 at 12:30 PM about the facility's interdisciplinary process with respect to conducting assessments within 30 days of admission and how the ISP was formulated. The FD stated "Everything stems from a medical assessment" which "generates referrals." Subsequent review of client A's physical indicated it did not address whether there was any need for occupational therapy, physical therapy, a speech and language evaluation, or a vocational assessment. The facility provided two other ISPs for review. The 9/22/11 ISP was identified by the Home Manager (HM) as being the current ISP that was being used. The 4/1/11 ISP was e-mailed for subsequent review. That ISP which occurred 39 days before client A's admission to the facility had the same training objectives listed in the ISP that was dated 7/11/11. No information was available for review for documentation identifying the participants in attendance at the pre-admission planning meeting.</p> <p>On 2/21/12 at 12:10pm, an interview with the Home Manager (HM) presented a copy of the AWS client A's 5/25/11 "Group Home Individual Support Plan Assessment" for review. The document did not address client A's work interests, work skills, work attitudes, work related behaviors and present and future employment options.</p>			

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	<p>On 2/21/12 at 12:30pm, an interview with the Qualified Mental Retardation Professional (QMRP) was completed. The QMRP was asked if the facility had a policy identifying the blanket restrictions used at the facility and if the clients and their legally sanctioned representatives had been informed of the facility practices. The QMRP indicated there was no policy regarding restrictions, but client A required restrictions related to sharps.</p> <p>On 2/21/12 at 12:10pm, an interview with the Qualified Mental Retardation Professional was completed. The QMRP was asked what types of programming client A was to expected to receive at the AWS day program. The QMRP indicated the current emphasis was on attendance and even though there had been some discussion about making referrals to established workshops in nearby cities, client A and the other clients were getting used to going to a program. When asked to describe the program structure, the QMRP indicated the emphasis was on community involvement and the QMRP indicated there was no contractual or paid work available at the AWS program at that time. The QMRP was asked if a vocational assessment had ever been completed for client A since admission, the QMRP stated she was unsure.</p> <p>2. For client B: On 2/20/12 from 6am until 8:57am, client B was observed. From 6am until 8:57am, client B had four (4) white hampers inside her bedroom connecting bathroom which held client A, B, C, and D's clothing in each of the white hampers. At</p>				

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	<p>7:36am, clients A, B, and C began to scream, cussed, and made derogatory hand gestures to one another. At 7:36am, GHT (Group Home Trainer) #1 redirected all three clients to each of their rooms. GHT #1 followed client B to her bedroom. At 7:36am, client B had a pair of boots on the floor beside her bed. At 7:45am, client B appeared at the doorway in her connecting bathroom next to the clothes hampers, cussed and screamed at the agency LPN (Licensed Practical Nurse) and GHT #1. Client B threw her cell phone at the nurse and then struck the nurse on the arm. At 8am, client B was inside her bedroom with GHT #1. Client B's boots and a pair of shoes were observed on the floor beside her bed, and client B's closet was padlocked. At 8:10am, client B and GHT #1 indicated client B had behaviors of throwing objects and was not to have access to shoes or boots. Both indicated client B's boots and shoes should be locked inside her closet. At 8:10am, GHT #1 indicated client B was restricted access to clothing as well because of threats to harm herself with clothing. GHT #1 indicated the four (4) hampers in client B's bathroom belonged to clients A, C, and D. When asked if client B made threats to harm herself with other clients' clothing, GHT #1 did not respond.</p> <p>On 2/20/12 from 6am until 8:57am, and on 2/20/12 from 3:35pm until 6:35pm, observation was completed at the group home, client B read a magazine, read her medication labels, and client B was not observed to wear her prescribed eye glasses.</p> <p>On 2/20/12 at 6:12am, GHT (Group Home Trainer) #6 went to the medication area inside the laundry room to complete medication administration. At 6:12am, GHT #6 retrieved her</p>						

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	<p>keys from her pocket, unlocked a lower cabinet, and removed wet wipes to wipe off the medication cart. Inside the locked lower cabinet was the laundry detergent, hand soap, Pine-Sol cleaner, toilet bowl cleaner, and bleach. GHT #6 stated the cabinet was "kept locked" and "only" staff had access to the keys. At 6:12am, GHT #6 showed a locked upper cabinet that held nail polish belonging to client B. At 6:12am, GHT #6 stated the items were kept "locked" because of client behaviors.</p> <p>On 2/20/12 at 6:30 AM facility Group Home Trainer (GHT) #6 retrieved a knife from inside a locked kitchen cabinet and indicated knives were kept inside locked. GHT #6 indicated and showed the locked cabinet held knives, butter knives, and forks and indicated the cabinet was kept locked. Inspection inside the cabinet at that time revealed there was a money lock box and a three holed paper punch kept with the sharp objects inside the locked cabinet. GHT #6 stated client B's bedroom closets was "also kept locked because of the client histories of harming [herself] with their clothing."</p> <p>On 2/20/12 from 7:25am until 8am, client B was observed to make toast and spread the butter with a spoon. No knife was offered or the use of a knife taught for client B by the facility staff.</p> <p>On 2/20/12 at 8am, client B completed medication administration with GHT #1 inside the medication room. GHT #1 selected, named, read the directions, and administered client B's medication. GHT #1 asked client B to take her medications.</p>			

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	<p>On 2/20/12 at 8:10am, client B's bedroom closet was locked with a pad lock. Client B indicated the facility staff had the keys to her locked closet. At 8:10am, client B and GHT #1 indicated client B's clothing, clothes hangers, and her shoes were kept inside the secured closet.</p> <p>On 2/20/12 at 6:30am, two of two closets inside the facility living room were locked and GHT #6 indicated client B did not have access to the locked cabinet in the kitchen or the two living room closets. GHT #6 indicated the emergency food supply was in one locked living room closet and she was unsure of what was in the other closet.</p> <p>On 2/20/12 at 4:55 PM, two second shift GHTs #7 and #8 were asked to identify what was kept inside the two locked living room closets. GHT #7 stated "it was extra food." GHT #7 was asked to open the doors. GHT #7 and GHT #8 tried to open the doors with a key, but was unsuccessful. GHT #7 attempted to open the doors but was not able to. GHT #2 suggested another key be tried, but even with another key that attempt to open the door was also unsuccessful.</p> <p>On 2/20/12 from 10:30am until 1:30pm, client B did not attend the agency owned workshop.</p> <p>On 2/21/12 at 11:30am, client B's record was reviewed. Client B was admitted to the facility 5/18/11 and indicated the following: -Client B had a 5/7/11 ISP, seventeen (17) days before her admission to the facility. -Client B's record indicated her mother was her</p>						

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	<p>guardian.</p> <p>-Client B's 8/13/2010 "Consent of Current BSP (Behavior Support Plan) and "Restrictions" which included Sharps, Footwear, Acrylic nails, belts, and a padlock on the basement door for safety. Client B and her legally sanctioned representative did not sign the form on 8/13/2010 and no update was available for review after admission to the new facility.</p> <p>-On 2/21/12 at 11:30am, client B's record was reviewed. Client B was admitted to the facility 5/18/11. Client B's record indicated her mother was her guardian. Client B's 8/13/2010 and updated 10/12/11 indicated "BSP (Behavior Support Plan) and Restrictions" which included Sharps, Footwear, Acrylic nails, belts, and a padlock on the basement door for safety.</p> <p>-Client B's 7/11/11 ISP and updated on 9/22/11 indicated goals/objectives to to make a purchase while in the community of an item of her choice and to turn in a receipt from her purchase. Client B's "Residential Monthly Report" hand written reports for 5/11 and 6/11 indicated client B did not have money to complete the objectives.</p> <p>-Client B's 7/11/11 ISP updated 9/22/11 indicated goals/objectives to brush her teeth twice daily, to communicate with her family once a week, to eat food prior to medication administration, to assist staff to clean her room, to wash her laundry, to assist in setting the table for meals, to shower daily, to punch out the packet of ortho cyclin medication, to make a purchase while in the community, to attend day services at least 3 times a week, and to participate in group activity while at day services.</p> <p>-Client B's 5/25/11 "Group Home Individual</p>						

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	<p>Support Plan Assessment" indicated client B had the skill to carry her own money, knows the purpose of money, exchanges money for a purchase, makes purchases based on need, budgets her own money for the week, and "regularly" understands individual values of coins and currency.</p> <p>-Client B's record indicated a 7/11/11 ISP which indicated a self-administration of medication training objective to "name her medications."</p> <p>-Client B's record was reviewed on 2/21/12 at 11:30am. Client B had a 9/26/11 Vision evaluation which indicated client B had prescribed eye glasses.</p> <p>In a phone interview with the Qualified Mental Retardation Professional (QMRP) on 2/21/12 at 12:20 PM, the QMRP indicated the facility had no documentation that client B or her legally sanctioned representatives had been informed of the facility practices to restrict access. The QMRP stated there was no policy regarding restrictions and stated client B and "all required restrictions" related to sharps.</p> <p>On 2/22/12 at 12:10 PM, an interview with the facility's Behavior Specialist (BS) was completed. The BS indicated client B's plan did not include restrictions related to money, clothing, food, cleaning supplies or finger nail polish. The BS indicated client B's record indicated an 8/13/10 verbal consent for locked items and client B was admitted on 5/18/11. The BS indicated no updated record of notification for the restrictions were available for review.</p>			

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	<p>On 2/21/12 at 12:10pm, an interview with the Qualified Mental Retardation Professional was completed. The QMRP was asked what types of programming client B was to expected to receive at the AWS day program. The QMRP indicated the current emphasis was on attendance and even though there had been some discussion about making referrals to established workshops in nearby cities, client B and the other clients were getting used to going to a program. When asked to describe the program structure, the QMRP indicated the emphasis was on community involvement. The QMRP indicated there was no contractual or paid work available at the AWS program at that time. The QMRP was asked if a vocational assessment had ever been completed for client B since admission, the QMRP stated she was unsure.</p> <p>On 2/23/12 at 9:30am, the HM indicated she did not know client B wore eye glasses.</p> <p>3. For client C: On 2/20/12 at 6:12am, client C completed medication administration with GHT #6 inside the medication room. GHT #6 selected, named, read the directions, and administered client C's medication. GHT #6 asked client C to "take" the medication.</p> <p>On 2/20/12 at 8:30am, client C completed her medication administration with GHT #2 inside the medication room. GHT #2 selected, named, read the directions, and administered client C's medication. GHT #2 asked client C to take her medications. Client C responded "I don't want the blue medicine."</p>			

