

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G303	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/29/2014
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 12736 EVAN LN AURORA, IN 47001
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W000000	<p>This visit was for the investigation of complaint #IN00147450.</p> <p>Complaint #IN00147450: Substantiated, Federal and state deficiencies related to the allegations are cited at W102, W104, W122, W149, W157, W186 and W249.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: May 15, 16 and 29, 2014.</p> <p>Facility Number: 000822 Provider Number: 15G303 AIM Number: 100243630</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/5/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview, the facility failed to meet the</p>	W000102	<p>PROVIDER IDENTIFICATION #: 15G303</p> <p>NAME OF PROVIDER:</p>	06/17/2014

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

TITLE

(X6) DATE

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

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	<p>Condition of Participation: Governing Body for 4 of 4 sample clients (A, B, C and D) and 4 additional clients (E, F, G and H). The governing body failed to exercise general policy and operating direction over the facility to prevent the neglect of clients B, C, D, G and H in regard to staff sleeping while on duty, to ensure the investigation of neglect included a specific plan of corrective oversight to include how the facility staff would be monitored to prevent reoccurrence in regard to staff neglect and staff sleeping while on duty for all clients living at the group home (clients A, B, C, D, E, F, G and H) and to ensure sufficient direct care staff were provided to supervise and care for clients A, B, C, D, E, F, G and H throughout the day to meet the clients' needs.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to prevent the neglect of clients B, C, D, G and H in regard to staff sleeping while on duty and to ensure the investigation of the neglect included a specific plan of corrective oversight to include how the facility staff would be monitored in regard to neglect and staff sleeping while on duty for all clients living at the group home to prevent recurrence of the neglect for clients A, B, C, D, E, F, G and H and to ensure sufficient direct care staff to supervise and care for clients A, B, C, D, E, F, G and H throughout the day to meet the</p>		<p>RESCARE COMMUNITY ALT., SOUTH CENTRAL ADDRESS: 127736 Evan Lane, Aurora, Indiana 47001 SURVEY EVENT ID #: T17611</p> <p>DATE SURVEY COMPLETED: 5/29/2014</p> <p>PROVIDER'S PLAN OF CORRECTION</p> <p><u>W102: Governing Body and Management:</u> <u>The Facility must ensure that specific governing body and management requirements are met</u></p> <p>Corrective action:</p> <ul style="list-style-type: none"> ·Sleeping staff suspended for neglect immediately. ·Investigation completed. <p><u>(ATTACHMENT A)</u></p> <ul style="list-style-type: none"> ·Staff terminated. ·Plan of corrective oversight developed. <u>(ATTACHMENT B)</u> ·Corrective oversight plan trained and implemented. <p><u>(ATTACHMENT C)</u></p> <ul style="list-style-type: none"> ·Schedule for this location had been updated to reflect 1 staff to 4 consumers during all waking hours. <u>(ATTACHMENT D)</u> ·The facility will train/in-service all staff at this location on policies and procedures concerning client neglect and abuse, the definition of all types of abuse including verbal abuse, emotional abuse, intimidation and psychological abuse <u>(ATTACHMENT E&C)</u> 				

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	<p>clients' needs. Please see W104.</p> <p>2. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for clients A, B, C, D, E, F, G and H. The governing body failed to prevent the neglect of clients B, C, D, G and H in regard to staff sleeping while on duty, to ensure the investigation included corrective/preventive measures to prevent recurrence of neglect in regard to staff sleeping for the clients living in the group home (A, B, C, D, E, F, G and H) and to ensure sufficient direct care staff were provided to supervise and care for clients A, B, C, D, E, F, G and H throughout the day to meet the clients' needs. Please see W122.</p> <p>This federal tag relates to complaint #IN00147450.</p> <p>9-3-1(a)</p>		<p>·The facility will train/in-service all staff at this location on policies and procedures concerning client rights and protections. <u>(ATTACHMENT A)</u></p> <p>How we will identify others:</p> <p>·RM will conduct monthly staff meetings and address all scheduling, oversight compliance, continuing education and training as needed for policy and procedure. <u>(ATTACHMENT A&E)</u></p> <p>·All documentation for oversight compliance visits will be submitted as laid out in the attached plan. <u>(ATTACHMENT B&F)</u></p> <p>·All schedules will be submitted to CS, and PM before being implemented.</p> <p>Measures to be put in place:</p> <p>·The Clinical Supervisor will ensure all staff have been trained on client's rights and protections, and have been trained on abuse and neglect. <u>(ATTACHMENT C)</u></p> <p>·Oversight procedure implemented effective 6/13/2014 To ongoing</p> <p>·Monthly staff training to include attendance and call off procedures to ensure staffing ratios is met. <u>(ATTACHMENT C)</u></p> <p>Monitoring of Corrective Action:</p> <p>·Clinical Supervisor, Program Manager, and or appropriate parties will conduct Quarterly Best in Class reviews, and periodic reviews to ensure all policies and</p>				

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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), the governing body failed to exercise general policy and operating direction over the facility to prevent neglect of clients B, C, D, G and H in regard to staff sleeping while on duty, to ensure the investigation of the neglect included a specific plan of corrective oversight of how the facility staff would be monitored in regard to neglect and staff sleeping for clients A, B, C, D, E, F, G and H and to ensure sufficient direct care staff to supervise and care for clients A, B, C, D, E, F, G and H throughout the day to meet the clients' needs.</p>	W000104	<p>procedures are being followed. ·Program Manager and Appropriate Parties will review all oversight compliance checks to determine ongoing need. Completion Date: June 28, 2014</p> <p>- - - W104: Governing Body: <u>The governing body must exercise general policy, budget, and operating direction over the facility.</u> Corrective action: ·Sleeping staff suspended for neglect immediately. ·Investigation completed. (ATTACHMENT A) ·Staff terminated. ·Plan of corrective oversight developed. (ATTACHMENT B) ·Corrective oversight plan trained and implemented. (ATTACHMENT C) ·Schedule for this location had been updated to reflect 1 staff to 4 consumers during all waking hours. (ATTACHMENT D)</p>	06/17/2014			

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	<p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to prevent the neglect of clients B, C, D, G and H in regard to staff sleeping while on duty, to ensure the investigation of the neglect included a specific plan of corrective oversight to include how the facility staff would be monitored to prevent reoccurrence in regard to neglect and staff sleeping while on duty for clients A, B, C, D, E, F, G and H and to ensure sufficient direct care staff to supervise and care for clients A, B, C, D, E, F, G and H throughout the day to meet the clients' needs. Please see W149.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the investigation of neglect included a specific plan of corrective oversight to include how the staff would be monitored to prevent reoccurrence of neglect in regard to staff sleeping while on duty for all clients living at the group home (clients A, B, C, D, E, F, G and H). Please see W157.</p> <p>3. The governing body failed to exercise general policy and operating direction</p>		<p>·The facility will train/inserve all staff at this location on policies and procedures concerning client neglect and abuse, the definition of all types of abuse including verbal abuse, emotional abuse, intimidation and psychological abuse <u>(ATTACHMENT E&C)</u></p> <p>·The facility will train/inserve all staff at this location on policies and procedures concerning client rights and protections. <u>(ATTACHMENT A)</u></p> <p>How we will identify others:</p> <p>·RM will conduct monthly staff meetings and address all scheduling, oversight compliance, continuing education and training as needed for policy and procedure. <u>(ATTACHMENT A&E)</u></p> <p>·All documentation for oversight compliance visits will be submitted as laid out in the attached plan. <u>(ATTACHMENT B&F)</u></p> <p>·All schedules will be submitted to CS, and PM before being implemented.</p> <p>Measures to be put in place:</p> <p>·The Clinical Supervisor will ensure all staff have been trained on client's rights and protections, and have been trained on abuse and neglect. <u>(ATTACHMENT C)</u></p> <p>·Oversight procedure implemented effective 6/13/2014 To ongoing</p> <p>·Monthly staff training to include attendance and call off procedures to ensure staffing ratios is met. <u>(ATTACHMENT C)</u></p>				

