STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	10311 E JACKSON SELMA, IN 47383

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W 0000 Bldg. 00	This visit was for a full recertification and state licensure survey. This visit included the investigation of complaint #IN00171811. This visit resulted in an Immediate Jeopardy. Complaint #IN00171811: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153, W154, W155, W156, W157, W159, W240, W252, W286, W318, W331, W342, W368 and W369. Survey dates: April 20, 21, 22, 23, 24, 27, 28, 29, 30 and May 13, 2015. Facility Number: 000878 Provider Number: 15G364 AIM Number: 100249230 These deficiencies also reflect state findings in accordance with 460 IAC 9.	W 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W 0100 Bldg. 00	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440. Based on observation, record review and interview for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients (E, F and G), the Intermediate Care Facility/ICF failed to provide active treatment services for which the facility received payment. Findings include: The facility (Intermediate Care Facility/ICF) failed to ensure clients A and B, received a continuous and aggressive active treatment program which addressed the training needs of each client. The ICF failed to ensure active treatment and behavioral programs were implemented for clients B, C and D living in the facility. The ICF failed to	W 0100	**W100 ICF Services Other than In Institutions** "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440. **1. What corrective action will**	06/12/2015

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	ensure sensorimotor and communication assessments were completed for client C, to ensure needed supports were added to client B, C and G's program plans, to ensure basic training needs were addressed for clients C and D and to ensure identified training needs were addressed for client G, to ensure the facility's Human Rights Committee reviewed and/or approved clients C and D's restrictive programs and to ensure client C and D's guardian gave written consent for the clients' restrictive programs. The ICF failed to ensure clients A, B, C, D, E, F and G assisted with cooking, dining room set up and ate in a manner consistent with their developmental levels. Please refer to W195 for the Intermediate Care Facility's failure to meet the Condition of Participation: Active Treatment Services. 9-3-1(a)		**be accomplished?** · Programming will be implemented for Clients A, B, C, D, E, F, and G to participate in dining skills and/or meal preparation within his and her functional capabilities. · Staff will be retrained on the importance of ensuring family style dining, active treatment during meal preparation and proper supervision of the client's needs during the meal. · Staff will be retrained on client's meal time objectives and dining plans. · Staff will be retrained on the importance of ensuring active treatment at all times during their next team meeting. · Training will be completed with the Program Coordinator and Program Director/QIDP regarding training of staff. · Prior to working with the clients in the home, staff will complete client specific training. · Programming will be implemented for Clients C and D to enhance/develop leisure skills. · Staff will be retrained on client's communication objectives. · Programming will be implemented for Client C regarding hand washing. · Programming will be implemented for Client C regarding dining skills including use of a utensil and wiping mouth. · Programming addressing Client C's communication skills will be reviewed and revised. · Programming will be	

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			implemented for Client C addressing personal hygiene, including toileting, dressing and oral hygiene. · Programming will be implemented for Client D addressing communication skill deficits as recommended by 5/30/14 Speech-Language evaluation. · Programming will be implemented for Client D addressing bathing and dressing. · The Program Director/QIDP will ensure at all times that programming is in place for all clients addressing their identified needs. · Obtain physician order for Occupational Therapy/Physical Therapy evaluation to assess/reassess sensorimotor needs for Client C with regards to using the gait belt. · Update/revise risk plans, MAR, ISP and complete staff training when OT/PT evaluation completed. · Obtain physician order for Client C Speech assessment · Once speech assessment completed, Program Director/QIDP will implement formal programming to address speech assessment recommendations for communication skill development. · Programming will be implemented to address Client G's dining needs/slow pace when eating and encouraging fluid between bites as well as privacy. · Staff will be trained on Client G's ISP revision. · Behavior Analyst has revised	