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	<p>On 2/20/12 at 6:12am, GHT (Group Home Trainer) #6 went to the medication area inside the laundry room to complete medication administration. At 6:12am, GHT #6 retrieved her keys from her pocket, unlocked a lower cabinet, and removed wet wipes to wipe off the medication cart. Inside the locked lower cabinet were the laundry detergent, hand soap, Pine-Sol cleaner, toilet bowl cleaner, and bleach. GHT #6 stated the cabinet was "kept locked" and "only" staff had access to the keys. At 6:12am, GHT #6 showed a locked upper cabinet that held nail polish belonging to client C. At 6:12am, GHT #6 stated the items were kept "locked" because of client behaviors.</p> <p>On 2/20/12 at 6:30 AM facility Group Home Trainer (GHT) #6 retrieved a knife from inside a locked kitchen cabinet and indicated knives were kept inside locked. GHT #6 indicated and showed the locked cabinet held knives, butter knives, and forks and indicated the cabinet was kept locked. Inside the cabinet showed a money lock box and a three holed paper punch kept with the sharp objects inside the locked cabinet.</p> <p>On 2/20/12 at 6:30am, two of two closets inside the facility living room were locked and GHT #6 indicated client C did not have access to the locked cabinet in the kitchen or the two living room closets. GHT #6 indicated the emergency food supply was in one locked living room closet and she was unsure of what was in the other closet.</p>			

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	<p>On 2/20/12 at 4:55 PM, two second shift GHTs #7 and #8 were asked to identify what was kept inside the two locked living room closets. GHT #7 stated "it was extra food." GHT #7 was asked to open the doors. GHT #7 and GHT #8 tried to open the doors with a key, but was unsuccessful. GHT #7 attempted to open the doors but was not able to. GHT #2 suggested another key be tried, but even with another key that attempt to open the door was also unsuccessful.</p> <p>Client C's record was reviewed on 2/21/12 at 9:30am. Client C was admitted to the facility on 6/21/11.</p> <p>-Client C's record indicated a 9/22/11 ISP which indicated a self-administration of medication training objective to "identify all of her AM (morning medications) with no more than 2 verbal prompts."</p> <p>-Client C's record indicated a 9/22/11 ISP which indicated a self-administration of medication training objective to "identify all of her AM (morning medications) with no more than 2 verbal prompts."</p> <p>In an interview with the Licensed Practical Nurse (LPN) on 2/21/12 at 12:20 PM, she was asked if the training objectives should have been conducted at the medication administration time on 2/20/12. The LPN stated, "A lot of new programs have been developed." The LPN indicated each clients objectives should be implemented at each opportunity.</p> <p>4. For client D: On 2/20/12 from 6am until 8:57am, and on</p>				

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	<p>2/20/12 from 3:35pm until 6:35pm, client D did not wear eye glasses. At 7:40am, Client D was observed in the kitchen trying to make toast. Client D hovered over the toaster, bent at the waist to lean her body over the toaster, looking downward closely into the toaster slots trying to insert bread. Throughout additional morning observations from 6am until 9:15 AM, client D was not observed wearing eye glasses.</p> <p>On 2/20/12 at 7:05am, client D completed medication administration with GHT #2 inside the medication room. GHT #2 selected, named, read the directions, and administered client D's medication. GHT #2 asked client D to hold her inhaler to her mouth.</p> <p>On 2/20/12 at 6:12am, GHT (Group Home Trainer) #6 went to the medication area inside the laundry room to complete medication administration. At 6:12am, GHT #6 retrieved her keys from her pocket, unlocked a lower cabinet, and removed wet wipes to wipe off the medication cart. Inside the locked lower cabinet were the laundry detergent, hand soap, Pine-Sol cleaner, toilet bowl cleaner, and bleach. GHT #6 stated the cabinet was "kept locked" and "only" staff had access to the keys. At 6:12am, GHT #6 showed a locked upper cabinet that held nail polish belonging to client D. At 6:12am, GHT #6 stated the items were kept "locked" because of client behaviors.</p> <p>On 2/20/12 at 6:30 AM facility Group Home Trainer (GHT) #6 retrieved a knife from inside a</p>						

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	<p>locked kitchen cabinet and indicated knives were kept locked. GHT #6 indicated and showed the locked cabinet held knives, butter knives, and forks and indicated the cabinet was kept locked. Inside the cabinet showed a money lock box and a three holed paper punch kept with the sharp objects inside the locked cabinet.</p> <p>On 2/20/12 from 7:25am until 8am, client D was observed to make toast and spread the butter with a spoon. No knife was offered or the use of a knife taught for client D by the facility staff. No youth spoon was taught or encouraged.</p> <p>On 2/20/12 at 6:30am, two of two closets inside the facility living room were locked and GHT #6 indicated client D did not have access to the locked cabinet in the kitchen or the two living room closets. GHT #6 indicated the emergency food supply was in one locked living room closet and she was unsure of what was in the other closet.</p> <p>On 2/20/12 at 4:55 PM, two second shift GHTs #7 and #8 were asked to identify what was kept inside the two locked living room closets. GHT #7 stated "it was extra food." GHT #7 was asked to open the doors. GHT #7 and GHT #8 tried to open the doors with a key, but was unsuccessful. GHT #7 attempted to open the doors but was not able to. GHT #2 suggested another key be tried, but even with another key that attempt to open the door was also unsuccessful.</p> <p>Client D's record was reviewed on 2/23/12 at 9:30am and indicated the following: -Client D was admitted to the facility on 5/18/11.</p>						

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	<p>Additional record review indicated an Individual Support Plan (ISP) in client D's record dated 7/11/11, completed 54 days after client D's admission. When the Home Manager (HM) was asked if an ISP had been completed within thirty days of client D's admission, the HM indicated she would look into the matter. The HM returned with a copy of another ISP dated 9/22/11. Though this document had updated information, it was dated 127 days after client D's admission. The HM indicated that ISP was the most current ISP.</p> <p>-Client D's 9/22/12 ISP indicated a self-administration of medication training objective to "will identify her Cymbalta capsules card daily at AM medication time with no more than 2 verbal cues at 75% success for 3 consecutive months."</p> <p>-Client D's record indicated she was admitted to the facility on 5/18/11. An Individual Support Plan (ISP) was in the record dated 7/11/11. The ISP indicated in addition to it having been completed 54 days after client D's admission to the facility, the template for the ISP was blank except for seven training objectives that had been recommended.</p> <p>-Client D's record indicated no comprehensive assessments identifying the functional abilities of client D in the following areas: psychology; sensorimotor development; affective development; speech and language development; auditory functioning; vocational skills. No references to previous assessments could be found.</p> <p>-Client D's record indicated a physician's order dated 11/29/11 which indicated client D should</p>						

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	<p>have glasses with an additional notation to "clean glasses every morning."</p> <p>On 2/22/12 at 12:30pm, an interview with the Facility Director (FD) was completed about the facility's interdisciplinary process with respect to conducting assessments within 30 days of admission and how the ISP was formulated. The FD stated "Everything stems from a medical assessment" which "generates referrals." Review of client D's physical indicated it did not address whether there was any need for occupational therapy, physical therapy, a speech and language evaluation, or a vocational assessment.</p> <p>On 2/22/12 at 12:30pm, the HM presented two other ISPs for review. The first ISP dated 9/22/11 was identified by the Home Manager (HM) as being the current ISP that was being used. An undated ISP was e-mailed for subsequent review. That ISP recommended six training objectives. There was no other information entered into that document, nor was there any documentation identifying the participants in attendance at client D's initial pre-admission ISP planning meeting.</p> <p>In an interview with the Licensed Practical Nurse (LPN) on 2/21/12 at 12:20 PM, she was asked if the training objectives should have been conducted at the medication administration time on 2/20/12. The LPN stated, "A lot of new programs have been developed." The LPN indicated each clients' objectives should be implemented at each opportunity.</p> <p>On 2/21/12 at 12:20pm, an interview with the</p>			

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	<p>Qualified Mental Retardation Professional (QMRP) was completed. The QMRP indicated the facility had no documentation that client D or her legally sanctioned representatives had been informed of the facility practices to restrict access. The QMRP stated there was no policy regarding restrictions and stated client D "required restrictions" related to sharps.</p> <p>On 2/22/12 at 12:10 PM, an interview with the facility's Behavior Specialist (BS) was completed. The BS indicated restrictions were identified as a separate addendum to the Behavior Support Plan (BSP). The BS indicated client D's addendum was not available for review for restrictions related to money, clothing, food, cleaning supplies or finger nail polish.</p> <p>On 2/29/12 at 2pm, an interview with the Facility Director (FD) was completed. The FD indicated goals/objectives should be implemented daily during fo</p>				

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W0206	<p>483.440(c)(1) INDIVIDUAL PROGRAM PLAN Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to:</p> <p>(i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and</p> <p>(ii) Designing programs that meet the client's needs.</p> <p>Based on interview and record review, for 2 of 2 sample clients (clients A and B) and one additional client (client D), the facility failed to have an ISP (Individual Support Plan) completed by the interdisciplinary team.</p> <p>Findings include:</p> <p>1. On 2/21/12 at 10:30am, client A's record was reviewed. Client A's record indicated client A was admitted to the AWS facility on 5/9/11. Client A's 7/11/11 Individual Support Plan (ISP) indicated it was completed sixty-four (64) days after client A's admission to the facility, the template for the ISP was blank except for seven training objectives that had been recommended.</p> <p>On 2/22/12 at 12:30pm, an interview with</p>	W0206	<p><b>W206</b></p> <p>ISP implemented within 30 days</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>The group home's original QMRP implemented basic ISPs prior to client admission that were based on pre-admission IDT meetings that went undocumented. The QMRP did not coordinate sufficiently with the individuals' IDTs to update and implement plans based on assessment within 30 days. Due to performance issues such as these, that QMRP no longer works for the agency. A highly experienced QMRP now works in the home, coordinates ongoing IDT activity across individuals, and has revised all ISP goals in coordination with the IDTs. As detailed throughout the agency's</p>	03/30/2012			