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W000122	<p>over the facility to ensure sufficient direct care staff to supervise and care for clients A, B, C, D, E, F, G and H. Please see W186.</p> <p>This federal tag relates to complaint #IN00147450.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H). The facility failed to implement their abuse/neglect policy to prevent the neglect of clients B, C, D, G and H in regard to staff sleeping while on duty. The facility failed to ensure the investigation of the neglect included a specific plan of corrective oversight to</p>	W000122	<p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> ·Clinical Supervisor, Program Manager, and or appropriate parties will conduct Quarterly Best in Class reviews , and periodic reviews to ensure all policies and procedures are being followed. ·Program Manager and Appropriate Parties will review all oversight compliance checks to determine ongoing need. <p>Completion Date: June 28, 2014</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p><u>W122: Client Protections:</u> <u>The facility must ensure that specific client protections are met.</u></p> <p>-</p> <p>Corrective action:</p> <ul style="list-style-type: none"> ·Sleeping staff suspended for neglect immediately. ·Investigation completed. <p><u>(ATTACHMENT A)</u></p> <ul style="list-style-type: none"> ·Staff terminated. ·Plan of corrective oversight developed. <u>(ATTACHMENT B)</u> ·Corrective oversight plan trained and implemented. 	06/17/2014	

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	<p>include how the facility staff would be monitored to prevent reoccurrence of neglect for all clients living in the group home (clients A, B, C, D, E, F, G and H) and the facility failed to provide sufficient direct care staff to supervise and care for clients A, B, C, D, E, F, G and H throughout the day to meet the clients' needs.</p> <p>Findings include:</p> <p>1. The facility failed to implement their abuse/neglect policy to prevent the neglect of clients B, C, D, G and H in regard to staff sleeping while on duty, to ensure the investigation of the neglect included a specific plan of corrective oversight to include how the staff would be monitored to prevent reoccurrence in regard to neglect and staff sleeping while on duty for all clients living at the group home (clients A, B, C, D, E, F, G and H) and to ensure sufficient direct care staff to supervise and care for clients A, B, C, D, E, F, G and H throughout the day to meet the clients' needs. Please see W149.</p> <p>2. The facility failed to ensure the investigation of neglect included a specific plan of corrective oversight to include how the staff would be monitored to prevent reoccurrence of neglect in regard to staff sleeping while on duty for</p>		<p><u>(ATTACHMENT C)</u></p> <ul style="list-style-type: none"> ·Schedule for this location had been updated to reflect 1 staff to 4 consumers during all waking hours. <u>(ATTACHMENT D)</u> ·The facility will train/inserve all staff at this location on policies and procedures concerning client neglect and abuse, the definition of all types of abuse including verbal abuse, emotional abuse, intimidation and psychological abuse <u>(ATTACHMENT E&C)</u> ·The facility will train/inserve all staff at this location on policies and procedures concerning client rights and protections. <u>(ATTACHMENT A)</u> <p>How we will identify others:</p> <ul style="list-style-type: none"> ·RM will conduct monthly staff meetings and address all scheduling, oversight compliance, continuing education and training as needed for policy and procedure. <u>(ATTACHMENT A&E)</u> ·All documentation for oversight compliance visits will be submitted as laid out in the attached plan. <u>(ATTACHMENT B&F)</u> ·All schedules will be submitted to CS, and PM before being implemented. <p>Measures to be put in place:</p> <ul style="list-style-type: none"> ·The Clinical Supervisor will ensure all staff have been trained on client's rights and protections, and have been trained on abuse and neglect. <u>(ATTACHMENT C)</u> ·Oversight procedure implemented effective 6/13/2014 				

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W000137	<p>all clients living at the group home (clients A, B, C, D, E, F, G and H). Please see W157.</p> <p>3. The facility failed to provide sufficient direct care staff to supervise and care for the clients throughout the day to meet the clients' needs for clients A, B, C, D, E, F, G and H. Please see W186.</p> <p>This federal tag relates to complaint #IN00147450.</p> <p>9-3-2(a)</p> <p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation and interview for 1 additional client (F), the facility failed to ensure client F was dressed appropriately when going out into the community.</p> <p>Findings include:</p> <p>Observations were conducted at the</p>	W000137	<p>To ongoing</p> <ul style="list-style-type: none"> ·Monthly staff training to include attendance and call off procedures to ensure staffing ratios is met. <u>(ATTACHMENT C)</u> <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> ·Clinical Supervisor, Program Manager, and or appropriate parties will conduct Quarterly Best in Class reviews , and periodic reviews to ensure all policies and procedures are being followed. ·Program Manager and Appropriate Parties will review all oversight compliance checks to determine ongoing need. <p>Completion Date: June 28, 2014</p> <p><u>W137: Protection of client right</u> <u>The facility must ensure the rights of all clients. Therefore, the facility must ensure that the clients have the right to retain and use appropriate personal possessions and clothing.</u></p> <p>- Corrective action:</p>	06/17/2014			

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	<p>group home on 5/15/14 between 4:30 PM and 7 PM. During this observation period client F was observed eating her evening meal which consisted of lasagna, bread sticks, salad and canned fruit.</p> <p>__At 4:57 PM client F retrieved her plate of lasagna from the kitchen counter, took it to the dining room table, sat down and began eating. Client F spilled some of the lasagna on the front of her T-shirt while eating, leaving red stains on her T-shirt.</p> <p>__By 5:10 PM client F had finished eating. Client F got up from the table and went to her bedroom to lie down. Client F did not change or put on a clean T-shirt.</p> <p>__At 6:30 PM staff #1 was preparing to take clients B, F and G on a van ride. Client F still had lasagna stains on the front of her T-shirt. Prior to walking out the door to go on the van ride this surveyor asked DCS (Direct Care Staff) #1 if client F was going to change her shirt prior to leaving the group home since it was stained with lasagna. DCS #1 stated, "Oh, it is stained." The CS (Clinical Supervisor) was standing nearby and stated, "No, unless you want her to have a behavior." The CS then asked client F, "Do you want to change your shirt?" Client F stated, "Yes" and went to her bedroom and put on a clean top.</p>		<p>The facility will train/inserve all staff at this location on policies and procedures concerning client neglect and abuse, the definition of all types of abuse including verbal abuse, emotional abuse, intimidation and psychological abuse <u>(ATTACHMENT E&C)</u></p> <p>The facility will train/inserve all staff at this location on policies and procedures concerning client rights and protections. <u>(ATTACHMENT A)</u></p> <p>RM will conduct monthly staff meetings and address all scheduling, oversight compliance, continuing education and training as needed for policy and procedure including BSP information and appropriate dress. <u>(ATTACHMENT A&C)</u></p> <p>How we will identify others:</p> <p>RM will conduct monthly staff meetings and address all scheduling, oversight compliance, continuing education and training as needed for policy and procedure including BSP information and appropriate dress. <u>(ATTACHMENT A&C)</u></p> <p>Staff will be trained that all clients are to wear clean and appropriate clothing at all times and when participating in activities in the community. <u>(ATTACHMENT C)</u></p> <p>Measures to be put in place:</p> <p>RM to conduct monthly staff trainings including, but not limited</p>				

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W000149	<p>During interview with the CS on 5/15/14 at 6:40 PM, the CS stated client F "will usually have a behavior if you ask her to change her clothes like that. I'm really surprised she didn't." The CS indicated the clients were to wear clean and unstained clothes when leaving the group home to go out into the community.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 4 of 4 sampled clients (A, B, C and D) and 4 additional clients (E, F, G and H), the facility failed to implement written policy and procedures to prevent the neglect of clients B, C, D, G and H in regard to staff sleeping while on duty, to ensure the investigation of the neglect included a specific plan of corrective oversight to include how the</p>	W000149	<p>to appropriate dress, BSP issues, abuse and neglect. <u>(ATTACHMENT E)</u> Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> ·Clinical Supervisor, Program Manager, and or appropriate parties will conduct Quarterly Best in Class reviews, and periodic reviews to ensure all policies and procedures are being followed. ·Program Manager and Appropriate Parties will review all oversight compliance checks to determine ongoing need. <p>Completion Date: June 28, 2014</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p><u>W149: Staff treatment of clients:</u> <u>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of the client.</u></p> <p>-</p> <p>Corrective action:</p> <ul style="list-style-type: none"> ·Sleeping staff suspended for neglect immediately. ·Investigation completed. 	06/17/2014	