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			Client B's Behavior Support plan to include how the staff were to restrain/hold Client B's arms/hands to assist with the applying protective mitts. · Behavior Analyst has re-trained staff regarding Client B's BSP revision, including how to restrain/hold Client B's arms/hands to assist with applying the protective mitts. · Behavior Analyst will continue to monitor monthly trends in behavior documentation for Client B regarding SIB and suggest to IDT revisions as needed. · Staff will be retrained on completing/documenting 15 minute checks for Client G. · IDT will convene to revise Client G's BSP to include how staff are to monitor/supervise to prevent Client G's SIB. · Behavior Analyst will retrain staff on Client G's BSP including documentation of behavior events regarding Client G. · IDT will convene to discuss and implement plan involving Client G's skin picking/wound on top of head as well as outline/define high-risk monitoring as referenced in physical form from facility nurse on 2/18/15. · Nursing staff will include in risk plan for Client G description of high-risk monitoring as referenced in physical form from facility nurse on 2/18/15. · Program Director/QIDP will implement programming for Client G	

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			to promote activity engagement to discourage/help prevent SIB. · Staff will be trained on how to access client programming information and documentation needs in Therap (ISP, risk plans, goals, assessments, BSP, etc). · Training will be completed with the Program Coordinator and Program Director/QIDP regarding training staff. · Obtain legal guardian and Human Rights Committee consent for restrictive measures regarding hazardous materials for Clients C and D as well as bite protective sleeves for Client D. · Program Director/QIDP will be retrained regarding obtaining informed consent from guardians and HRC approval regarding restrictive measures. **1. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The Program Director/QIDP will monitor the residents programming and behavior needs at a minimum, monthly basis. As needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plans, dining plans, etc. · Monthly, Area Director will	

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			ensure the Program Director/QIDP is monitoring treatment programs for all 8 clients in the home. · Prior to working with the clients in the home, staff will complete client specific training. · Performance Audits, involving review of program data collection will be completed annually by Quality Assurance. **2. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The Program Director/QIDP will monitor the residents programming and behavior needs at a minimum, monthly basis. As needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plans, dining plans, etc. · Monthly, Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all 8 clients in the home. · Prior to working with the clients in the home, staff will complete client specific training. · Performance Audits, involving review of program data collection will be completed annually by Quality Assurance. **3. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Director/QIDP	

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			will monitor the residents programming and behavior needs at a minimum, monthly basis. As needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plans, dining plans, etc. · Monthly, Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all 8 clients in the home. · Prior to working with the clients in the home, staff will complete client specific training. · Performance Audits, involving review of program data collection will be completed annually by Quality Assurance. **4. What is the date by which the systemic changes will be completed?** · June 12, 2015	
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients (E, F and G). The governing body failed to ensure the clients, who lived in the group home,	W 0102	**inW 102 Governing Body and Management** The facility must ensure that specific governing body and management requirements are met. 1. **What corrective action will be accomplished?** · Staff training has been completed by facility nurse regarding	06/12/2015

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	were not abused/neglected in regard to staffs' medication errors, and due to a client's self-injurious behavior which resulted in injury which required outside care/treatment. The governing body failed to ensure its management and/or administrative staff recognized allegations of abuse and/or reported all allegations of abuse, neglect, mistreatment and/or injuries of unknown source to the administrator/state officials when made aware. The governing body failed to ensure the facility investigated all allegations of abuse, neglect, injuries of unknown source the management/administrative staff were made aware of, to ensure a facility staff was immediately suspended when an allegation of abuse was made against the staff, to ensure the facility reported the results of its investigation to its administrator with 5 working days, and to ensure the facility took appropriate corrective actions regarding medication errors at the group home. The facility's governing body failed to ensure the facility provided each client an aggressive active treatment program, provided sufficient staffing to meet the needs of the clients, and ensured the Qualified Intellectual Disabilities Professional monitored, integrated and coordinated clients' programs, and failed		medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth medication error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check	