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	<p>the Facility Director (FD) was completed. The FD indicated the facility's interdisciplinary process with respect to conducting assessments within 30 days of admission and how the ISP was formulated. The FD stated "Everything stems from a medical assessment" which "generates referrals." The facility presented two other ISPs for review. The first ISP dated 9/22/11 was identified by the Home Manager (HM) as being the current ISP that was being used. An ISP dated 4/1/11 was e-mailed for subsequent review. That ISP which occurred 39 days before client A's admission to the facility had the same training objectives listed in the 7/11/11 ISP. No information was available for review to determine the participants in attendance at the pre-admission planning meeting.</p> <p>2. Client B's record was reviewed on 2/21/12 at 11:30am. Client B was admitted to the facility on 5/18/11. Client B's 7/11/11 ISP indicated the ISP was completed fifty-four (54) days after client B's admission to the facility, client B's template for the ISP was blank except for seven training objectives that had been</p>		<p>Plan of Correction, new assessments have been conducted, on-going plans have been part of the IDT process, and staff have been trained on implementation of treatment.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>A new QMRP was hired who has significant experience implementing ISPs and coordinating IDT activity. New ISPs have been implemented across clients based on IDT consensus. The QMRP will ensure that all new admissions include appropriate assessments and that IDT activity and ISP goals are developed within the required 30-day timeframe. A new checklist has been developed for this purpose.</p> <p><b>How corrective actions will be monitored to ensure no</b></p>				

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	<p>recommended. Client B's record had no references to previous assessments.</p> <p>On 2/22/12 at 12:30pm, an interview with the Facility Director (FD) was completed. The FD stated "Everything stems from a medical assessment" for the 30 day planning meeting which "generates referrals." The FD indicated client B had been a client at another group home operated by AWS agency. Additionally, the facility presented two other ISPs for review. The first ISP dated 9/22/11 was identified by the Home Manager (HM) as being the current ISP that was being used. An 5/1/11 ISP was e-mailed for subsequent review. That ISP recommended six training objectives and was completed seventeen (17) days before the client was admitted to the facility. There was no other information entered into that document, nor was there any documentation identifying the participants in attendance at client B's initial pre-admission ISP planning meeting.</p> <p>3. Client D's record was reviewed on 2/22/12 at 9:30 AM. Client D was admitted to the facility on 5/18/11. Client</p>		<p><b>recurrence</b></p> <p>The QMRP coordinates the activity of the IDT, which is responsible for development of ISPs. For all new admissions, the QMPR is responsible to ensure that the 30-day requirement is met for all appropriate assessments and for the development of the ISP. Other management staff, including the Nurse, the Behavior Clinician, and the Group Home Manager, take part in the process and will assist with appropriate appointments, assessments, and staff training as needed. The Director supervises the management staff and will monitor implementation of all plans during regularly scheduled meetings or more often, as necessary. A checklist will be used by the Director to monitor the status and appropriate scheduling of all required assessments for all new admissions.</p>				

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	<p>D's 7/11/11 ISP indicated the ISP was completed fifty-four (54) days after client D's admission to the facility, client D's template for the ISP was blank except for seven training objectives that had been recommended. Client D's record had no references to previous assessments.</p> <p>On 2/22/12 at 12:30pm, an interview with the Facility Director (FD) was completed. The FD stated "Everything stems from a medical assessment" for the 30 day planning meeting which "generates referrals." Additionally, the facility presented two other ISPs for review. The first ISP dated 9/22/11 was identified by the Home Manager (HM) as being the current ISP that was being used. An undated ISP was e-mailed for subsequent review. That ISP recommended six training objectives. There was no other information entered into that document, nor was there any documentation identifying the participants in attendance at client D's initial pre-admission ISP planning meeting.</p> <p>This federal tag relates to complaint #IN00104098.</p>						

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W0210	<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 record review and interview, for 2 of 2 sample clients (clients A and B) who were new admissions to the facility, the facility failed to perform a comprehensive functional assessment (CFA) which included audio and vision assessments within 30 days of their admission.</p> <p>Findings include:</p> <p>1 Client A's record was reviewed on 2/21/12 at 10:30am. Client A's record indicated client A was admitted to the AWS facility on 5/9/11. Client A had the following assessments completed within 30 days of admission: Nutritional on 5/9/11; Choking Risk Assessment on 5/10/11; and Vision exam on 5/24/11. Client A's record indicated no comprehensive assessments identifying the functional abilities of client A had been completed in the following areas: psychology; sensorimotor development; affective development; speech and</p>	W0210	<p><b>W210</b></p> <p>Assessments of Hearing and Vision in CFA</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>The group home's original QMRP did not ensure that the comprehensive functional assessments due within 30 days of admission included vision and hearing testing. Due to performance issues such as these, that QMRP no longer works for the agency. A highly experienced QMRP now works in the home, coordinates ongoing IDT activity across individuals, and is responsible for ensuring assessments are completed as needed. The QMRP and Nurse have made vision and hearing appointments for all clients who need them.</p> <p><b>How facility will identify other residents potentially affected &amp;</b></p>	03/30/2012	

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	<p>language development; auditory functioning; or vocational skills. Client A's record did not indicate the previous assessments were valid.</p> <p>On 2/22/12 at 12:30pm, an interview with the Facility Director (FD) was completed. The FD stated the facility's interdisciplinary process to completing assessments within 30 days of admission was "Everything stems from a medical assessment" which generates referrals. Client A's physical did not address whether there was any need for occupational therapy, physical therapy, a speech and language evaluation, or a vocational assessment.</p> <p>2. Client B's record was reviewed on 2/21/12 at 11:30am. Client B's record indicated client B was admitted to the facility on 5/18/11. Client B had the following assessments completed within 30 days of admission: Nutritional on 5/18/11; Dysphasia Plan on 5/4/11, and a physical on 5/31/11. Client B's record indicated no comprehensive assessments identifying the functional abilities of client B had been completed in the</p>		<p><b>what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>Vision and Hearing assessments have been scheduled. A highly qualified QMRP was hired who will ensure that all new admissions include appropriate assessments, including hearing and vision, are completed within the required 30-day timeframe for all future admissions. A new checklist of needed assessments has been developed for this purpose.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>For all new admissions, the QMPR is responsible to ensure that the 30-day requirement is met for all appropriate assessments, including hearing and vision. Other management staff, including the Nurse, the Behavior Clinician, and the Group Home Manager, take part in the process and will assist with appropriate appointments,</p>				

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	<p>following areas: psychology; sensorimotor development; affective development; speech and language development; auditory functioning; or vocational skills. Client B's Vision assessment was completed on 9/26/11, and a dental assessment on 9/8/11.</p> <p>On 2/22/12 at 12:30pm, an interview with the Facility Director (FD) was completed. The FD stated the facility's interdisciplinary process to completing assessments within 30 days of admission was "Everything stems from a medical assessment" which generates referrals. The FD indicated client B's physical did not address whether there was any need for occupational therapy, physical therapy, a speech and language evaluation, or a vocational assessment. The FD indicated client B's CFA, vision, and hearing were not completed within 30 days of admission.</p> <p>This federal tag relates to complaint #IN00104098.</p> <p>9-3-4(a)</p>		<p>assessments, and staff training as needed. The Director supervises the management staff and will monitor implementation of all plans during regularly scheduled meetings or more often, as necessary. A checklist will be used by the Director to monitor the status and appropriate scheduling of all required assessments for all new admissions.</p>				

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W0225	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills.</p> <p>Based on record review and interview, for 2 of 2 sample clients (clients A and B), the facility failed to perform a comprehensive functional assessment (CFA) which included client A and B's vocational assessments.</p> <p>Findings include:</p> <p>1. On 2/20/12 at 10:30am, client A arrived at the facility owned day program. During observations, client A was asked to participate in a money concepts activity using cardboard money. Client A ate lunch at the day program and departed from the facility at 1:30 PM, three hours from entering the facility. No other activity was observed.</p> <p>Client A's record was reviewed on 2/21/12 at 10:30am. Client A's record indicated client A was admitted to the AWS facility on 5/9/11. Client A's 7/12/11 Individual Support Plan (ISP) indicated training objectives had been recommended, but none were related to any vocational aspirations or employment</p>	W0225	<p><b>W225</b></p> <p>Vocational Assessment in CFA</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>The group home's original QMRP did not ensure that the comprehensive functional assessments due within 30 days of admission included a vocational assessment. Due to performance issues such as these, that QMRP no longer works for the agency. A highly experienced QMRP now works in the home, coordinates ongoing IDT activity across individuals, and is responsible for ensuring assessments are completed as needed. The QMRP has scheduled with Vocational Rehabilitation to perform assessments for all four clients.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address</p>	03/30/2012			

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	<p>goals. Additional record review indicated there was no vocational assessment in the record.</p> <p>2. On 2/21/12 from 10:30am until 1:30pm, client B did not attend day services.</p> <p>Client B's record was reviewed on 2/21/12 at 11:30am. Client B's record indicated client B was admitted to the facility on 5/18/11. Client B's 7/11/11 Individual Support Plan (ISP) indicated training objectives had been recommended, but none were related to any vocational aspirations or employment goals. Additional record review indicated there was no vocational assessment in the record.</p> <p>In a teleconference interview with the Qualified Mental Retardation Professional (QMRP) on 2/21/12 at 12:10 PM, the QMRP was asked what clients A and B received at the AWS day program. The QMRP indicated the current emphasis was on attendance and even though there had been some discussion about making referrals to established</p>		<p>the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>Vocational assessments have been scheduled. A highly qualified QMRP was hired who will ensure that all new admissions include appropriate assessments, including vocational, are completed within the required 30-day timeframe for all future admissions. A new checklist of needed assessments has been developed for this purpose.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>For all new admissions, the QMPR is responsible to ensure that the 30-day requirement is met for all appropriate assessments, including vocational. Other management staff, including the Nurse, the Behavior Clinician, and the Group Home Manager, take part in the process and will assist with appropriate appointments, assessments, and staff training as needed. The Director supervises the management staff and will monitor implementation</p>				