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	<p>facility staff would be monitored to prevent reoccurrence in regard to neglect and staff sleeping while on duty for clients A, B, C, D, E, F, G and H and to ensure sufficient direct care staff to supervise and care for clients A, B, C, D, E, F, G and H throughout the day to meet the clients' needs.</p> <p>Findings include:</p> <p>1. The facility's reportable and investigative records were reviewed on 5/15/14 at 12:30 PM. A 4/6/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 4/5/14 at 7 PM upon arrival the facility LPN noticed client C in front of the group home and the front door to the group home open. The report indicated when the LPN entered the group home, DCS (Direct Care Staff) #3 was "apparently asleep on the couch" and client H was in the living room watching television. The report indicated the LPN notified the CS (Clinical Supervisor) and DCS #3 was suspended pending investigation. The report indicated a "Plan to Resolve (Immediate and Long Term): [Clients D and G] were in their rooms at the time of this incident and neither [clients C, D, G nor H experienced any negative effects from this incident. Staff to receive training on client rights and client</p>		<p><u>(ATTACHMENT A)</u></p> <ul style="list-style-type: none"> ·Staff terminated. ·Plan of corrective oversight developed. <u>(ATTACHMENT B)</u> ·Corrective oversight plan trained and implemented. <p><u>(ATTACHMENT C)</u></p> <ul style="list-style-type: none"> ·Schedule for this location had been updated to reflect 1 staff to 4 consumers during all waking hours. <u>(ATTACHMENT D)</u> ·The facility will train/inserve all staff at this location on policies and procedures concerning client neglect and abuse, the definition of all types of abuse including verbal abuse, emotional abuse, intimidation and psychological abuse <u>(ATTACHMENT E&C)</u> ·The facility will train/inserve all staff at this location on policies and procedures concerning client rights and protections. <p><u>(ATTACHMENT A)</u></p> <ul style="list-style-type: none"> ·Active treatment observation will be completed 2x weekly by RM, or appropriate parties. <p><u>(ATTACHMENT H)</u></p> <ul style="list-style-type: none"> ·All Active treatment documentation will be submitted to CS weekly. <p>How we will identify others:</p> <ul style="list-style-type: none"> ·RM will conduct monthly staff meetings and address all scheduling, oversight compliance, continuing education and training as needed for policy and procedure. <u>(ATTACHMENT A&E)</u> ·All documentation for oversight compliance visits will be 				

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	<p>protections to avoid future incidents of this nature."</p> <p>A 4/12/14 investigative report indicated an interview with the facility LPN. The interview indicated "She [the LPN] stated that she got to the group home on 4/5/14 at about 5 minutes till 7:00 pm. She (the LPN) stated that [client C] was walking down the driveway and when she saw [name of LPN] she (client C) turned around and came up to her van. [Name of LPN] stated that she was speaking with [client C] outside and was using a fairly loud voice. She stated that she asked [client C] what she was doing and why she was in the driveway and [client C] said she didn't know. [Name of LPN] stated that [client C] then said to leave her alone and [name of LPN] entered the group home. [Name of LPN] stated that she noticed that the front door was open and the med room door was open and that two of the desk drawers were open. She stated that she announced herself and said 'hello' really loud and did not receive an answer from anyone. She stated that she walked into the living room and saw [name of DCS #3] lying on her stomach under a blanket snoring softly. [Name of LPN] stated that she called [name of DCS #3's] name, saying '[Name of DCS #3] you need to wake up' and there was no response so [name of LPN] shook</p>		<p>submitted as laid out in the attached plan. <u>(ATTACHMENT B&F)</u></p> <ul style="list-style-type: none"> All schedules will be submitted to CS, and PM before being implemented. <p>Measures to be put in place:</p> <ul style="list-style-type: none"> The Clinical Supervisor will ensure all staff have been trained on client's rights and protections, and have been trained on abuse and neglect. <u>(ATTACHMENT C)</u> Oversight procedure implemented effective 6/13/2014 To ongoing Monthly staff training to include attendance and call off procedures to ensure staffing ratios is met. <u>(ATTACHMENT C)</u> <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> Clinical Supervisor, Program Manager, and or appropriate parties will conduct Quarterly Best in Class reviews, and periodic reviews to ensure all policies and procedures are being followed. Program Manager and Appropriate Parties will review all oversight compliance checks to determine ongoing need. <p>Completion Date: June 28, 2014</p>				

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	<p>[name of DCS #3's] foot gently and she awoke with a start. [Name of LPN] stated that she asked [name of DCS #3] if she was the only staff on duty and if she was clocked in and [name of DCS #3] said yes to both. [Name of LPN] stated the she told [name of DCS #3] that she cannot sleep while on the clock and [name of DCS #3] apologized and said it was an accident. [Name of LPN] stated that she told [name of DCS #3] that when [name of LPN] came in that [client C] was down the driveway and that it smelled like [client G] might have had a bowel movement. She stated that [name of DCS #3] got up and tended to [client G]. [Name of LPN] stated that [client H] came into the office to talk to [name of LPN] and to tell [name of LPN] that [client H] was unhappy that staff was sleeping because [client H] was out of cigarettes and staff was supposed to take [client H] to the store and she hadn't. [Name of LPN] asked [client H] if she had noticed if [name of DCS #3] had been asleep for long or if she had just fallen asleep. [Name of LPN] stated that [client H] was not good at measuring time and [client H] said it had been awhile. [Name of LPN] stated that she went into the office and contacted [name of CS] and explained to her what had happened. [Name of LPN] stated that they decided an incident report would be</p>			
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	<p>the best way to address it and after the incident report was written she kept [name of the CS] on the phone an (sic) asked [name of DCS #3] to come into the office. [Name of LPN] stated that she explained again to [name of DCS #3] that she couldn't sleep while at work, then had [name of DCS #3] read the incident report and asked [name of DCS #3] to sign it if she agreed to the events as [name of LPN] had written them. [Name of LPN] stated that [name of DCS #3] read it and signed it...."</p> <p>The investigative records indicated client D tried to "tap" DCS #3's face to wake her and [DCS #3] stated, "I'm sleeping." The investigative records indicated when client D was asked if she had seen staff sleeping, client D stated, "yes." The records indicated client D cried throughout the interview. The investigative records indicated the allegation of neglect "is substantiated that [DCS #3] was asleep while on duty.... Based on verbal statements of individuals and staff it is substantiated that [DCS #3] neglected [clients B, C, D, G and H] by falling asleep while being the only staff on duty." The investigative record indicated no specific plan of corrective oversight and/or how the facility would be monitored to prevent the neglect from reoccurrence.</p>			

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	<p>The follow up BDDS report dated 4/23/14 indicated "Through investigation the allegation of neglect was verified and the staff was terminated. As preventative measures all staff to receive training on client rights and client protections. Supervisory staff will continue to provide active treatment observation as further preventative measures." The facility records indicated no documentation of administrative and/or supervisory staff observations and/or monitoring.</p> <p>The facility LPN was interviewed on 5/16/14 at 3 PM.</p> <p>__The LPN indicated she drove up the driveway to the group home on 4/5/14 and found client C walking down the driveway to the road. The LPN stated the group home drive way was "very steep and dangerous" and the facility had put up a wooden hand rail along the sidewalk as a protective measure because of the "steep hill" in the front of the group home.</p> <p>__The LPN stated client C "usually doesn't go all the way down the driveway without staff being with her. She (client C) said she was going for a walk that day and I believe she would have walked right onto the road if I hadn't come along."</p> <p>__The LPN indicated upon entering the</p>			
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	<p>group home on 4/5/14 the doors to the group home and the medication door were open. The LPN stated DCS #3 was lying on the couch, face down "on her stomach and a blanket on top of her" and "there was a smell of feces." The LPN indicated client G was in her bedroom and had been incontinent of a bowel movement. The LPN stated, "She (DCS #3) had intent to sleep."</p> <p>The CS/QIDP (Clinical Supervisor/Qualified Intellectual Disabilities Professional) was interviewed on 5/16/14 at 3 PM.</p> <p>__The CS stated client G required close supervision due to food seeking behaviors and "has to be watched like a toddler." The CS stated client G would "grab anything, hot food on the stove or food out of the refrigerator it didn't matter to her (client G)." The CS indicated there was an alarm on client G's bedroom door to alarm the staff whenever client G came out of her bedroom.</p> <p>__The CS indicated prior to client A's admission to the facility on 4/28/14 the facility staffing ratio was one staff to four clients. The CS stated now with client A "I need to increase the staffing to two."</p> <p>__When asked how the facility monitors the staff to ensure staff were not sleeping while on duty, the CS stated, "We don't</p>						

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	<p>have an official plan to monitor if that's what you're asking. I'm here a lot since our staffing levels are down and I also text the night shift staff throughout the night to make sure she's awake and everything's ok."</p> <p>__The CS indicated no documentation of administrative monitoring of the group home in regard to the incident of neglect on 4/5/14.</p> <p>__The CS stated "to my knowledge" the facility did not develop and/or implement a plan of protective oversight to monitor the staff in the group home to ensure no further neglect due to staff sleeping while on duty for clients living in the group home (clients A, B, C, D, E, G, G and H).</p> <p>2. Observations were conducted at the group home on 5/15/14 between 4:30 PM and 7 PM. Upon entering the group home at 4:30 PM there were two staff and the CS/QIDP (Clinical Supervisor/Qualified Intellectual Disabilities Professional) with clients A, B, C, D, E, F, G, and H.</p> <p>__Client A was in a wheel chair and used her arms to maneuver the wheelchair independently throughout the group home. Client A's feet did not touch the floor and her legs dangled without support from the wheelchair. Client A's knees were red and callused. Client A was incontinent of feces and urine during this observation period and required two</p>			