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	to ensure the facility's health care services were able to meet the nursing needs of the clients. The facility's governing body failed to ensure the facility did not violate a client's rights, accounted for clients' funds, ensured clients' programs were implemented, assessments were completed/obtained, and clients' identified training needs and/or basic needs were addressed. The governing body failed to ensure the facility did not discipline clients, did not use a client's gait belt for the convenience of staff, respected a client's dignity by cleaning the client's wheelchair and ensured the facility's specially constituted committee reviewed and/or approved restrictive plans. The facility's governing body failed to ensure the facility documented client's behavior data, repositioning, refusals and/or 15 minute checks as indicated by the clients' program plans. The governing body failed to ensure physician orders were followed and to ensure the facility's nurse trained staff in regard to clients' health care needs. Findings include: 1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections. The governing body failed to ensure the		daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors. · Home Manager's (Program Coordinator) employment relationship with facility has been severed. · Client F's Behavior Support Plan will be revised to include descriptions of restrictions/consequences to ensure facility staff do not restrict Client F unfairly and/or appear as disciplinary/punitive for client's actions. · Staff will be retrained on client right restrictions and on Client F's Behavior Support Plan. · Program Coordinator and Program Director will be retrained on client right restrictions as well as not implementing right restrictions	

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	facility implemented its written policy and procedures to prevent clients from being neglected due to medication errors, and in regard to putting corrective measures/actions in place to prevent medication errors which could cause potential harm to clients B, C, D, E, F and G. The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of client G in regard to her self-injurious behavior (SIB) which resulted in the client going to wound care center, and/or abuse/mistreatment of clients B and F in regard to the clients' behaviors. The governing body failed to ensure management and/or administrative staff immediately reported allegations of abuse, neglect, mistreatment and/or injuries of unknown source to the administrator and/or to state officials. The governing body failed to investigate all reported allegations of abuse, neglect, mistreatment and/or injuries of unknown source once reported to management/administrative staff. The governing body failed to take appropriate corrective action with a staff who made repeated medication errors, to suspend staff immediately when an allegation was made, and to conduct its investigations/report the results of their		until IDT has convened, plans have been updated, staff training has occurred and Human rights committee has reviewed and/or approved restrictions (with consideration given to emergency restrictions for client's safety). · For Client F, Human Rights Committee will review and/or approve restrictive measures regarding any rights restrictions included in Behavior Support plan. · IDT will convene to discuss Client A 'giving money away,' and will revise plans as needed. · IDT will convene to discuss client 'allowance' and approval will be obtained from IDT for any 'allowance' moving forward. · Program Director/QIDP will update ISPs and IPOPs as required regarding any IDT concluded money handling limit. · Program Director/QIDP will discuss with IDT any client request for shopping/spending that does not appear to be in client's best interest. · Program Coordinator and Program Director/QIDP will be retrained regarding facility policy and procedure regarding maintaining a full and complete accounting of client finances. · Program Director/QIDP will audit client finances weekly for one month and thereafter monthly. · Area Director will audit finances monthly for three months and will re-evaluate continued need for monthly audits thereafter. · Training with Program	

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	investigations within 5 working days to the administrator. The governing body failed to ensure the rights of a client in regard to money and/or going out into the community, and to ensure clients' funds held by the facility were accounted for clients A, B, C, D, E, F and G. Please see W122. 2. The governing body failed to meet the Condition of Participation: Active Treatment Services for clients A, B, C, D, E, F and G. The governing body failed to ensure each client received a continuous, aggressive active treatment program. The governing body failed to ensure facility staff implemented clients' program plans across all environments/times of the day. The governing body failed to ensure staff collected data per the clients' program plans, and failed to ensure clients participated in aspects of meal preparation and/or were allowed to assist in feeding themselves. The governing body failed to ensure the facility addressed clients' basic training needs, addressed clients' identified needs, to ensure needed supports were included in the clients' program plans, and to needed assessments were completed. The governing body failed to ensure its Human Rights Committee reviewed and/or approved all restrictive programs		Director/QIDP regarding immediately reporting to the administrator or to other officials in accordance with State law allegations of mistreatment, neglect or abuse as well as injuries of unknown source. · Training with Program Director/QIDP regarding incidents requiring investigation. · Training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, and injuries of unknown origin). · Training with Program Coordinator and Program Director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, and injuries of unknown origin). · Area Director will review thorough and timely completion of investigations as well as immediate reporting of incidents to administrator or to other officials in accordance with State law through established procedures. · Training with Program Director/QIDP regarding completing investigations thoroughly as well as incidents requiring investigations. · Training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect,	