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	<p>workshops in nearby cities. The QMRP indicated client A, B, and the other clients were just getting used to going to a program. When asked to describe the program structure, the QMRP indicated there was emphasis on community involvement. The QMRP indicated there was no contractual or paid work available at the AWS program at that time. The QMRP was asked if a vocational assessment had ever been completed for clients A and B since admission, the QMRP indicated she was unsure.</p> <p>On 2/21/12 at 12:10pm, an interview was completed and the Home Manager (HM) provided a copy client A's of the AWS "Group Home Individual Support Plan Assessment" dated 5/25/11 for review. That document did not address any of client A's work interests, work skills, work attitudes, work related behaviors and present and future employment options. The HM indicated client B's "Group Home Individual Support Plan Assessment." did not address any of client B's work interests, work skills, work attitudes, work related behaviors and present and future employment options.</p>		<p>of all plans during regularly scheduled meetings or more often, as necessary. A checklist will be used by the Director to monitor the status and appropriate scheduling of all required assessments for all new admissions.</p>				

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W0226	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan.</p> <p>Based on interview and record review, for 2 of 2 sample clients (clients A and B) and for one additional client (client D) the facility failed to develop an ISP (Individual Support Plan) within 30 days of admission to the facility.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 2/21/12 at 10:30 AM. Client A's record indicated she was discharged from a state hospital to the facility on 5/9/11. Client A's 7/12/11 ISP indicated it was completed sixty-four (64) days after client A's admission to the facility and had five training objectives identified. Other than the projected training objective documentation, the ISP template was blank. At 10:30am, the Home Manager (HM) was asked if an ISP had been completed within thirty days of client A's admission and the HM indicated she would look into the matter. The HM returned with a copy of another ISP dated 9/22/11. Though this document had all</p>	W0226	<p><b>W226</b></p> <p>ISP implemented within 30 days</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>The group home's original QMRP implemented basic ISPs prior to client admission that were based on pre-admission IDT meetings that went undocumented. The QMRP did not coordinate sufficiently with the individuals' IDTs to update and implement plans based on assessment within 30 days. Due to performance issues such as these, that QMRP no longer works for the agency. A highly experienced QMRP now works in the home, coordinates ongoing IDT activity across individuals, and has revised all ISP goals in coordination with the IDTs. As detailed throughout the agency's Plan of Correction, new assessments have been conducted, on-going plans have been part of the IDT process, and staff have been trained on implementation of treatment.</p>	03/30/2012			

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	<p>the template information completed, it was dated 135 days after client A's admission. The HM indicated the 9/22/11 ISP was the most current ISP.</p> <p>2. Client B's record was reviewed on 2/21/12 at 11:30am. Client B was admitted to the facility on 5/18/11. Client B's 7/11/11 ISP indicated the ISP was completed fifty-four (54) days after client B's admission to the facility, and client B's template for the ISP was blank except for seven training objectives that had been recommended. On 2/21/11 at 12:30pm, the HM presented two other ISPs for review. The first ISP dated 9/22/11 was identified by the HM as being the current ISP that was being used.</p> <p>3. Client D's record review was reviewed on 2/23/12 at 9:30 AM. Client D was admitted to the facility on 5/18/11. Additional record review indicated an Individual Support Plan (ISP) in Client D's record dated 7/11/11 was completed 54 days after client D's admission. The HM indicated she would look into the matter of client D's ISP was dated 7/11/11 and client D was admitted on 5/18/11. At</p>		<p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>A new QMRP was hired who has significant experience implementing ISPs and coordinating IDT activity. New ISPs have been implemented across clients based on IDT consensus. The QMRP will ensure that all new admissions include appropriate assessments and that IDT activity and ISP goals are developed within the required 30-day timeframe. A new checklist has been developed for this purpose.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>The QMRP coordinates the activity of the IDT, which is responsible for development of ISPs. For all new admissions, the QMPR is responsible to ensure</p>		

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	<p>10am, the HM returned with a copy of another ISP dated 9/22/11. Though this document had updated information, it was dated 127 days after client D's admission. The HM indicated client D's 9/22/11 ISP was the most current.</p> <p>This federal tag relates to complaint #IN00104098.</p> <p>9-3-4(a)</p>		<p>that the 30-day requirement is met for all appropriate assessments and for the development of the ISP. Other management staff, including the Nurse, the Behavior Clinician, and the Group Home Manager, take part in the process and will assist with appropriate appointments, assessments, and staff training as needed. The Director supervises the management staff and will monitor implementation of all plans during regularly scheduled meetings or more often, as necessary. A checklist will be used by the Director to monitor the status and appropriate scheduling of all required assessments for all new admissions.</p>		

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview, and record review, for 2 of 2 sample clients (clients A and B) and for two additional clients (C and D), the facility failed to ensure a choking management plan was implemented (client A), and to use formal and informal opportunities to teach and implement ISP (Individual Support Plan) objectives and skill acquisition when opportunities existed for coping skills and medication administration.</p> <p>Findings include:</p> <p>1. On 2/20/12 from 6am until 8:57am, client B was observed at the group home and her bedroom closet was locked. From 6am until 8:57am, client B had four (4) white hampers inside her bedroom connecting bathroom which held client A, B, C, and D's clothing in each of the white hampers. At 7:36am, clients A, B, and C began to scream, cussed, and made derogatory hand gestures to one another. At 7:36am, GHT (Group Home Trainer)</p>	W0249	<p><b>W249</b></p> <p>Program implementation</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>Staff members have been trained on the essential aspect of proper implementation of all ISP goals and Physician Orders. The Dysphasia Plan and Dining Plan for Client A were revised and trained to the staff members, including the use of the proper sized spoon. All clients in the home are having regular "house meetings" with the Group Home Manager and Behavior Clinician to discuss getting along with one another and using coping skills rather than resorting to interpersonal conflict. Unapproved restrictions were eliminated, but per IDT consensus, the sharps restriction remains in place for all four residents. This was trained to</p>	03/30/2012			

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	<p>#1 redirected all three ladies to each of their rooms. GHT #1 followed client B to her bedroom. At 7:36am, client B had a pair of boots on the floor beside her bed. At 7:45am, client B appeared at the doorway in her connecting bathroom next to the clothes hampers, cussed and screamed at the agency LPN (Licensed Practical Nurse) and GHT #1. Client B threw her cell phone at the nurse and then struck the nurse on the arm. At 8am, client B was inside her bedroom with GHT #1, client B's boots and a pair of shoes were observed on the floor beside her bed, and client B's closet was padlocked. At 8:10am, client B and GHT #1 indicated client B had behaviors of throwing objects and was not to have access to shoes or boots. Both indicated client B's boots and shoes should be locked inside her closet. At 8:10am, GHT #1 indicated client B was restricted access to clothing as well because of threats to harm herself with clothing. GHT #1 indicated the four (4) hampers in client B's bathroom belonged to clients A, C, and D. When asked if client B made threats to harm herself with other clients' clothing, GHT #1 did not respond.</p> <p>On 2/21/12 at 11:30am, client B's record was reviewed. Client B was admitted to the facility 5/18/11. Client B's 8/13/2010 and updated 10/12/11 indicated "BSP</p>		<p>staff, including how access is provided to sharps under supervision during certain times, including meals. New reminders will be added to the MAR to ensure that (a) medication administration goals, such as naming medications, and (b) prompting the use and cleaning of eye glasses are implemented.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>New dysphasia and dining plans; house meetings; unapproved restrictions eliminated; reminders added to the MAR; and staff trained across domains of implementation.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>The QMRP monitors program development and</p>				

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	<p>(Behavior Support Plan) and Restrictions" which included Sharps, Footwear, Acrylic nails, belts, and a padlock on the basement door for safety. No goal/objective was available for review to teach her about personal space, physical aggression, clothing, or footwear.</p> <p>2. On 2/20/12 at AM, client A was observed preparing breakfast. Client A made oatmeal and toast. Client A independently prepared her oatmeal by pouring the oat contents from a container into a bowl, placing water in a bowl and then placing the bowl in a microwave. Client A also placed two pieces of bread in a toaster and when completed, Client A used a tablespoon to spread butter on the toast. Client A ate the oatmeal with the same tablespoon she used to spread butter on her toast and client A consumed the whole pieces of toast by biting off small pieces with her teeth.</p> <p>Client A's record review was conducted on 2/21/12 at 10:30 AM. Client A's 6/8/11 "Choking Management Plan" indicated outlined instructions for staff to encourage the use of a "youth sized spoon, to cut food into small bite sized pieces," and staff were to encourage client A to "take smaller bites."</p> <p>In an interview with the Licensed</p>		implementation. Management staff complete home visit forms and will assist in monitoring program implementation. The Director supervises management staff and reviews home visit forms at regular staff meetings.				

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	<p>Practical Nurse (LPN) on 2/21/12 at 12:20 PM, she was asked if client A was a choking risk. The LPN indicated client A was a choking risk and needed to take small bites. The LPN indicated she was unaware of the youth spoon plan for client A.</p> <p>3. On 2/20/12 at 6:12am, client C completed medication administration with GHT #6 inside the medication room. GHT #6 selected, named, read the directions, and administered client C's medication. GHT #6 asked client C to "take" the medication.</p> <p>Client C's record was reviewed on 2/23/12 at 9:30am, and indicated a 9/22/11 ISP which indicated a self-administration of medication training objective to "identify all of her AM (morning medications) with no more than 2 verbal prompts."</p> <p>4. On 2/20/12 at 7:05am, client D completed medication administration with GHT #2 inside the medication room. GHT #2 selected, named, read the directions, and administered client D's medication. GHT #2 asked client D to hold her inhaler to her mouth.</p> <p>Client D's record was reviewed on 2/22/12 at 9:30am and indicated a 9/22/12</p>						

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	<p>ISP which indicated a self- administration of medication training objective to "will identify her Cymbalta capsules card daily at AM medication time with no more than 2 verbal cues at 75% success for 3 consecutive months."</p> <p>5. On 2/20/12 at 8am, client B completed medication administration with GHT #1 inside the medication room. GHT #1 selected, named, read the directions, and administered client B's medication. GHT #1 asked client B to take her medications.</p> <p>Client B's record was reviewed on 2/21/12 at 11:30am, and indicated a 7/11/11 ISP which indicated a self-administration of medication training objective to "name her medications."</p> <p>6. On 2/20/12 at 8:30am, client C completed her medication administration with GHT #2 inside the medication room. GHT #2 selected, named, read the directions, and administered client C's medication. GHT #2 asked client C to take her medications. Client C responded "I don't want the blue medicine."</p> <p>Client C's record was reviewed on 2/23/12 at 9:30am, and indicated a 9/22/11 ISP which indicated a self-administration of medication training objective to "identify all of her AM</p>				