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	<p>staff to assist her with getting cleaned up and changed. Client A required staff assistance with all her basic ADLs (Adult Daily Living Skills).</p> <p>__ Client G walked around the group home, sat curled up in a recliner in the living room and/or lay in her bed periodically sucking her thumb throughout the observation period. Client G required staff assistance with all of her basic ADLs. During the evening meal client G grabbed at food on the stove and required one staff to one client supervision while eating. Client G had an alarm on her bedroom door.</p> <p>Client A's record was reviewed on 5/16/14 at 11 AM. Client A ' s record indicated diagnoses of, but not limited to, Cerebral Palsy (a disorder of posture, muscle tone and movement resulting from brain damage) and Dysphasia (difficulty swallowing). Client A's ISP (Individual Support Plan) of 4/28/14 indicated client A ambulated with the aid of a "Merry Walker" (a type of rolling walker) and a wheel chair with staff assistance getting up and down. The ISP indicated client A required staff assistance with all ADLs. Client A's ISP indicated client A was at risk for aspiration and choking and was to be supervised while eating.</p>				

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	<p>Client E's record was reviewed on 5/16/14 at 12:30 PM. Client E's ISP of 1/20/14 indicated client E was legally blind in the right eye. Client E's record indicated diagnoses of, but not limited to, blindness and Cerebral Palsy. Client E's record indicated client E required staff assistance with all ADLs.</p> <p>Client G's record was reviewed on 5/16/14 at 1:30 PM. Client G's record indicated diagnoses of, but not limited to, Autism and Impaired hearing. Client G's record indicated client G was non-verbal and had a history of stealing food/drinks, stuffing her mouth and chugging fluids. Client G's ISP of 9/23/13 indicated client G required staff assistance for all ADLs.</p> <p>Interview with DCS #2 on 5/15/14 at 6 PM indicated client G had to be watched whenever there was food out or whenever she was in the kitchen because client G would grab hot food off the stove or uncooked food in the refrigerator and eat it. DCS #2 indicated when the staff were preparing the frozen bread sticks for the evening meal on 5/15/14, client G grabbed one of the frozen bread sticks from the baking pan and ate it before the staff saw her and could stop her. DCS #2 stated due to client G's behaviors, client A's physical needs and the needs of the other clients, "It's really hard for just two</p>			

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	<p>of us to do it all."</p> <p>The facility LPN was interviewed on 5/16/14 at 3 PM.</p> <p>__The LPN indicated she drove up the driveway to the group home on 4/5/14 and found client C walking down the driveway to the road. The LPN stated the group home drive way was "very steep and dangerous" and the facility had put up a wooden hand rail along the sidewalk as a protective measure because of the "steep hill" in the front of the group home.</p> <p>__The LPN stated client C "usually doesn't go all the way down the driveway without staff being with her. She (client C) said she was going for a walk that day and I believe she would have walked right onto the road if I hadn't come along." The LPN indicated client C required staff supervision while outside in the driveway and/or walking past the driveway.</p> <p>__The LPN indicated there was one staff in the group home at that time to supervise four clients.</p> <p>The CS/QIDP (Clinical Supervisor/Qualified Intellectual Disabilities Professional) was interviewed on 5/16/14 at 3 PM. The CS stated client G required close supervision due to food seeking behaviors and "has to</p>			
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	<p>be watched like a toddler." The CS stated client G would "grab anything, hot food on the stove or food out of the refrigerator it didn't matter to her (client G)." The CS indicated there was an alarm on client G's bedroom door to alarm the staff whenever client G came out of her bedroom.</p> <p>__The CS indicated client A required staff assistance getting in and out of the bed, the wheelchair and the facility van. The CS indicated the facility had a wheelchair accessible van, but to get all eight clients in the van with client A in her wheelchair, they would have to remove the back seat of the van and to do that, they would not be able to get eight clients on the van. The CS stated the staff "have been picking her (client A) up out of her wheel chair and lifting her into the van." The CS stated client A required "two to three staff to get her on the van." The CS stated she had asked for a Hoyer (a mechanical lift) to be provided to assist the staff in getting client A in and out of her wheelchair and bed, "But I was told I couldn't have one."</p> <p>__The CS indicated prior to client A's admission to the facility on 4/28/14 the facility staffing ratio was one staff to four clients. The CS stated now with client A "I need more staff." The CS stated the facility had currently terminated an employee for sleeping and another</p>			

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W000157	<p>employee recently quit and she was having to pull from her other group homes to "try to fill" the vacancies. The CS indicated one staff worked the overnight shift and two staff worked the evening shift. The CS indicated client A required two staff to shower/bathe her. The CS indicated with two staff assisting client A in the bathroom, clients B, C, D, E, F, G and H were left unsupervised and unassisted.</p> <p>__The CS stated she had been trying to fill in as much as possible, but "I can't be here all the time." The CS stated "We need three staff in the evenings and I have asked for a second staff for the night shift because of [client A]."</p> <p>This federal tag relates to complaint #IN00147450.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 1 of 2 allegations of abuse/neglect reviewed, the facility failed to ensure the investigation of the neglect included a specific plan of corrective oversight to</p>	W000157	<p><u>W157: Staff treatment of Clients:</u> <u>If the alleged violation is verified, appropriate action must be taken.</u></p> <p>-</p>	06/17/2014			

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	<p>include how the facility staff would be monitored to prevent reoccurrence in regard to neglect and staff sleeping while on duty for all clients living at the group home (clients A, B, C, D, E, F, G and H).</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 5/15/14 at 12:30 PM. A 4/6/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 4/5/14 at 7 PM upon arrival the facility LPN noticed client C in front of the group home and the front door to the group home open. The report indicated when the LPN entered the group home, DCS (Direct Care Staff) #3 was "apparently asleep on the couch" and client H was in the living room watching television. The report indicated the LPN notified the CS (Clinical Supervisor) and DCS #3 was suspended pending investigation. The report indicated a "Plan to Resolve (Immediate and Long Term): [Clients D and G] were in their rooms at the time of this incident and neither [clients C, D, G nor H experienced any negative effects from this incident. Staff to receive training on client rights and client protections to avoid future incidents of this nature."</p> <p>A 4/12/14 investigative report indicated</p>		<p>Corrective action:</p> <ul style="list-style-type: none"> ·Sleeping staff suspended for neglect immediately. ·Investigation completed. <p><u>(ATTACHMENT A)</u></p> <ul style="list-style-type: none"> ·Staff terminated. ·Plan of corrective oversight developed. <u>(ATTACHMENT B)</u> ·Corrective oversight plan trained and implemented. <p><u>(ATTACHMENT C)</u></p> <ul style="list-style-type: none"> ·Schedule for this location had been updated to reflect 1 staff to 4 consumers during all waking hours. <u>(ATTACHMENT D)</u> ·The facility will train/inservice all staff at this location on policies and procedures concerning client neglect and abuse, the definition of all types of abuse including verbal abuse, emotional abuse, intimidation and psychological abuse <u>(ATTACHMENT E&C)</u> ·The facility will train/inservice all staff at this location on policies and procedures concerning client rights and protections. <p><u>(ATTACHMENT A)</u></p> <ul style="list-style-type: none"> ·Active treatment observation will be completed 2x weekly by RM, or appropriate parties. <p><u>(ATTACHMENT H)</u></p> <ul style="list-style-type: none"> ·All Active treatment documentation will be submitted to CS weekly. <p>How we will identify others:</p> <ul style="list-style-type: none"> ·RM will conduct monthly staff meetings and address all scheduling, oversight compliance, continuing education and training 				