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	and to ensure clients' guardians gave written informed consent for each restrictive program. Please see W195. 3. The governing body failed to meet the Condition of Participation: Health Care Services for clients B, C, D, F and G. The governing body failed to ensure its nursing services met the healthcare and nursing needs of each client who resided at the facility. Please see W318. 4. The governing body failed to ensure the facility implemented policy and procedures to ensure clients were not neglected in regard to medication errors. The governing body failed to ensure clients' medications were administered without error, and to prevent neglect in regard to a pattern of medication errors. The governing body failed to ensure the facility implemented its corrective actions/measures and/or put in place corrective actions/measures to prevent medication errors. The governing body failed to ensure a staff, who made multiple errors with client B's medications, was not allowed to pass/administer clients' medications. The governing body failed to implement its policy and procedures to conduct thorough investigations in regard to the medication errors to ensure the staff administered the medications as ordered.		exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Training with Program Coordinator and Program director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Program Director/QIDP and/or Area Director will ensure investigations are completed and reported to the administration within 5 business days. · Training with Program Coordinator and Program Director/QIDP regarding policy on reporting abuse, neglect and exploitation, including removal/suspension of staff for client protection. · Any allegation of abuse, neglect and/or exploitation will result in immediate removal/suspension of staff for client protection. · Training with Program Director/QIDP regarding ensuring each client receives continuous, aggressive and consistent active treatment programs. · At a minimum twice weekly for one month, Program Director/QIDP will document via electronic documentation system (Therap) t-log/note on site observations at the facility to ensure integration and coordination of active treatment programming. After	

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	The governing body failed to ensure its nursing services provided oversight/supervision of the group home, due to repeated medication errors to ensure facility staff administered medications without error to prevent potential harm to the clients who resided at the group home for clients A, B, C, D, E, F and G. The facility's governing body failed to ensure client A and F's right to due process in regard to restricting the clients' monies and ability to go on outings/shopping in the community. The facility's governing body failed to maintain a system that assured a full and complete accounting of clients A, B, C, D, E and G's personal funds. The facility's governing body failed to ensure allegations of abuse, neglect and/or injuries of unknown source reviewed for clients A, B, E, F and G were immediately reported to the administrator, and/or reported to state officials when management and/or administrative staff were made aware of the allegations and/or injuries of unknown source. The facility's governing body failed to ensure allegations of abuse, neglect, mistreatment and/or injuries of unknown source reviewed, were thoroughly investigated and documented regarding clients B, C, D, F		twice weekly for one month observations, Program Director/QIDP will document via Therap t-log at a minimum once weekly for one month, observations to ensure integration and coordination of active treatment programming. After once weekly for one month observations, Program Director/QIDP will complete at a minimum once monthly observations at the facility to ensure integration and coordination of active treatment programming. · The Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all clients in the home via monthly completion of data collection reports, which includes electronic documentation system data review. Area Director will comment on electronic documentation system data review report as reviewed. · Area Director will review Program Director/QIDP's Therap t-log regarding site observation of integration and coordination of active treatment programming twice weekly for one month, once weekly for one month and monthly thereafter and will address any concerns with the Program Director/QIDP within 48 hours of review. · Area Director will make unannounced visit to facility weekly for one month and monthly thereafter, to ensure the Program Director/QIDP has effectively integrated and coordinated the active treatment programs.	