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	<p>(morning medications) with no more than 2 verbal prompts."</p> <p>In an interview with the Licensed Practical Nurse (LPN) on 2/21/12 at 12:20 PM, she was asked if the training objectives should have been conducted at the medication administration time on 2/20/12. The LPN stated, "A lot of new programs have been developed." The LPN indicated each clients' objectives should be implemented at each opportunity.</p> <p>This federal tag relates to complaint #IN00104098.</p> <p>9-3-4(a)</p>				

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W0263	<p><b>483.440(f)(3)(ii)</b> <b>PROGRAM MONITORING &amp; CHANGE</b> The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview, for 1 of 2 sample clients (client B) with restrictive practices in her Behavior Support Plan (BSP), the facility's specially constituted committee (HRC) failed to ensure the BSP was consented to by client B and her legally sanctioned representatives.</p> <p>Findings include:</p> <p>On 2/21/12 at 11:30am, client B's record was reviewed. Client B's record indicated her mother was her guardian. Client B's 8/13/2010 "Consent of Current BSP (Behavior Support Plan) and "Restrictions" which included Sharps, Footwear, Acrylic nails, belts, and a padlock on the basement door for safety. Client B's 8/16/2010 BSP was updated 10/12/11 included the targeted behaviors of physical aggression, verbal aggression, property destruction, inappropriate sexual behavior, suicidal gestures, and elopement. Client B's BSP included a physical restraint hold when client B was physically aggressive "If [client B] is not able to calm...staff should follow facility policy and procedures as necessary to protect her and others from harm. These are part of the AWS trained Mandt (physical holds staff apply to hold the client) interventions. Acceptable Mandt interventions include the following blocks, holds or restraints with a priority placed on using least restrictive intervention that can provide safety...Hold her arms when she drops to the floor...hold her feet when she drops to the floor...." Client B's legally sanctioned representative gave verbal consent for the plan on 8/13/2010 and no</p>	W0263	<p><b>W263</b></p> <p>Written Consent for all BSPs and Restrictive Measures</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>Only verbal consent was obtained from a client's guardian for BSP interventions and restrictions. Written consent will be obtained.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>Written consent will be obtained for all clients' BSPs and</p>	03/30/2012			

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	<p>update was available for review after admission to the new facility. An e-mail from HRC members agreeing to the plan was reviewed before the client was admitted to the facility.</p> <p>In a phone interview with the Qualified Mental Retardation Professional (QMRP) on 2/21/12 at 12:20 PM, the QMRP indicated the facility had no documentation that client B or her legally sanctioned representatives had been informed of client B's plans after admission. The QMRP stated there was no policy regarding restrictions and stated client B "all required restrictions" related to sharps.</p> <p>On 2/22/12 at 12:10 PM, an interview with the facility's Behavior Specialist (BS) was completed. The BS indicated restrictions were identified as a separate addendum to the Behavior Support Plan (BSP). The BS indicated client B's record indicated an 8/13/10 verbal consent for locked items and client B's 8/16/10 BSP. The BS indicated client B was admitted on 5/18/11. The BS indicated no updated record of notification or approvals for the restrictions were available for review.</p> <p>9-3-4(a)</p>		<p>restrictions. Additionally, HRC procedures have changed and now require guardian approval with signature prior to consideration.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>Behavior Clinician is responsible for all BSPs, restrictions, and HRC applications. Any new intervention or restriction requires HRC approval, which now requires verification of signed consent prior to consideration. Additionally, at a minimum, BSPs (which include the restrictions) are renewed on an annual basis and submitted for HRC approval.</p>		

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W0264	<p>483.440(f)(3)(iii) <b>PROGRAM MONITORING &amp; CHANGE</b> The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, interview, and record review for 2 of 2 sample clients (clients A and B) and for two additional clients (clients C and D), the facility's HRC (Human Rights Committee) failed to ensure facility oversight for blanket restrictions for money, knives, forks, cleaning supplies, food, clothing, or nail polish.</p> <p>Findings include:</p> <p>On 2/20/12 at 6:12am, GHT (Group Home Trainer) #6 went to the medication area inside the laundry room with client C to complete medication administration. At 6:12am, GHT #6 retrieved her keys from her pocket, unlocked a lower cabinet, and removed wet wipes to wipe off the medication cart. Inside the locked lower cabinet were the laundry detergent, hand soap, Pine sol cleaner, toilet bowl cleaner, and bleach. GHT #6 stated the cabinet was "kept locked" and "only" staff</p>	W0264	<p><b>W264</b></p> <p>Blanket Restrictions – money, sharps, cleaning supplies, food, clothing, nail polish</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>All restrictions not approved by the IDT and HRC have been removed. Among the issues cited, only the sharps restriction, which was reconsidered and approved by the Individuals' IDTs, remains. It has provisions for each client to obtain access to sharps when needed and appropriate, such as at mealtime.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address</p>	03/30/2012			

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	<p>had access to the keys. At 6:12am, GHT #6 showed a locked upper cabinet that held nail polish belonging to clients A, B, C, and D. At 6:12am, GHT #6 stated the items were kept "locked" because of client behaviors.</p> <p>On 2/20/12 at 6:30 AM facility Group Home Trainer (GHT) #6 retrieved a knife from inside a locked kitchen cabinet and indicated knives were kept inside to secure knives. GHT #6 indicated and showed the locked cabinet held knives, butter knives, and forks and indicated the cabinet was kept locked. Observation inside the cabinet at that time showed there was a money lock box and a three holed paper punch kept with the sharp objects inside the locked cabinet. GHT #6 stated client A and B's bedroom closets were "also kept locked because of the client histories of harming themselves with their clothing."</p> <p>On 2/20/12 at 7:25 AM, client A was observed making toast for breakfast. Client A used a spoon to spread butter on her toast and no knife was offered or encouraged. From 7:25am until 8am, clients A, B, C, and D were observed to make toast and spread the butter with a spoon. No knife was offered or the use of a knife taught for clients A, B, C, and D by the facility staff.</p>		<p>the needs of all clients. Additionally, HRC procedures have changed and now require guardian approval with signature prior to consideration.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>Most restrictions removed, and staff will be trained on restrictions in place. This training will include not restricting things unless specifically listed in the BSP.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>The Behavior Clinician monitors restrictions and reports to the IDT. The IDT determines the need for restrictions. A new section will be added to the BC monthly report that is distributed to the team that monitors restrictions in place. Management staff complete home visit forms and will assist in monitoring restrictions, including sharps and whether clients have appropriate access during meal times. The Director supervises staff and reviews home review forms at regular staff meetings.</p>				

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	<p>On 2/20/12 at 7:45am, client A's bedroom closet in her room was noted to be locked. At 8am, GHT #2 opened client A's bedroom closet with a key she carried on a ring. In the locked closet were client A's clothing, stuffed animals, a fire truck, a belt, and a dresser. GHT #2 stated client A's closet was kept locked and "only" staff had keys because she could hurt herself with her clothing.</p> <p>On 2/20/12 at 8:10am, client B's bedroom closet was locked with a pad lock. Client B indicated the facility staff had the keys to her locked closet. At 8:10am, client B and GHT #1 indicated client B's clothing, clothes hangers, and her shoes were kept inside the secured closet.</p> <p>On 2/20/12 at 6:30am, two of two closets inside the facility living room were locked and GHT #6 indicated clients A, B, C, and D did not have access to the locked cabinet in the kitchen or the two living room closets. GHT #6 indicated the emergency food supply was in one locked living room closet and she was unsure of what was in the other closet.</p> <p>On 2/20/12 at 8:28 AM, Clients A and D approached a Group Home Trainer (GHT) and wanted to know how much money they had. The GHT told the clients they</p>			

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	<p>had to "wait until we get the key." On 2/20/12 at 8:37 AM, client A stated to another GHT #1, "I want my money." GHT #1 responded, "As soon as meds pass is done, so I can get the key." In an interview with the GHT #1 on 2/20/12 at 8:55 AM, GHT #1 stated the clients "didn't carry money" and stated the main reasons was "either [clients] lost or threw out" their money.</p> <p>On 2/20/12 at 4:55 PM, GHTs #7 and #8 were asked to identify what was kept inside the two locked living room closets. GHT #7 stated "It was extra food." GHT #7 was asked to open the doors. GHT #7 and GHT #8 tried to open the doors with a key, but were unsuccessful. GHT #7 attempted to open the doors but was not able to. GHT #2 suggested another key be tried, but even with another key that attempt to open the door was also unsuccessful.</p> <p>On 2/21/12 at 10:30am, client A's record was reviewed. No documentation was available for review that the HRC reviewed the blanket restriction regarding limited access to: a butter knife; fork; her money; her clothing; household supplies for cleaning; finger nail polish since client A's admission on 5/9/11.</p> <p>On 2/21/12 at 11:30am, client B's record</p>						

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	<p>was reviewed. Client B was admitted to the facility 5/11/11. Client B's 8/13/2010 "Consent of Current BSP (Behavior Support Plan) and "Restrictions" which included Sharps, Footwear, Acrylic nails, belts, and a padlock on the basement door for safety.</p> <p>On 2/20/12 at 10:25 AM, the Home Manager (HM) provided the facility's Human Rights Committee meeting minutes for review. No meeting minutes were available for review to ascertain if the facility's specially constituted committee had reviewed any of the restrictive practices.</p> <p>In a phone interview with the Qualified Mental Retardation Professional (QMRP) completed on 2/21/12 at 12:20 PM, the QMRP stated the facility had "no" policy identifying "all blanket restrictions" used at the facility. The QMRP stated there was no policy regarding restrictions and clients A, B, and D "all required restrictions" related to sharps. The QMRP indicated client C had no documented information available for review for sharp objects and indicated the lack of information regarding the sharps restrictions was an oversight.</p> <p>On 2/22/12 at 12:10pm, an interview with the Facility Director (FD) was completed.</p>						