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	<p>an interview with the facility LPN. The interview indicated "She [the LPN] stated that she got to the group home on 4/5/14 at about 5 minutes till 7:00 pm. She (the LPN) stated that [client C] was walking down the driveway and when she saw [name of LPN] she (client C) turned around and came up to her van. [Name of LPN] stated that she was speaking with [client C] outside and was using a fairly loud voice. She stated that she asked [client C] what she was doing and why she was in the driveway and [client C] said she didn't know. [Name of LPN] stated that [client C] then said to leave her alone and [name of LPN] entered the group home. [Name of LPN] stated that she noticed that the front door was open and the med room door was open and that two of the desk drawers were open. She stated that she announced herself and said 'hello' really loud and did not receive an answer from anyone. She stated that she walked into the living room and saw [name of DCS #3] lying on her stomach under a blanket snoring softly. [Name of LPN] stated that she called [name of DCS #3's] name, saying '[Name of DCS #3] you need to wake up' and there was no response so [name of LPN] shook [name of DCS #3's] foot gently and she awoke with a start. [Name of LPN] stated that she asked [name of DCS #3] if she was the only staff on duty and if she was</p>		<p>as needed for policy and procedure. <u>(ATTACHMENT A&E)</u> ·All documentation for oversight compliance visits will be submitted as laid out in the attached plan. <u>(ATTACHMENT B&F)</u> ·All schedules will be submitted to CS, and PM before being implemented.</p> <p>Measures to be put in place: ·The Clinical Supervisor will ensure all staff have been trained on client's rights and protections, and have been trained on abuse and neglect. <u>(ATTACHMENT C)</u> ·Oversight procedure implemented effective 6/13/2014 To ongoing ·Monthly staff training to include attendance and call off procedures to ensure staffing ratios is met. <u>(ATTACHMENT C)</u></p> <p>Monitoring of Corrective Action: ·Clinical Supervisor, Program Manager, and or appropriate parties will conduct Quarterly Best in Class reviews, and periodic reviews to ensure all policies and procedures are being followed. ·Program Manager and Appropriate Parties will review all oversight compliance checks to determine ongoing need.</p> <p>Completion Date: June 28, 2014</p>				

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	<p>clocked in and [name of DCS #3] said yes to both. [Name of LPN] stated the she told [name of DCS #3] that she cannot sleep while on the clock and [name of DCS #3] apologized and said it was an accident. [Name of LPN] stated that she told [name of DCS #3] that when [name of LPN] came in that [client C] was down the driveway and that it smelled like [client G] might have had a bowel movement. She stated that [name of DCS #3] got up and tended to [client G]. [Name of LPN] stated that [client H] came into the office to talk to [name of LPN] and to tell [name of LPN] that [client H] was unhappy that staff was sleeping because [client H] was out of cigarettes and staff was supposed to take [client H] to the store and she hadn't. [Name of LPN] asked [client H] if she had noticed if [name of DCS #3] had been asleep for long or if she had just fallen asleep. [Name of LPN] stated that [client H] was not good at measuring time and [client H] said it had been awhile. [Name of LPN] stated that she went into the office and contacted [name of CS] and explained to her what had happened. [Name of LPN] stated that they decided an incident report would be the best way to address it and after the incident report was written she kept [name of the CS] on the phone an (sic) asked [name of DCS #3] to come into the</p>			

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	<p>office. [Name of LPN] stated that she explained again to [name of DCS #3] that she couldn't sleep while at work, then had [name of DCS #3] read the incident report and asked [name of DCS #3] to sign it if she agreed to the events as [name of LPN] had written them. [Name of LPN] stated that [name of DCS #3] read it and signed it...."</p> <p>The investigative records indicated client D tried to "tap" DCS #3's face to wake her and [DCS #3] stated, "I'm sleeping." The investigative records indicated when client D was asked if she had seen the staff sleeping, client D stated, "yes." The records indicated client D cried throughout the interview. The investigative records indicated the allegation of neglect "is substantiated that [DCS #3] was asleep while on duty.... Based on verbal statements of individuals and staff it is substantiated that [DCS #3] neglected [clients B, C, D, G and H] by falling asleep while being the only staff on duty." The investigative record indicated no plan of corrective oversight and/or how the facility was to be monitored to prevent the neglect from reoccurrence.</p> <p>The follow up BDDS report dated 4/23/14 indicated "Through investigation the allegation of neglect was verified and</p>						

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	<p>the staff was terminated. As preventative measures all staff to receive training on client rights and client protections. Supervisory staff will continue to provide active treatment observation as further preventative measures." The facility records indicated no documentation of administrative and/or supervisory staff observations and/or monitoring. The facility records indicated no specific plan of correction to include how the facility was to monitor the clients and staff to prevent further incidents of neglect in regard to staff sleeping while on duty.</p> <p>The CS/QIDP (Clinical Supervisor/Qualified Intellectual Disabilities Professional) was interviewed on 5/15/14 at 3 PM. When asked how the facility monitored the clients and staff to ensure staff were not sleeping while on duty, the CS stated, "We don't have an official plan to monitor if that's what you're asking. I'm here a lot since our staffing levels are down and I also text the night shift staff throughout the night to make sure she's awake and everything's ok." The CS indicated no documentation of administrative monitoring of the group home in regard to the incident of neglect on 4/5/14. The CS stated "to my knowledge" the facility did not develop and/or implement a plan of protective</p>						

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W000186	<p>oversight to monitor the staff in the group home to ensure no further neglect due to staff sleeping while on duty for clients living in the group home (clients A, B, C, D, E, F, G and H).</p> <p>This federal tag relates to complaint #IN00147450.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (A, B, C and D) and 4 additional clients (E, F, G and H), the facility failed to provide sufficient direct care staff to supervise and care for the clients throughout the day to meet the clients' needs.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 5/15/14 between 4:30 PM</p>	W000186	<p>W186: Direct Care Staff The facility must provide sufficient direct care staff to manage and supervise clients in accordance with Their individual program plans. Corrective action:</p> <ul style="list-style-type: none"> ·Sleeping staff suspended for neglect immediately. ·Investigation completed. <p>(ATTACHMENT A)</p> <ul style="list-style-type: none"> ·Staff terminated. ·Plan of corrective oversight developed. (ATTACHMENT B) ·Corrective oversight plan 	06/17/2014			

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	<p>and 7 PM. Upon entering the group home at 4:30 PM there were two staff and the CS/QIDP (Clinical Supervisor/Qualified Intellectual Disabilities Professional) with clients A, B, C, D, E, F, G, and H.</p> <p>__ Client A was in a wheel chair and used her arms to maneuver the wheelchair independently throughout the group home. Client A's feet did not touch the floor and her legs dangled without support from the wheelchair. Client A's knees were red and callused. Client A was incontinent of feces and urine during this observation period and required two staff to assist her with getting cleaned up and changed. Client A required staff assistance with all her basic ADLs (Adult Daily Living Skills).</p> <p>__ Client G walked around the group home, sat curled up in a recliner in the living room and/or lay in her bed periodically sucking her thumb throughout the observation period. Client G required staff assistance with all of her basic ADLs. During the evening meal client G grabbed at food on the stove and required one staff to one client supervision while eating. Client G had an alarm on her bedroom door.</p> <p>Client A's record was reviewed on 5/16/14 at 11 AM. Client A ' s record indicated diagnoses of, but not limited to, Cerebral Palsy (a disorder of posture,</p>		<p>trained and implemented.</p> <p><u>(ATTACHMENT C)</u></p> <ul style="list-style-type: none"> ·Schedule for this location had been updated to reflect 1 staff to 4 consumers during all waking hours. <u>(ATTACHMENT D)</u> ·The facility will train/inserve all staff at this location on policies and procedures concerning client neglect and abuse, the definition of all types of abuse including verbal abuse, emotional abuse, intimidation and psychological abuse <u>(ATTACHMENT E&C)</u> ·The facility will train/inserve all staff at this location on policies and procedures concerning client rights and protections. <u>(ATTACHMENT A)</u> ·Active treatment observation will be completed 2x weekly by RM, or appropriate parties. <u>(ATTACHMENT H)</u> ·All Active treatment documentation will be submitted to CS weekly. <p>How we will identify others:</p> <ul style="list-style-type: none"> ·RM will conduct monthly staff meetings and address all scheduling, oversight compliance, continuing education and training as needed for policy and procedure. <u>(ATTACHMENT A&E)</u> ·All documentation for oversight compliance visits will be submitted as laid out in the attached plan. <u>(ATTACHMENT B&F)</u> ·All schedules will be submitted to CS, and PM before being implemented. <p>Measures to be put in place:</p>	