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	and G. The facility's governing body failed to ensure a staff was immediately suspended when an allegation of abuse was made involving client B. The facility's governing body failed to complete an investigation within 5 working days for client B. The facility's governing body failed to ensure its recommended corrective actions/measures in regard to medication errors prevented additional errors. The facility's governing body failed to ensure its nursing services were involved in retraining staff and/or corrective actions. The facility's governing body failed to take appropriate corrective action in regard to a pattern of medication errors made by the same facility staff to ensure clients' medications were administered without error for clients B, C, D, F and G. The facility's governing body failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) monitored the clients' programs in regard to ensuring each client received an aggressive active treatment program, addressed identified needs of clients, addressed basic training needs of clients and coordinated obtaining sensorimotor and/or communication assessments of clients. The governing body failed to ensure the QIDP monitored staff in		· The Program Director/QIDP will ensure that programming is in place for all clients addressing their identified need at all times. · Staff will be retrained on the importance of ensuring active treatment at all times. · Training will be completed with the Program Coordinator and Program Director/QIDP regarding training of staff. · Staff will be re-trained on taking weekly weights and documenting weights as ordered by physician for Client C. · Nurse staff to obtain order for albumin level for Client C as recommended by dietary recommendation 1/15. · Nurse staff to clarify order for Client C's Ensure and update MAR as needed. · IDT to convene to discuss Client C's health status change related to weight loss. · Programming will be implemented for Client D addressing communication skill deficits as recommended by 5/30/14 Speech-Language evaluation. · Obtain physician order for Occupational Therapy/Physical Therapy evaluation to assess/reassess sensorimotor needs for Client C with regards to using the gait belt. · Revise risk plan, IPOP, MAR and train staff for Client C after OT/PT evaluation, should OT/PT evaluation recommend continued use of gait belt. · Obtain physician order for	

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	regard to implementing clients' program plans when opportunities for training existed, and to ensure needed supports were incorporated into clients' program plans for clients B, C, D and G. The facility's governing body failed to ensure sufficient staff worked at the group home to meet the needs of the clients A, B, C, D, E, F and G. The facility's governing body failed to ensure each client received a continuous, aggressive and consistent active treatment program for clients C and D. The facility's governing body failed to ensure the facility assessed client C's sensorimotor/ambulation skills. The facility's governing body failed to ensure the facility assessed and/or re-assessed client C's communication skills. The facility's governing body failed to ensure the facility addressed client G's identified training needs in regard to mealtime and privacy. The facility's governing body failed to ensure clients' Individual Support Plans included the needed supports to indicate how facility staff were to monitor/supervise client G to prevent self injury, to indicate how facility staff were to assist client C in regard to her gait belt, and/or indicate how facility staff were to restrain client B to prevent injuries. The facility's governing body failed to ensure the		Client C Speech assessment · Once speech assessment completed, Program Director/QIDP will implement formal programming to address speech assessment recommendations for communication skill development. · Programming will be implemented to address Client G's dining needs/slow pace when eating and encouraging fluid between bites and privacy. · Staff will be trained on Client G's ISP revision. · Behavior Analyst has revised Client B's Behavior Support plan to include how the staff were to restrain/hold Client B's arms/hands to assist with the applying protective mitts. · Behavior Analyst has re-trained staff regarding Client B's BSP revision, including how to restrain/hold Client B's arms/hands to assist with applying the protective mitts. · Behavior Analyst will continue to monitor monthly trends in behavior documentation for Client B regarding SIB and suggest to IDT revisions as needed. · Staff will be retrained on completing/documenting 15 minute checks for Client G. · IDT will convene to revise Client G's BSP to include how staff are to monitor/supervise to prevent Client G's SIB. · Behavior Analyst will retrain staff on Client G's BSP including documentation of behavior events	

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	facility addressed client C and D's basic training needs in regard to communication, toileting, bathing, dressing and/or oral hygiene. The facility's governing body failed to ensure clients' B, C and D's Individual Program Plan objectives and/or behavior plans were implemented when formal and/or informal training opportunities existed. The facility's governing body failed to ensure the facility's Human Rights Committee reviewed all restrictive plans for clients C and D. The facility's governing body failed to ensure clients C and D's guardian gave written informed consent in regard to the clients' restrictive programs. The facility's governing body failed to ensure the facility allowed and/or encouraged clients to participate in all aspects of meal preparation, and to allow/encourage clients to feed themselves for clients A, B, C, D, E, F and G. The facility's governing body failed to ensure its nursing services met the health care needs of clients. The facility's governing body failed to ensure the facility's health care services monitored and supervised staff in regard to medication errors/medication administration, to ensure clients' physicians were contacted in regard to clients' medication errors, updated and/or		regarding Client G. · IDT will convene to discuss and implement plan involving Client G's skin picking/wound on top of head as well as outline/define high-risk monitoring as referenced in physical form from facility nurse on 2/18/15. · Nursing staff will include in risk plan for Client G description of high-risk monitoring as referenced in physical form from facility nurse on 2/18/15. · Program Director/QIDP will implement programming for Client G to promote activity engagement to discourage/help prevent SIB. · Programming will be implemented for Client C addressing personal hygiene, including toileting, dressing and oral hygiene. · Programming will be implemented for Client D addressing bathing and dressing. · Clients B, C and D will be placed on programming for them to assist with meal preparation/dining skills. · Clients C and D will be placed on programming to develop leisure skills. · Staff will be retrained on the importance of ensuring family style dining, active treatment during meal preparation and proper supervision of the client's needs during the meal. · Staff will be retrained on client's meal time objectives, communication objectives and dining plans. · Programming will be	