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	<p>The FD indicated no HRC meeting minutes were available for review. The FD stated "several" of Human Rights Committee (HRC) approvals for restrictive practices and Behavior Support Plans (BSPs) had been obtained initially through e-mail correspondence. The FD indicated meetings including teleconferences were now in place. The FD stated medications in the same class or dosage changes did not require HRC review, but consents for "all" techniques used were obtained and reviewed by the committee.</p> <p>On 2/22/12 at 12:10 PM, an interview with the Behavior Specialist (BS) was completed. The BS indicated restrictions were identified as separate addendums to the Behavior Support Plans (BSP). The BS presented an addendum dated 4/8/11, 31 days before Client A's admission. The addendum indicated "Due to her history of SIB, physical and physical aggression sharps such as knives, forks scissors, etc. will be kept locked. [Client A] will have supervised access when needed for food preparation or engaging in craft activities." On 2/20/12 during the morning observations the facility GHTs did not offer a butter knife under supervision to client A at breakfast and there was no mention in the addendum documentation of any restrictions related</p>						

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	to money, clothing, food, cleaning supplies or finger nail polish.  9-3-4(a)				

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W0304	<p>483.450(d)(5) <b>PHYSICAL RESTRAINTS</b> Restraints must be designed and used so as not to cause physical injury to the client.</p> <p>Based on record review and interview, for 1 of 2 sample clients (client B) and one additional client (client C), the facility failed to ensure clients B and C were not injured during physical restraints applied by the facility staff.</p> <p>Findings include:</p> <p>On 2/20/12 at 11am, the facility's BDDS (Bureau of Developmental Disability Services) reports was completed and indicated the following injuries during restraint: For client B: -A 1/16/12 BDDS report for an incident on 1/16/12 no time, indicated client B bit herself, threw tables, and was hitting and spitting at staff. Staff used a "Mandt (a physical hold staff apply to a client) restraint to ensure safety," after client B was calm, client B complained of her thumb hurting. The report indicated client B's thumb was scratched, "swelling and discoloration (sic)." Client B was sent to the emergency room and given antibiotics.</p> <p>-A BDDS report on 11/11/11 for an incident on 11/10/11 at 4pm, indicated client B had behaviors, facility staff applied a "mandt" physical restraint, and after release client B complained of neck and shoulder pain. The report indicated client B was seen by her physician.</p> <p>For client C: -A BDDS report on 11/2/11 for an incident on 11/2/11 no time, indicated client C was scratched by GHT (Group Home Trainer) #9 during a physical restraint applied by the facility staff. -A BDDS report on 11/15/11 for an incident on</p>	W0304	<p><b>W304</b></p> <p>Injury during physical restraints</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>A certified trainer is providing specific training to staff on how to safely provide restraint without injuring clients. This includes proper hand placement to prevent bruising.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>Staff training will take place.</p>	03/30/2012			

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	<p>11/15/11 at 3:30pm, indicated staff used "Mandt physical restraint" because of client C's behaviors and client C sustained a bruise to her right pinkie.</p> <p>On 2/22/12 at 11:05am, an interview with the Facility Director (FD) was completed. The FD indicated the facility investigated injuries in restraint. The FD indicated there was no specific documentation to determine if the facility investigated if the restraints applied to clients B and C caused their injuries. The FD indicated the facility had taken systemic action in response to these incidents by; instituting case conferences in relation to the sentinel events; revising Behavior Support Plan (BSPs) in response to incidents; and trending the frequency of aggression caused by each of the clients. The FD indicated behaviors were continuing and increasing in rate. The FD indicated the behavior management intervention techniques employed were able to reduce the seriousness of injuries and most incidents were of a brief duration. The FD stated facility staff were trained on the use of "Mandt" techniques to apply the least restrictive measure. The FD indicated no documented evidence was available for review to determine if facility staff were monitored or retrained after the use of a restrictive technique which caused client injuries. The FD indicated no documented evidence was available for review to determine if the restraints applied caused the client injuries.</p> <p>9-3-5(a)</p>		<p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>All staff are supervised by the Group Home Manager who is responsible to ensure that staff receive proper training. The Manager is supervised by the Director. Training needs are reviewed during regular management team meetings.</p>				

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W0318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on observation, record review, and interview, the Condition of Participation: Health Care Services, was not met as the facility failed to provide health care monitoring and oversight of nursing services for 2 of 2 sample clients (clients A and B) and for two additional clients (clients C and D).</p> <p>Findings include:</p> <p>Please refer to W322. The facility failed to ensure clients A and B received routine health screening for pap smears for 2 of 2 sampled clients (clients A and B).</p> <p>Please refer to W323. The facility failed to ensure clients A and B's hearing had been assessed annually for 2 of 2 sampled clients (clients A and B).</p> <p>Please refer to W327. The facility failed to complete and to document tuberculosis control testing in millimeter duration for 1 of 2 sampled client (client B) and for one additional client (client D).</p> <p>Please refer to W336. The facility failed to complete nursing quarterlies for 2 of 2</p>	W0318	<p><b>W318</b> Condition of Health Care Services <b>Corrective action for resident(s) found to have been affected</b> A number of measures have been put into place to address cited deficiencies related to Health Care Services, which are detailed throughout the agency's Plan of Correction (including W322, W323, W327, W336, W351, W369, and W382). The group home's original Nurse and QMRP did not adequately coordinate treatment for clients, which was especially problematic for new admissions because of the many required assessments. Neither of those individuals still work for the agency. The nurse who took over healthcare coordination responsibilities spends significant time in the homes and works closely with clients, direct support staff members, and community providers. To correct cited deficiencies, the nurse coordinated with healthcare providers to obtain records that were missing and to schedule those assessments that were not completed on time. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially affected, and corrective measures address the needs of all clients. <b>Measures</b></p>	03/30/2012			

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	<p>sampled clients (clients A and B) and one additional client (client D).</p> <p>Please refer to W351. The facility failed to obtain a dental assessment which included a complete extraoral and intraoral dental examination for 1 of 2 sampled clients reviewed who were new admits to the facility (client B) within 30 days of their admission.</p> <p>Please refer to W369. The facility failed to assure medications were administered without error according to physician's orders for 3 of 20 medications administered (clients B and C).</p> <p>Please refer to W382. The facility failed to maintain proper medication security for 4 of 4 clients (clients A, B, C, and D),</p> <p>9-3-6(a)</p>		<p><b>or systemic changes facility put in place to ensure no recurrence</b> Nurse has coordinated with community healthcare providers to obtain missing records and schedule needed appointments. For future admissions, a new checklist of needed assessments was developed to ensure compliance with the 30-day requirement as well as on-going appointment needs (e.g., Dental every six months). The nurse also is revising and improving the home's record keeping to improve record retention and to provide easy access for review. <b>How corrective actions will be monitored to ensure no recurrence</b> The Group Home Nurse coordinates healthcare and is responsible to work with community health care providers to ensure appropriate on-going healthcare needs. The QMRP coordinates new admissions and monitors assessment needs. The Director supervises all management staff and will utilize a checklist of needed assessments during new admissions to ensure compliance with the 30-day requirement.</p>		

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W0322	<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, for 2 of 2 sampled clients (clients A and B), the facility failed to ensure clients A and B received routine health screening including a pap smear.</p> <p>Findings include:</p> <p>1. On 2/21/12 at 10:30am, client A's record was reviewed. Client A was a 25 year old female who was admitted to the facility on 5/9/11. The initial physical exam in the record for Client A was signed by a physician and dated 5/26/11. The exam was blank with a notation to "see attached notes." No notes were attached.</p> <p>In an interview with the facility's Licensed Practical Nurse (LPN) on 2/22/12 at 12:20 PM to ascertain when a complete physical exam had been completed for Client A, the LPN searched the record and found an mammogram exam that had been completed. Review of that exam did not identify whether a pap smear had ever been completed for Client A.</p> <p>2. On 2/21/12 at 11:30am, client B's</p>	W0322	<p><b>W322</b></p> <p>Routine physician care, including pap smear</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>One client had a pap smear in June of 2011, and another had one in July of 2011. The other two will have pap smears conducted by March 30, 2012, unless otherwise indicated by the community primary health care provider.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p>	03/30/2012	

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	<p>record was reviewed. Client B was a 23 year old female. Client B's 5/31/2011 physician's History and Physical signed by client B's personal physician did not include a pap smear. Client B was admitted to the facility on 5/18/11.</p> <p>On 2/22/12 at 12:20pm, an interview with the LPN (Licensed Practical Nurse) was completed. The LPN indicated client had no current pap smear available for review.</p> <p>9-3-6(a)</p>		<p>Pap smears will be conducted for the clients who need this. Due to performance issues such as not coordinating new admissions properly, the home's original QMRP no longer works for the agency. A highly experienced QMRP now works in the home and will ensure that new admissions have all the appropriate assessments within the 30-day requirement, including pap smears when indicated.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b> The Group Home Nurse coordinates healthcare and is responsible to work with community health care providers to ensure appropriate on-going healthcare needs. The QMRP coordinates new admissions and monitors assessment needs. The Director supervises all management staff and will utilize a checklist of needed assessments during new admissions to ensure compliance with the 30-day requirement.</p>		

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W0323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, for 2 of 2 sampled clients (clients A and B), the facility failed to ensure clients A and B's hearing had been assessed annually.</p> <p>Findings include:</p> <p>On 2/21/12 at 10:30am, client A's record was reviewed. Client A's 5/26/2011 physician's History and Physical signed by client A's personal physician did not include a hearing assessment. Client A was admitted to the facility on 5/9/11.</p> <p>On 2/21/12 at 11:30am, client B's record was reviewed. Client B's 5/31/2011 physician's History and Physical signed by client B's personal physician did not include hearing assessment. Client B was admitted to the facility on 5/18/11.</p> <p>On 2/22/12 at 12:20pm, an interview with the LPN (Licensed Practical Nurse) was completed. The LPN indicated clients A and B had no current hearing assessments available for review.</p> <p>9-3-6(a)</p>	W0323	<p><b>W323</b></p> <p>Annual physicals did not include hearing evaluation</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>Two of four clients had their hearing tested in June of 2011. The other two will have their hearing tested by March 30, 2012.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>Hearing will be tested for two</p>	03/30/2012	