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	<p>muscle tone and movement resulting from brain damage) and Dysphasia (difficulty swallowing). Client A's ISP (Individual Support Plan) of 4/28/14 indicated client A ambulated with the aid of a "Merry Walker" (a type of rolling walker) and a wheel chair with staff assistance getting up and down. The ISP indicated client A required staff assistance with all ADLs. Client A's ISP indicated client A was at risk for aspiration and choking and was to be supervised while eating.</p> <p>Client E's record was reviewed on 5/16/14 at 12:30 PM. Client E's ISP of 1/20/14 indicated client E was legally blind in the right eye. Client E's record indicated diagnoses of, but not limited to, blindness and Cerebral Palsy. Client E's record indicated client E required staff assistance with all ADLs.</p> <p>Client G's record was reviewed on 5/16/14 at 1:30 PM. Client G's record indicated diagnoses of, but not limited to, Autism and Impaired hearing. Client G's record indicated client G was non-verbal and had a history of stealing food/drinks, stuffing her mouth and chugging fluids. Client G's ISP of 9/23/13 indicated client G required staff assistance for all ADLs.</p> <p>Interview with DCS #2 on 5/15/14 at 6</p>		<ul style="list-style-type: none"> ·The Clinical Supervisor will ensure all staff have been trained on client's rights and protections, and have been trained on abuse and neglect. <u>(ATTACHMENT C)</u> ·Oversight procedure implemented effective 6/13/2014 To ongoing ·Monthly staff training to include attendance and call off procedures to ensure staffing ratios is met. <u>(ATTACHMENT C)</u> <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> ·Clinical Supervisor, Program Manager, and or appropriate parties will conduct Quarterly Best in Class reviews, and periodic reviews to ensure all policies and procedures are being followed. ·Program Manager and Appropriate Parties will review all oversight compliance checks to determine ongoing need. <p>Completion Date: June 28, 2014</p>		

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	<p>PM indicated client G had to be watched whenever there was food out or whenever she was in the kitchen because client G would grab hot food off the stove or uncooked food in the refrigerator and eat it. DCS #2 indicated when the staff were preparing the frozen bread sticks for the evening meal on 5/15/14, client G grabbed one of the frozen bread sticks from the baking pan and ate it before the staff saw her and could stop her. DCS #2 stated due to client G's behaviors, client A's physical needs and the needs of the other clients, "It's really hard for just two of us to do it all."</p> <p>The facility LPN was interviewed on 5/16/14 at 3 PM.</p> <p>__The LPN indicated she drove up the driveway to the group home on 4/5/14 and found client C walking down the driveway to the road. The LPN stated the group home drive way was "very steep and dangerous" and the facility had put up a wooden hand rail along the sidewalk as a protective measure because of the "steep hill" in the front of the group home.</p> <p>__The LPN stated client C "usually doesn't go all the way down the driveway without staff being with her. She (client C) said she was going for a walk that day and I believe she would have walked right onto the road if I hadn't come</p>			

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	<p>along." The LPN indicated client C required staff supervision while outside in the driveway and/or walking past the driveway.</p> <p>__The LPN indicated there was one staff in the group home at that time to supervise four clients.</p> <p>The CS/QIDP (Clinical Supervisor/Qualified Intellectual Disabilities Professional) was interviewed on 5/16/14 at 3 PM. The CS stated client G required close supervision due to food seeking behaviors and "has to be watched like a toddler." The CS stated client G would "grab anything, hot food on the stove or food out of the refrigerator it didn't matter to her (client G)." The CS indicated there was an alarm on client G's bedroom door to alarm the staff whenever client G came out of her bedroom.</p> <p>__The CS indicated client A required staff assistance getting in and out of the bed, the wheelchair and the facility van. The CS indicated the facility had a wheelchair accessible van, but to get all eight clients in the van with client A in her wheelchair, they would have to remove the back seat of the van and to do that, they would not be able to get eight clients on the van. The CS stated the staff "have been picking her (client A) up out of her wheel chair and lifting her into the</p>			

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	<p>van." The CS stated client A required "two to three staff to get her on the van." The CS stated she had asked for a Hoyer (a mechanical lift) to be provided to assist the staff in getting client A in and out of her wheelchair and bed, "But I was told I couldn't have one."</p> <p>__The CS indicated prior to client A's admission to the facility on 4/28/14 the facility staffing ratio was one staff to four clients. The CS stated now with client A "I need more staff." The CS stated the facility had currently terminated an employee for sleeping and another employee recently quit and she was having to pull from her other group homes to "try to fill" the vacancies. The CS indicated one staff worked the overnight shift and two staff worked the evening shift. The CS indicated client A required two staff to shower/bathe her. The CS indicated with two staff assisting client A in the bathroom, clients B, C, D, E, F, G and H were left unsupervised and unassisted.</p> <p>__The CS stated she had been trying to fill in as much as possible, but "I can't be here all the time." The CS stated "We need three staff in the evenings and I have asked for a second staff for the night shift because of [client A]."</p> <p>This federal tag relates to complaint #IN00147450.</p>						

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W000249	<p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION 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, record review and interview for 4 of 4 sampled clients (A, B, C and D) and 3 additional clients (E, F and G), the facility failed to ensure the staff implemented the clients' program plans and dining plans when formal and informal training opportunities existed.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 5/15/14 between 4:30 PM and 7 PM. Upon entering the group home at 4:30 PM there were two staff and the CS/QIDP (Clinical Supervisor/Qualified Intellectual Disabilities Professional) with eight clients.</p> <p>__ Client A was in a wheel chair and used her arms to maneuver the wheelchair independently throughout the group home. Client A's feet did not touch the</p>	W000249	<p>W249: Program Implementation As soon as the interdisciplinary team has formulated a client's individual program plan each client must receive a continuous active treatment program plan 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>Corrective action:</p> <ul style="list-style-type: none"> ·Client A will be evaluated by OT/PT for wheelchair needs. (ATTACHMENT C) ·Client G's plan was reviewed for leisure choices and staff trained utilize all opportunities for training. (ATTACHMENT C) ·Family Style dining/ Active treatment inserviced for all staff. (ATTACHMENT C) ·Abuse/Neglect; dignity/respect/privacy issues 	06/17/2014

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	<p>floor and her legs dangled without support from the wheelchair. Client A's knees were red and callused. Client A required staff assistance with all of her basic ADLs (Adult Daily Living Skills).</p> <p>__ Client G walked around the group home, sat curled up in her recliner in the living room, lay in her bed and periodically sucked her thumb during this observation period. Client G required staff assistance with all of her basic ADLs.</p> <p>__ During this observation period, the staff prepared the meal with minimal client assistance. The evening meal consisted of lasagna, spinach, bread sticks, salad and canned fruit. Once the food was prepared, it was placed on the kitchen counter near the sink.</p> <p>__ At 4:40 PM client A came out of the bathroom, sitting in her wheelchair and no clothes on. Client A was incontinent of urine and feces. Client A went back into the bathroom, leaving the bathroom door open behind her. The CS saw client A trying to get up out of her wheelchair and stated, "Sit back down before you fall. [DCS #1 and #2] will be here in a second to help you get cleaned up."</p> <p>__ At 4:45 PM clients B, C, D, E, F, G and H were sitting at the two dining room tables. The CS spooned out a portion of lasagna and placed one portion per client on each plate. Client H walked to the</p>		<p>inserviced. <u>(ATTACHMENT C)</u></p> <ul style="list-style-type: none"> ·Staff trained to utilize given opportunities to train with individuals on privacy issues. <u>(ATTACHMENT C)</u> ·Staff trained on all individuals dining plans; including training objectives; individual diets; monitoring of the meal. <u>(ATTACHMENT C)</u> ·Staff trained on utilizing natural opportunities for training concerning meal prep and clean up and active treatment. <u>(ATTACHMENT C)</u> ·Staff trained on ensuring all individuals wear clean and appropriate clothing at all times. <u>(ATTACHMENT C)</u> ·All behavior plans reviewed; staff inserviced to contact nurse for signs of change or issues. <u>(ATTACHMENT C)</u> ·All staff inserviced on individuals need to remain up after meals and meds for a minimum of 30 minutes. <u>(ATTACHMENT C)</u> <p>How we will identify others:</p> <ul style="list-style-type: none"> ·All individuals will be assessed upon admission to services, quarterly, and annually, <u>(ATTACHMENT G,I,J)</u> ·All staff will receive continuing education in the form of monthly staff meetings to review changes or needed information. <u>(ATTACHMENT E)</u> ·All staff will receive annual training on Abuse and neglect, dignity, respect, active treatment, privacy, and rights. 		