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	developed needed risk plans. The facility's governing body failed to ensure facility staff were trained in regard to wound care and documentation. The facility's governing body failed to ensure the facility's health care services ensured staff repositioned clients, monitored/assessed a client's health care need, addressed a client's dietary recommendations, addressed a client's weight loss and/or ensured facility staff weighed the client weekly as ordered for clients B, C and G. The facility's governing body failed to ensure facility staff were initially trained and demonstrated competency in wound care and on using a Hoyer Lift for clients B and G. The facility's governing body failed to ensure staff followed doctor's orders in regard to medication administration for clients B, C, D, F and G. The facility's governing body failed to ensure client G's medication was administered without error. Please see W104. This federal tag relates to complaint #IN00171811. 9-3-1(a)		implemented for Client C regarding hand washing. · Programming will be implemented for Client C regarding dining skills including use of a utensil and wiping mouth. · Staff will be retrained on Client Ds BSP regarding interventions when Client D engages in self-injury/biting. · Staff will be retrained on Client B's BSP regarding redirection to visual schedule. · Obtain legal guardian consent for restrictive measures for hazardous materials for Clients C and D as well as for bite protective sleeves for Client D. · Program Director/QIDP will be retrained regarding obtaining informed consent from guardians regarding restrictive measures. · The Program Director/QIDP will ensure at all times that programming is in place for all clients addressing their identified needs. · Area Director and Program Director/QIDP will evaluate current staff patterns to ensure adequate staffing numbers present in the home at all times to meet client needs. · Program Coordinator and Program Director/QIDP will ensure there are adequate staffing numbers present in the home at all times to meet client needs. · Prior to working with the clients in the home, staff will complete client specific training. · Staff will be trained on how to	

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			access client programming information and documentation needs in Therap (ISP, risk plans, goals, BSP, etc). · Staff will be retrained on client's meal time objectives, communication objectives and dining plans. · Staff will be retrained on Client Ds BSP regarding interventions when Client D engages in self-injury/biting. · Staff will be retrained on Client Bs BSP regarding redirection to visual schedule. · Human Rights Committee will review and/or approve restrictive measures regarding hazardous materials for Clients C and D as well as bite protective sleeves for Client D. · Programming will be implemented for Clients A, E, F and G for them to assist with meal preparation/dining skills. 2. **How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in	

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			a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth medication error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program	

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			Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will review the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will review the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors. · Home Manager's (Program Coordinator) employment relationship with facility has been severed. · Client F's Behavior Support Plan will be revised to include descriptions of restrictions/consequences to ensure facility staff do not restrict Client F unfairly and/or appear as disciplinary/punitive for client's actions. · Staff will be retrained on client right restrictions and on Client F's Behavior Support Plan. · Program Coordinator and Program Director will be retrained on client right restrictions as well as not implementing right restrictions until IDT has convened, plans have been updated, staff training has occurred and Human rights committee has reviewed and/or approved restrictions (with consideration given to emergency restrictions for client's safety). · Training with Program Director/QIDP regarding incidents requiring investigation. · Program	