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			<p>clients who need this. Due to performance issues such as not coordinating new admissions properly, the home's original QMRP no longer works for the agency. A highly experienced QMRP now works in the home and will ensure that new admissions have all the appropriate assessments within the 30-day requirement, including hearing assessment.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>The Group Home Nurse coordinates healthcare and is responsible to work with community health care providers to ensure appropriate on-going healthcare needs. The QMRP coordinates new admissions and monitors assessment needs. The Director supervises all staff and will utilize a checklist of needed assessments during new admissions to ensure compliance with the 30-day requirement.</p>		

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W0327	<p>483.460(a)(3)(iv) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both.</p> <p>Based on record review and interview, the facility failed to complete and to document tuberculosis control testing in millimeter duration for 1 of 2 sampled client (client B) and for one additional client (client D).</p> <p>Findings include:</p> <p>On 2/21/12 at 11:30am, client B's record was reviewed. Client B's 5/31/2011 physician's History and Physical signed by client B's personal physician did not include mantoux/tuberculosis control testing.</p> <p>On 2/22/12 at 9:30am, client D's record was reviewed. Client D's was admitted to the facility on 5/18/11. An immunization record was present and did not include information identifying the current mantoux/tuberculosis testing.</p> <p>On 2/22/12 at 12:20pm, an interview with the facility's Licensed Practical Nurse</p>	W0327	<p><b>W327</b> Annual physicals did not include a TB test <b>Corrective action for resident(s) found to have been affected</b> Two of four clients had TB tests in May of 2011. The other two will have TB tests completed by March 30, 2012. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> TB tests will be conducted for two clients who need this. Due to performance issues such as not coordinating new admissions properly, the home's original QMRP no longer works for the agency. A highly experienced QMRP now works in the home and will ensure that new admissions have all the appropriate assessments within the 30-day requirement, including a TB test. <b>How corrective actions will be monitored to ensure no recurrence</b> The</p>	03/30/2012			

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	<p>(LPN) was completed. The LPN indicated there was a new staff member who had been filing information in the client records and some records may not have yet been filed. The LPN indicated no current mantoux/tuberculosis control testing for clients B and D were available for review.</p> <p>On 2/22/12 at 12:20pm, an interview with the Facility Director (FD) was completed and the FD indicated no further information was available for review.</p> <p>9-3-6(a)</p>		<p>Group Home Nurse coordinates healthcare and is responsible to work with community health care providers to ensure appropriate on-going healthcare needs. The QMRP coordinates new admissions and monitors assessment needs. The Director supervises all staff and will utilize a checklist of needed assessments during new admissions to ensure compliance with the 30-day requirement.</p>		

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W0336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>Based on record review and interview, for 2 of 2 sampled clients (clients A and B) and for one additional client (client D), the facility failed to complete nursing quarterlies.</p> <p>Findings include:</p> <p>On 2/21/11 at 10:30am, client A's record was reviewed. Client A's record indicated she was admitted to the facility on 5/9/11. No quarterly nursing assessments were available for review from 5/9/11 through 2/21/12.</p> <p>On 2/21/12 at 11:30am, client B's record was reviewed and indicated no "Nursing Quarterly" assessments completed. Client B's record indicated she was admitted on 5/18/11. No nursing quarterly assessment was available for review from 5/18/11 through 2/21/12.</p> <p>On 2/22/12 at 9:30am, client D's record was reviewed. Client D was admitted to the facility on 5/18/11. No quarterly nursing assessments were available for</p>	W0336	<p><b>W336</b> Nursing quarterlies <b>Corrective action for resident(s) found to have been affected</b> Nursing quarterlies are being completed at this time. The most recent quarterlies were not in the chart at the time of survey. Nursing quarterlies will be presented to the IDT on a quarterly basis and placed in the chart as required. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> Nursing quarterlies will be written by the group home nurse, presented to the IDT on a quarterly basis, and placed in the appropriate chart as required. The nurse also is revising and improving the home's record keeping to enhance record retention and provide easy access for review. <b>How corrective actions will be monitored to ensure no recurrence</b> The group home nurse is a member of the IDT and creates a quarterly report that is</p>	03/30/2012	

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	<p>review from 5/18/11 through 2/22/12.</p> <p>On 2/22/12 at 12:20pm, an interview with the facility's Licensed Practical Nurse (LPN) was completed. The LPN indicated clients A, B, and D's nursing quarterly assessments had been completed and the LPN then searched the record. The LPN indicated she could not locate clients A, B, and D's quarterly assessments. The LPN indicated a new staff person at the facility had been filing documents and it was possible the quarterly documents had not yet been filed in the master records.</p> <p>9-3-6(a)</p>		presented to the team. The Director supervises the nurse.		

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W0351	<p>483.460(f)(1) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission).</p> <p>Based on record review and interview, the facility failed to obtain a dental assessment which included a complete extraoral and intraoral dental examination for 1 of 2 sampled clients reviewed who was a new admission to the facility (client B) within 30 days of their admission.</p> <p>Findings include:</p> <p>Client B's record was reviewed on 2/21/12 at 11:30am. Client B's record indicated she was admitted to the facility on 5/18/11. Client B's record indicated she had an initial dental examination on 9/8/11. Client B's record indicated the dental examination was not completed within 30 days of her admission to the facility.</p> <p>An interview with the facility LPN (Licensed Practical Nurse) was conducted on 2/22/12 at 12:10pm. The LPN indicated client B's dental examination</p>	W0351	<p><b>W351</b> Dental exam within 30 days of admission <b>Corrective action for resident(s) found to have been affected</b> Two of four clients had dental exams in May of 2011. Another had a dental exam in June of 2011. All four individuals will have a bi-annual dental exam scheduled by March 30, 2012. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> A dental exam will be conducted for all four clients. Due to performance issues such as not coordinating new admissions properly, the home's original QMRP no longer works for the agency. A highly experienced QMRP now works in the home and will ensure that new admissions have all the appropriate assessments within the 30-day requirement, including</p>	03/30/2012			

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	had not been completed within 30 days of her admission to the facility.  9-3-6(a)		a dental exam. <b>How corrective actions will be monitored to ensure no recurrence</b> The Group Home Nurse coordinates healthcare and is responsible to work with community health care providers to ensure appropriate on-going healthcare needs. The QMRP coordinates new admissions and monitors assessment needs. The Director supervises all staff and will utilize a checklist of needed assessments during new admissions to ensure compliance with the 30-day requirement.		

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W0369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview, the facility failed to assure medications were administered without error according to physician's orders for 3 of 20 medications administered (clients B and C).</p> <p>Findings include:</p> <p>1. On 2/20/12 at 7:36am, client B was observed eating breakfast with GHT (Group Home Trainer) #1 at the dining room table. At 8am, GHT #1 requested client B to come to the medication room. GHT #1 selected and administered client B's oral medications of "Omeprazole 20mg (milligrams) capsule, give 1 capsule orally once a day for GERD (stomach upset) 1 hour before meal, (and) Levothyroxine 25mg tablet, give 1 tablet orally once a day for Hypothyroidism." Client B's Levothyroxine medication had a pharmacy cautionary label which indicated "give on an empty stomach." GHT #1 handed the medications to client B and client B took the medications.</p> <p>Client B's record was reviewed on</p>	W0369	<p><b>W369</b></p> <p>POs and med administration</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>Staff members have been trained to follow Physician Orders (POs) precisely in order to correctly administer medications. The training included the three specific medications listed in the survey report and how to properly administer those, and it also addressed general need to follow the instructions from POs.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure</b></p>	03/30/2012			

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	<p>2/21/12 at 9:30am. Client B's 12/10/11 "Physician's Order" indicated "Omeprazole 20mg (milligrams) capsule, give 1 capsule orally once a day for GERD 1 hour before meal, (and) Levothyroxine 25mg tablet, give 1 tablet orally once a day for Hypothyroidism."</p> <p>2. On 2/20/12 at 7:05am, GHT #2 asked client D to come to the medication area. GHT #2 selected client D's "Polyethylene Glycol 3350 give 17 grams dissolved in 6oz (ounces) fluid orally every morning for constipation." GHT #2 unscrewed the gray measuring cap covering the white medication cap from the container at one time. GHT #2 turned the combined lids upward on the medication cart, two lines for medication measuring could be seen on the inside of the gray cap, and the white medication cap could be seen inside the gray measuring cap. GHT #2 measured client D's Polyethylene Glycol medication inside the two (2) caps to the first line on the gray cap. At 8am, the agency nurse was present at the group home and indicated client D did not have the correct amount of medication. The agency nurse stated as she read the instructions on the Polyethylene Glycol bottle "If using the one cap method the first line on the gray cap should be used. If using the two cap method, one lid inside the other cap, then the second line</p>		<p><b>no recurrence</b></p> <p>Staff were trained on specific medications cited (Levothyroxine, Omeprazole, and Polyethylene Glycol) as well as a more general instruction to precisely follow POs. Additionally, the Group Home Nurse will conduct an audit of all MARs in order to ensure that all POs are properly represented on them.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>The Group Home Nurse coordinates healthcare and is responsible for medication administration training. The Director supervises the Group Home Nurse.</p>		

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	<p>(top line) should be used to measure 17 grams." At 7:30am, client D's 2/2012 MAR indicated "Polyethylene Glycol 3350 give 17 grams dissolved in 6oz fluid every morning."</p> <p>Client D's record was reviewed on 2/21/12 at 9:30am. Client D's 12/12/11 "Physician's Order" indicated "Polyethylene Glycol 3350 give 17 grams dissolved in 6oz fluid every morning."</p> <p>On 2/21/12 at 9:30am, the agency LPN (Licensed Practical Nurse) was interviewed. The LPN indicated the facility followed core A/core B guidelines for medication administration. The LPN indicated the staff did not follow the physician's orders for client B's medications to be given on an empty stomach. The LPN indicated the facility staff did not follow client D's physician's order to give 17 grams of medication. The LPN indicated the three medications were given in error.</p> <p>On 2/21/12 at 9:20am, a record review of the facility's 5/8/2008 "Medication Administration" policy and procedure was completed. The policy indicated staff were to administer medications according to physician's order and pharmacy cautionary labels.</p>						

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	On 2/21/12 at 9:20am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated the pharmacy cautionary labels should be followed.  9-3-6(a)						