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	<p>kitchen counter retrieved her plate and returned to the dining room table to eat. The CS prompted client B to come get her plate of food and at the same time, client E asked, "Can I come get mine?" The CS stated, "You can be next." ___ At 4:53 PM DCS #1 and #2 came out of the bathroom with client A. Client C came up to the kitchen counter to get her plate of food and returned to the dining room table to sit down and began eating. ___ At 4:55 PM the CS filled client G's plate, took it to her and sat it down at the table in front of her. Client G immediately began eating. The CS sat down beside client G. ___ At 4:57 PM client F retrieved her plate from the kitchen counter, took it to the dining room table and sat down. Client F then poured a large amount of parmesan cheese on top of the lasagna and looked around to see if anyone was watching her and then proceeded to dump more parmesan cheese on her food. Client F had finished her lasagna by 5 PM and was eating her bread stick. Client F took large bites and ate at a fast pace. ___ At 5 PM staff #2 placed a serving of lasagna, a bread stick and water in the blender and pureed the food together. Staff #2 then placed the pureed mixture of food onto a plate and sat the plate down on the table in front of client A. ___ At 5:05 PM the CS received a phone</p>		<p>Measures to be put in place: ·QDIP to complete annual assessments. (ATTACHMENT G) ·QDIP to complete quarterly reviews. (ATTACHMENT J) ·QDIP to amend and update programming as indicated by individual need. ·RM to conduct monthly trainings for all staff. (ATTACHMENT C) Monitoring of Corrective Action: Clinical Supervisor to review and approve all programming completed by QDIP. Clinical supervisor will review and sign off on all quarterly reviews. ·Clinical Supervisor, Program Manager, and or appropriate parties will conduct Quarterly Best in Class reviews, and periodic reviews to ensure all policies and procedures are being followed. Completion Date: 6/28/2014</p>		

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	<p>call. The CS got up from the table and walked into the medication room, leaving client G unsupervised while eating. Client G took large bites of food, ate at a fast pace and used her fingers to eat when not supervised. Client E finished her meal, got up from the table and took her dishes to the sink while staff #2 rinsed the dishes and put them in the dishwasher.</p> <p>__At 5:07 PM the CS returned from her phone call and prompted client G to use her spoon and to take smaller bites. The CS wiped client G's hands with the clothing protector on her chest.</p> <p>__At 5:10 PM client G had finished her meal and sat at the table sucking her thumb. Staff #2 sat down at the end of the table beside client A while eating a few bites of lasagna. Client C asked for and was given a second helping of lasagna. Staff #1 asked client C, "Do you want another bread stick?" Client C shook her head to indicate no.</p> <p>__At 5:12 PM client B was finished eating and sitting in the living room watching television. Client G was assisted to take her plate to the kitchen sink after eating. While doing so, client G grabbed for a bread stick off of the pan on the stove.</p> <p>__At 5:15 PM client C had finished eating and got up from the table to take her dishes to the sink. The front of her</p>			

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	<p>pants was wet. Staff #1 indicated client C was incontinent of urine and was going to the bathroom to change her adult brief. Client D sat alone at one table in the dining room finishing her meal while client A sat alone at another table. Staff #1 and #2 were busy cleaning up the kitchen, doing dishes and putting the food away. Client E stated, "I'm gonna go lay down for a little bit." Staff prompted client E to take the trash out prior to lying down. Client E took out the trash and then went to her bedroom to lie down.</p> <p>__At 5:20 PM client D finished eating and took her dishes to the sink. At 5:24 PM client D was in her bedroom lying down.</p> <p>__Clients C, D, E, F and G all went to bed right after eating their evening meal.</p> <p>__At 5:25 PM client A had finished her meal. Client A went to her bedroom.</p> <p>__At 5:30 PM client A came out of her bedroom, both knees were bright reddish purple in color. The CS stated, "She must have been on the floor again. She slides out of her wheel chair down to the floor and crawls around on the floor on her hands and knees."</p> <p>__At 6:30 PM staff #1 was preparing to take clients B, F and G on a van ride. Client C came out of her bedroom and stated, "I want to go." Client C was prompted to change her clothes prior to leaving. Client F had lasagna on the front</p>			
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	<p>of her T-shirt. When asked if client F was going to change prior to leaving the house, the CS stated, "Yes, she can if you want her to have a behavior." The CS asked client F, "Do you want to change your shirt?" Client F stated, "Yes" and went to her bedroom and put on a clean top.</p> <p>At 6:50 PM clients D, G and E were in their beds. Client D was lying across her bed crying, her face red, tears coming down her cheek. When asked what was wrong, the client indicated she was upset. The CS stated, "She's been doing that a lot lately."</p> <p>The staff did not include the clients in the meal preparation and did not directly supervise the clients while eating. The staff did not prompt clients A, C, D, E, F and G to put their spoon down between bites, to slow their pace of eating, to take smaller bites, to take a drink between bites and/or to swallow before taking another bite and/or each time the clients took a bite. The staff did not provide the clients with training objectives and/or choices of leisure time activities when opportunity was available.</p> <p>Client A's record was reviewed on 5/16/14 at 11 AM. Client A's ISP (Individual Support Plan) of 4/28/14 indicated client A was at risk for</p>			

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	<p>aspiration and choking. Client A's Dining Plan dated 4/28/14 indicated client A had a history of "rapid spooning of foods, stuffing her mouth, and chugging fluids. [Client A] should be encouraged to chew food thoroughly and swallow before spooning in more and to put her spoon down between bites." Client A's ISP indicated client A was to be supervised while eating.</p> <p>Client A's ISP indicated client A had objectives to:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lay her eating utensil down between bites. <input type="checkbox"/> Point to a nickel. <input type="checkbox"/> Complete her daily chores. <input type="checkbox"/> Brush her teeth. <input type="checkbox"/> Identify her medications. <p>Client B's record was reviewed on 5/16/14 at 12 PM. Client B's ISP of 9/27/13 indicated client B had the following "needs:"</p> <ul style="list-style-type: none"> <input type="checkbox"/> To increase her hand washing skills. <input type="checkbox"/> To increase her tooth brushing skills. <input type="checkbox"/> To increase her medication skills. <input type="checkbox"/> To increase her money management skills. <input type="checkbox"/> To increase her laundry cleaning skills. <input type="checkbox"/> To increase her meal preparation skills. <input type="checkbox"/> To increase her home living skills. <input type="checkbox"/> Assistance with self care skills. <input type="checkbox"/> Assistance with ADLs (Adult Daily Living Skills). 			

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	<p>Client C's record was reviewed on 5/16/14 at 1 PM. Client C's 3/20/14 revised dining plan indicated client C was not to have seconds and the staff were to encourage client C to comply with her diet. Client C's dining plan indicated client C was at risk of pneumonia and was to be encouraged to remain upright for at least 30 minutes after meals to prevent aspiration.</p> <p>Client C's ISP of 12/17/13 indicated client C had objectives to:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Identify a dime with verbal assistance. <input type="checkbox"/> Identify her medication. <input type="checkbox"/> Brush her teeth for 30 seconds. <input type="checkbox"/> Open can goods with verbal prompting from the staff. <input type="checkbox"/> Set her spoon down between bites with verbal prompting from staff. The methodology for this objective indicated the staff were to supervise all meals, assist client C in serving herself appropriate sized portions, prompt client C to take appropriate sized bites "approximately 1/2 inch sized bites," prompt client C to set her spoon down between bites and to take a drink in between each bite. <p>Client D's record was reviewed on 5/16/14 at 2 PM. Client D's ISP of 12/16/13 indicated client D had objectives to:</p>			
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	<p><input type="checkbox"/> Identify her medications.</p> <p><input type="checkbox"/> Identify a nickel.</p> <p><input type="checkbox"/> Brush her teeth for 2 minutes.</p> <p><input type="checkbox"/> Complete her daily chores.</p> <p><input type="checkbox"/> Open canned goods with the can opener.</p> <p>Client D's revised 3/20/14 dining plan indicated the staff were to encourage client D to put her spoon down in between bites of food.</p> <p>Client E's record was reviewed on 5/16/14 at 12:30 PM. Client E's ISP of 1/20/14 indicated client E was legally blind in the right eye. Client E's ISP indicated diagnoses of, but not limited to, blindness and Cerebral Palsy. Client E's dining plan indicated client E had a "tendency to spoon food rapidly and chug liquids. Staff will encourage [client E] to eat/drink slowly; chew all food in her mouth before spooning additional bites, to swallow the food currently in her mouth before adding more, and to put her spoon down in-between bites of food." Client E's ISP indicated client E had the following "needs:"</p> <p><input type="checkbox"/> Around the clock staff supervision.</p> <p><input type="checkbox"/> Staff assistance to finish one task before starting another one.</p> <p><input type="checkbox"/> Staff assistance to complete her personal hygiene.</p> <p><input type="checkbox"/> Staff assistance to take her medications.</p>			