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			Director/QIDP will revise Client A's ISP and IPOP to indicate Client A giving money away. · IDT will convene to discuss client 'allowance' and approval will be obtained from IDT for any 'allowance' moving forward. · Program Director/QIDP will update ISPs and IPOPs as required regarding any IDT concluded money handling limit. · Program Director/QIDP will discuss with IDT any client request for shopping/spending that does not appear to be in client's best interest. · Program Coordinator and Program Director/QIDP will be retrained regarding facility policy and procedure regarding maintaining a full and complete accounting of client finances. · Program Director/QIDP will audit client finances weekly for one month and thereafter monthly. · Area Director will audit finances monthly for three months and will re-evaluate continued need for monthly audits thereafter. · Training with Program Director/QIDP regarding immediately reporting to the administrator or to other officials in accordance with State law allegations of mistreatment, neglect or abuse as well as injuries of unknown source · Training with Program Director/QIDP regarding incidents requiring investigation. · Training with staff, Program Coordinator and Program Director/QIDP	

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			regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Area Director will review thorough and timely completion of investigations as well as immediate reporting of incidents to administrator or to other officials in accordance with State law through established procedures. · Training with Program Director/QIDP regarding incidents requiring investigation as well as completing investigations thoroughly. · Program Director/QIDP and/or Area Director will ensure investigations are completed and reported to the administration within 5 business days. · Training with Program Coordinator and Program Director/QIDP regarding policy on reporting abuse, neglect and exploitation, including removal/suspension of staff for client protection. · Any allegation of abuse, neglect and/or exploitation will result in immediate removal/suspension of staff for client protection. 3. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Staff training has been completed by facility nurse regarding	

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			medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth medication error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and	

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			thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will review the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will review the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors. · Home Manager's (Program Coordinator) employment relationship with facility has been severed. · Client F's Behavior Support Plan will be revised to include descriptions of restrictions/consequences to ensure facility staff do not restrict Client F unfairly and/or appear as disciplinary/punitive for client's actions. · Staff will be retrained on client right restrictions and on Client F's Behavior Support Plan. · Program Coordinator and Program Director will be retrained on client right restrictions as well as not implementing right restrictions until IDT has convened, plans have been updated, staff training has occurred and Human rights committee has reviewed and/or approved restrictions (with	

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			consideration given to emergency restrictions for client's safety). · Training with Program Director/QIDP regarding incidents requiring investigation. · Program Director/QIDP will revise Client A's ISP and IPOP to indicate Client A giving money away. · IDT will convene to discuss client 'allowance' and approval will be obtained from IDT for any 'allowance' moving forward. · Program Director/QIDP will update ISPs and IPOPs as required regarding any IDT concluded money handling limit. · Program Director/QIDP will discuss with IDT any client request for shopping/spending that does not appear to be in client's best interest. · Program Coordinator and Program Director/QIDP will be retrained regarding facility policy and procedure regarding maintaining a full and complete accounting of client finances. · Program Director/QIDP will audit client finances weekly for one month and thereafter monthly. · Area Director will audit finances monthly for three months and will re-evaluate continued need for monthly audits thereafter. · Training with Program Director/QIDP regarding immediately reporting to the administrator or to other officials in accordance with State law allegations of mistreatment, neglect or abuse as well as injuries of unknown source ·	

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			Training with Program Director/QIDP regarding incidents requiring investigation. · Training with staff, Program Coordinator and Program Director/QIDP regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Area Director will review thorough and timely completion of investigations as well as immediate reporting of incidents to administrator or to other officials in accordance with State law through established procedures. · Training with Program Director/QIDP regarding incidents requiring investigation as well as completing investigations thoroughly. · Program Director/QIDP and/or Area Director will ensure investigations are completed and reported to the administration within 5 business days. · Training with Program Coordinator and Program Director/QIDP regarding policy on reporting abuse, neglect and exploitation, including removal/suspension of staff for client protection. · Any allegation of abuse, neglect and/or exploitation will result in immediate removal/suspension of staff for client protection. 4. **How will the corrective action be monitored to ensure the**	

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			deficient practice will not recur? · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth medication error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a min	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 3 additional	W 0104	**W104 Governing Body** The governing body must exercise general policy, budget, and operating direction over the	06/12/2015