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W0382	<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 observation, record review, and interview, for 4 of 4 clients (clients A, B, C, and D) who lived in the group home, the facility failed to maintain proper medication security.</p> <p>Findings include:</p> <p>On 2/20/12 at 8am GHT (Group Home Trainer) #1 with client B entered the medication room. At 8am, GHT #1 removed the medication keys from his pocket, unlocked the medication cart, and administered client B's medication from the medication cart. At 8:10am, client B sat inside the medication room, GHT #1 left the room, and left the medication cart keys dangling from the open lock in the lock to the medication cart. From 8:10am, until 8:13am, client B was in the medication room with the unlocked medication cart and the unsecured medications for clients A, B, C, and D. At 8:13am, GHT #1 returned to the medication room and indicated he left the keys dangling from the open lock on the medication cart.</p> <p>On 2/21/12 at 9:30am, the agency LPN</p>	W0382	<p>W382 Medications Locked</p> <p>Corrective action for resident(s) found to have been affected</p> <p>Staff will be retrained in the need to keep medications locked when not being administered.</p> <p>How facility will identify other residents potentially affected &amp; what measures taken</p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>Staff training.</p> <p>How corrective actions will be monitored to ensure no recurrence</p>	03/30/2012			

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	<p>(Licensed Practical Nurse) indicated the facility followed Core A/Core B policy and procedures for administering medications.</p> <p>On 2/21/12 at 9:20am, the facility's 5/8/2008 policy and procedure "Medication Administration" indicated medications should have been secured except when administered.</p> <p>On 2/21/12 at 9:20am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated "Core Lesson 3: Principles of Administering Medication" indicated medications should be kept secured.</p> <p>9-3-6(a)</p>		<p>The nurse trains staff in safe medication storage. Management staff complete home visit forms and will assist in monitoring program implementation, including the proper locking of medications during medication pass. The Director supervises management staff and reviews home visit forms at regular staff meetings.</p>		

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W0436	<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 2 of 2 sample clients (clients A and B) and one additional client (client D) who used adaptive devices, the facility failed to ensure a youth sized spoon was used in accordance with the individual program plan for client A and failed to teach and encourage clients B and D to wear their prescribed eye glasses.</p> <p>Findings include:</p> <p>1. On 2/20/12 at 7:30am, client A was observed preparing breakfast. Client A made oatmeal and toast. Client A independently prepared her oatmeal by pouring the oat contents from a container into a bowl, placing water in a bowl, and then placing the bowl in a microwave. Client A fed herself the oatmeal with a tablespoon.</p>	W0436	<p><b>W436</b></p> <p>Use of devices, including a "youth sized" spoon and eyeglasses</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>Updated dysphasia and dining plans to reflect that regular sized teaspoon was to be used by Client A. These plans were trained to staff and also differentiated teaspoons from serving spoons. Encouraging eyeglass wearing and cleaning has been added to the MAR in order to effectively and accurately track their use.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p>	03/30/2012			

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	<p>On 2/21/12 at 10:30am, client A's record was reviewed. Client A's 6/8/11 "Choking Management Plan" outlined instructions for staff to encourage the use of a "youth sized spoon." Client A was not provided a youth sized spoon at breakfast on 2/20/12 as outlined in the plan.</p> <p>2. On 2/20/12 from 6am until 8:57am, and on 2/20/12 from 3:35pm until 6:35pm, observation was completed at the group home, client B read a magazine, read her medication labels, and client B was not observed to wear her prescribed eye glasses.</p> <p>Client B's record was reviewed on 2/21/12 at 11:30am. Client B had a 9/26/11 Vision evaluation which indicated client B had prescribed eye glasses.</p> <p>3. On 2/20/12 at 7:40am, Client D was observed in the kitchen trying to make toast. Client D hovered over the toaster, bent at the waist to lean her body over the toaster, looking downward closely into</p>		<p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>Changes to dysphasia and dining plans, staff training, and changes to the MAR were completed.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>The QMRP monitors program development and implementation. Management staff complete home visit forms and will assist in monitoring program implementation, including the proper use of spoons and eyeglasses. The Director supervises management staff and reviews home visit forms at regular staff meetings.</p>				

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	<p>the toaster slots trying to insert bread.</p> <p>Throughout additional morning observations from 6am until 9:15 AM, client D was not observed wearing eye glasses. On 2/20/12 at 4:00 PM, client D was observed in the residence until 6:15 PM. and did not wear eye glasses.</p> <p>Client D's record was reviewed on 2/22/12 at 9:30 AM. Client D's 11/29/11 physician orders indicated client D should have eye glasses with an additional notation to "clean glasses every morning."</p> <p>On 2/23/12 at 9:30am, the HM indicated she did not know clients B and D wore eye glasses.</p> <p>9-3-7(a)</p>						

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W0440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based on interview and record review, for 4 of 4 clients (clients A, B, C, and D) living in the group home, the facility failed to ensure evacuation drills were conducted every ninety (90) days for each shift of personnel.</p> <p>Findings include:</p> <p>The facility evacuation drills for clients A, B, C, and D were reviewed on 2/21/12 at 11:00 AM and indicated the following: -Evacuation drills for first shift personnel- on 5/25/11 at 1:35 PM, on 6/16/11 at 2:45 PM, and on 2/21/12 at 10:00 AM. No evacuation drills were available for review from 6/16/11 until 2/21/12. -Evacuation drills for second shift personnel- on 5/21/11 at 4:00 PM and on 7/23/11 at 7:00 PM. No evacuation drills were available for review from 7/23/11 through 2/21/12. -Evacuation drills for third shift personnel- on 5/25/11 at 6:49 AM; on 6/1/11 at 12:05 AM and on 6/11/11 at</p>	W0440	<p><b>W440</b></p> <p>Quarterly evacuation drills</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>Evacuation drills will be conducted for each shift.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>Evacuation drills will be conducted across shifts, and a new drill schedule will be put in place to ensure that they continue to be conducted in the future.</p>	03/30/2012			

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	<p>11:08 PM. No evacuation drills were available for review from 6/1/11 through 2/21/12.</p> <p>On 2/21/12 at 11am, an interview with the Licensed Practical Nurse (LPN) at that time who presented the drills indicated no other evacuation drills were available for review.</p> <p>On 2/22/12 at 12pm, an interview with the Home Manager (HM) and Facility Director was completed. The HM indicated the Team Leader was responsible for conducting evacuation drills and the drills were the HM's responsibility. Both indicated no additional evacuation drills were available for review.</p> <p>On 2/29/12 at 2pm, an interview with the Facility Director (FD) was completed. The FD indicated the first shift personnel was 7am until 3pm, the second shift of personnel was 3pm until 11pm, and the third shift of personnel was 11pm until 7am. The FD indicated clients A, B, C, and D lived in the group home.</p> <p>9-3-7(a)</p>		<p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>The Group Home Manager is responsible to ensure that drills are conducted as required. The Director supervises the Group Home Manager.</p>				

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W0484	<p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation, interview, and record review, for 1 of 2 sample clients (client A) and for one additional client (client D) who lived in the facility, the facility failed to provide and teach the use of dining utensils.</p> <p>Findings include:</p> <p>1. On 2/20/12 from 6:30am until 7:30am, client A was observed preparing breakfast. Client A made oatmeal and toast. Client A independently prepared her oatmeal by pouring the oat contents from a container into a bowl, placing water in a bowl, and then placing the bowl in a microwave. Client A placed two pieces of bread in a toaster, client A used a tablespoon to spread butter on the toast. Client A was not offered a butter knife to spread butter on her toast as the knives were locked in a kitchen cabinet. Client A fed herself the oatmeal with the tablespoon.</p>	W0484	<p><b>W484</b> Use of dining utensils <b>Corrective action for resident(s) found to have been affected</b> The IDT met and decided that all four women need to have sharps restrictions in place. The sharps restrictions stem from safety rather than because the women do not actually know how to use utensils to eat. Therefore, training goals are not needed. The restrictions allow access for appropriate use of dining utensils during meal time. This includes knives and forks. The sharps restrictions will be trained to staff to ensure that all clients have appropriate access and can use utensils appropriately. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> IDT met and discussed the need for sharps restrictions. It was decided that they do. The sharps restrictions will be trained to staff members, including how and when access to sharps is provided. This</p>	03/30/2012	

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	<p>An interview with the Team Leader (TL) was completed on 2/20/12 at 7:56 AM. The TL stated clients in the home did not have access to knives, clients "only" used tablespoons.</p> <p>On 2/20/12 at 4pm, an interview with the Home Manager (HM) and Group Home Trainer (GHT) #7 was completed. The HM and GHT #7 both indicated client A was prohibited from using a butter knife at any meals, the HM indicated sharps as described earlier in the day by the TL included butter knives and forks and those were kept locked in the kitchen cabinet. GHT #7 stated "all" clients were given a full set of utensils at meals.</p> <p>Client A's record was reviewed on 2/21/12 at 10:30 AM. Client A's 6/8/11 "Choking Management Plan" outlined instructions for to encourage the use of a "youth sized spoon." Client A was not provided a youth sized spoon at breakfast on 2/20/12 as outlined in the plan.</p> <p>2. During observation on 2/20/12 at 7:40am, client D placed two slices of</p>		<p>includes meal times. <b>How corrective actions will be monitored to ensure no recurrence</b>The Behavior Clinician monitors restrictions and reports to the IDT. The IDT determines the need for restrictions. A new section will be added to the BC monthly report that is distributed to the team that monitors restrictions in place. Management staff complete home visit forms and will assist in monitoring restrictions, including sharps and whether clients have appropriate access during meal times. The Director supervises management staff and reviews home visit forms at regular staff meetings.</p>				

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	<p>toast in the toaster. Client D was observed to use a tablespoon to scoop peanut butter from a jar, spread the peanut butter on the two slices of toast, and no butter knife was encourage or accessible for client D to use.</p> <p>Client D's record was reviewed on 2/23/12 at 9:30am. Client D's record indicated she had the skill to use a knife. Client D's record indicated the identified need for safety when using a knife or sharp objects.</p> <p>In a phone interview with the Qualified Mental Retardation Professional (QMRP) on 2/21/12 at 12:20 PM, the QMRP indicated client D had a documented need for the restriction from use of sharp objects and indicated client D could not use knives.</p> <p>9-3-8(a)</p>				