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	<p>__ Staff assistance to increase her money management skills.</p> <p>__ Staff assistance with all ADLs.</p> <p>__ Staff assistance to prepare a meal.</p> <p>__ Staff assistance for all household chores and tasks.</p> <p>Client F's record was reviewed on 5/16/14 at 2:30 PM. Client F's 3/20/14 revised Dining Plan indicated client F "has a tendency to spoon food rapidly and chug liquids. Staff will encourage [client F] to eat/drink slowly; chew all food in her mouth before spooning additional bites, to swallow the food currently in her mouth before adding more, and to put her fork down in-between bites of food."</p> <p>Client G's record was reviewed on 5/16/14 at 1:30 PM. Client G's ISP of 9/23/13 indicated client G required staff assistance for all ADLs. Client G's revised 3/20/14 dining plan indicated "[Client G] is nonverbal; she has a Dx (diagnoses) of Autism and Impaired hearing. [Client G] has a Hx (history) of stealing food/drinks, rapid spooning of foods, stuffing her mouth and chugging fluids. [Client G] should be encouraged to chew food thoroughly and swallow before spooning in more and to put her spoon down between bites."</p> <p>Interview with DCS #2 on 5/15/14 at 6</p>						

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	<p>PM indicated the evening meal was prepared by the staff prior to the clients getting home from the day program. DCS #2 stated, "They (the clients) usually lay down every evening after eating." DCS #2 indicated client G had to be watched whenever there was food out or when in the kitchen because client G would grab hot food off the stove and eat it. DCS #2 indicated when the staff were preparing the frozen bread sticks for the evening meal, client G grabbed one off of the pan and began eating it.</p> <p>During interview with the facility LPN on 5/16/14 at 1 PM, the LPN stated, "All of them (clients A, B, C, D, E, F, G and H) should be prompted to stay up after eating and to participate in an activity of some kind. They shouldn't be going straight to bed after eating. That's not what I've trained them (the DCS)."</p> <p>Interview with the CS (Clinical Supervisor) on 5/16/14 at 3 PM indicated the staff were to offer the clients training objectives and/or leisure time activities whenever possible and/or when indicated in the clients' plans. The CS indicated the staff were to follow the clients dining plans at every meal.</p> <p>This federal tag relates to complaint #IN00147450.</p>			
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W000488	<p>9-3-4(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 8 of 8 clients living in the group home (clients A, B, C, D, E, F, G and H), the facility failed to ensure the staff provided training in meal preparation and family style dining.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 5/15/14 between 4:30 PM and 7 PM. The evening meal consisted of lasagna, spinach, bread sticks, salad and canned fruit. The meal was prepared primarily by DCS (Direct Care Staff) #1 and #2 with minimal participation of the clients. Once the food was prepared, it was placed on the kitchen counter near the sink/stove.</p> <p>__At 4:45 PM clients B, C, D, E, F, G and H were sitting at the two dining room tables. The CS (Clinical Supervisor) spooned out a portion of lasagna and placed one portion per client on each plate. Client H walked to the kitchen</p>	W000488	<p>W488: The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Corrective Action:</p> <ul style="list-style-type: none"> ·All home staff inserviced on active treatment <u>(ATTACHMENT C)</u> ·Family Style dining/ Active treatment inserviced for all staff. <u>(ATTACHMENT C)</u> ·Abuse/Neglect; dignity/respect/privacy issues inserviced. <u>(ATTACHMENT C)</u> ·Staff trained to utilize given opportunities to train with individuals on privacy issues. <u>(ATTACHMENT C)</u> ·Staff trained on all individuals dining plans; including training objectives; individual diets; monitoring of the meal. <u>(ATTACHMENT C)</u> ·Staff trained on utilizing natural opportunities for training concerning meal prep and clean up and active treatment. <u>(ATTACHMENT C)</u> ·Staff trained on ensuring all individuals wear clean and appropriate clothing at all times. 	06/17/2014
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	<p>counter retrieved her plate and returned to the dining room table to eat. The CS prompted client B to come get her plate of food and at the same time, client E asked, "Can I come get mine?" The CS stated, "You can be next."</p> <p>__At 4:53 PM client C came up to the kitchen counter to get her plate of food and returned to the dining room table to sit down and began eating.</p> <p>__At 4:55 PM the CS filled client G's plate, took it to her and sat it down at the table in front of client G. Client G immediately began eating.</p> <p>__At 4:57 PM client F retrieved her pre-filled plate of food from the kitchen counter, took it to the dining room table and sat down. Client F then poured a large amount of parmesan cheese on top of her lasagna and looked around to see if anyone was watching and proceeded to dump more parmesan cheese on the lasagna. Client F had finished her lasagna by 5 PM and was eating her bread stick. Client F ate at a fast pace and took large bites while eating.</p> <p>__At 5 PM staff #2 put a serving of lasagna, a bread stick and water in a blender and pureed it. Staff #2 then poured the pureed food onto a plate and sat the plate on the dining room table in front of client A.</p> <p>__At 5:05 PM the CS received a phone call. The CS got up from the table and</p>		<p><u>(ATTACHMENT C)</u> ·All behavior plans reviewed; staff inserviced to contact nurse for signs of change or issues.</p> <p><u>(ATTACHMENT C)</u> ·All staff inserviced on individuals need to remain up after meals and meds for a minimum of 30 minutes.</p> <p><u>(ATTACHMENT C)</u> How will we identify others: ·All individuals' ability to participate in mealtime activities will be assessed in accordance with their developmental capabilities. Upon admission, annually, and with any change in dinning needs reviewed quarterly(ATTACHMENT G,H,J,I) Measures to be put in place: __ ·All staff will be trained on dining plans upon admission, annually, and with any implemented changes quarterly.</p> <p><u>(ATTACHMENT A&E)</u> ·Residential Manager will do Active Treatment Observations two times weekly to ensure all plans are being followed.</p> <p><u>(ATTACHMENT H)</u> Monitoring of Corrective Action: Clinical Supervisor will review plans quarterly with IDT to ensure all issues are being addressed. . Program Manager and or appropriate parties will perform quarterly service reviews to ensure that plans are being monitored changed when needed, and implemented appropriately. Completion Date:</p>				

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	<p>walked into the medication room, leaving client G unsupervised while eating. Client G took large bites of food, ate at a fast pace and used her fingers to eat when not supervised. Client E finished her meal, got up from the table and took her dishes to the sink while staff #2 rinsed the dishes and put them in the dishwasher.</p> <p>__At 5:07 PM the CS returned from her phone call and prompted client G to use her spoon and to take smaller bites. The CS wiped client G's hands with the clothing protector on her chest.</p> <p>__At 5:10 PM client G had finished her meal and sat at the table sucking her thumb. Staff #2 sat down at the end of the table beside client A and ate a few bites of lasagna. Client C asked for and was given a second helping of lasagna. Staff #1 asked client C, "Do you want another bread stick?" Client C shook her head to indicate no.</p> <p>__At 5:12 PM client B was finished eating and sitting in the living room watching television. Client G was assisted to take her plate to the kitchen sink after eating. While doing so, client G grabbed for a bread stick off of the pan on the stove.</p> <p>__At 5:15 PM client C had finished eating and got up from the table to take her dishes to the sink. The front of her pants was wet. Staff #1 indicated client C</p>		6/28/2014				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G303	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/29/2014
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	<p>was incontinent of urine and was going to the bathroom to change her adult brief. Client D sat alone at one table in the dining room finishing her meal while client A sat alone at another table. Staff #1 and #2 were cleaning up the kitchen, doing dishes and putting the food away. Client E stated, "I'm gonna go lay down for a little bit." Staff prompted client E to take the trash out prior to lying down. Client E took out the trash and then went to her bedroom to lie down.</p> <p>__At 5:20 PM client D finished eating and took her dishes to the sink. At 5:24 PM client D was in her bedroom lying down.</p> <p>__Clients C, D, E, F and G all went to bed right after eating their evening meal.</p> <p>__At 5:25 PM client A had finished her meal and went to her bedroom.</p> <p>The staff did not include the clients in the entire meal preparation. The staff did not directly supervise the clients throughout the meal while the clients were eating and the staff did not sit with the clients throughout their meal and/or provide the clients with the opportunity for family style dining.</p> <p>Interview with DCS #2 on 5/15/14 at 6 PM indicated the lasagna was prepared by staff prior to the clients getting home from the day program. DCS #2 indicated</p>			
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	<p>client G did not assist in the kitchen because of her behavior of grabbing food.</p> <p>During interview with the CS (Clinical Supervisor) on 5/16/14 at 3 PM, the CS stated "They (the DCS) usually set the food on the table and provide family style dining" but had not done so during this observation period because of the hot pan of lasagna and client G's behavior of grabbing food. When asked why the two dining room tables were separated and not together, the CS stated, "Because [client G] has a tendency to grab everybody's food and we thought this might prevent that to an extent." The CS indicated the staff were to supervise the clients while eating, provide the clients with training in meal preparation and family style dining at every available opportunity.</p> <p>9-3-8(a)</p>						