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	clients (E, F and G), the governing body failed to exercise general policy and operating direction over the facility to ensure the clients, who lived in the group home, were not abused/neglected in regard to staffs' medication errors, and due to a client's self-injurious behavior which resulted in injury which required outside care/treatment. The governing body failed to exercise general policy and operating direction over the facility to ensure its management and/or administrative staff recognized allegations of abuse and/or reported all allegations of abuse, neglect, mistreatment and/or injuries of unknown source to the administrator/state officials when made aware. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility investigated all allegations of abuse, neglect, injuries of unknown source the management/administrative staff were made aware of, to ensure a facility staff was immediately suspended when an allegation of abuse was made against the staff, to ensure the facility reported the results of its investigation to its administrator with 5 working days, and to ensure the facility took appropriate corrective actions regarding medication errors at the group home.		facility. **1. What corrective action will be accomplished?** · **Staff training has been completed by facility nurse regarding medication administration procedures.** · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth medication error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will	

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	The facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility provided each client an aggressive active treatment program, provided sufficient staffing to meet the needs of the clients, and ensured Qualified Intellectual Disabilities Professional monitored, integrated and coordinated clients' programs, and failed to ensure the facility's health care services were able to meet the nursing needs of the clients. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility did not violate a client's rights, accounted for clients' funds, ensured clients' programs were implemented, assessments were completed/obtained and clients' identified training needs and/or basic needs were addressed. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility did not discipline clients, did not use a client's gait belt for the convenience of staff, respected a client's dignity by cleaning the client's wheelchair, ensured the facility's specially constituted committee reviewed and/or approved restrictive plans. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility documented client's		monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors. · Home Manager's (Program Coordinator) employment relationship with facility has been severed. · Client F's Behavior Support Plan will be revised to include descriptions of restrictions/consequences to ensure facility staff do not restrict Client F unfairly and/or appear as disciplinary/punitive for client's actions. · Staff will be retrained on client right restrictions and on Client F's Behavior Support Plan.	

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	behavior data, repositioning, refusals and/or 15 minute checks as indicated by the clients' program plans. The governing body failed to exercise general policy and operating direction over the facility to ensure physician orders were followed and to ensure the facility's nurse trained staff in regard to clients' health care needs. Findings include: 1. The facility's governing body failed to exercise general policy and operating direction over the facility to implement its policy and procedures to ensure clients were not neglected in regard to medication errors. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure clients' medications were administered without error, and to prevent neglect in regard to a pattern of medication errors. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its corrective actions/measures and/or put in place corrective actions/measures to prevent medication errors. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure a staff, who made multiple errors with client B's		· Program Coordinator and Program Director will be retrained on client right restrictions as well as not implementing right restrictions until IDT has convened, plans have been updated, staff training has occurred and Human rights committee has reviewed and/or approved restrictions (with consideration given to emergency restrictions for client's safety). · For Client F, Human Rights Committee will review and/or approve restrictive measures regarding any rights restrictions included in Behavior Support plan. · IDT will convene to discuss Client A 'giving money away,' and will revise plans as needed. · IDT will convene to discuss client 'allowance' and approval will be obtained from IDT for any 'allowance' moving forward. · Program Director/QIDP will update ISPs and IPOPs as required regarding any IDT concluded money handling limit. · Program Director/QIDP will discuss with IDT any client request for shopping/spending that does not appear to be in client's best interest. · Program Coordinator and Program Director/QIDP will be retrained regarding facility policy and procedure regarding maintaining a full and complete accounting of client finances. · Program Director/QIDP will audit client finances weekly for one month and thereafter monthly. · Area Director will audit	

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	medications, was not allowed to pass/administer clients' medications. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to conduct thorough investigations in regard to the medication errors to ensure the staff administered the medications as ordered. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure its nursing services provided oversight/supervision of the group home, due to repeated medication errors to ensure facility staff administered medications without error to prevent potential harm to the clients who resided at the group home for clients A, B, C, D, E, F and G. Please see W149. 2. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure client A and F's right to due process in regard to restricting the clients' monies and ability to go on outings/shopping in the community. Please see W125. 3. The facility's governing body failed to exercise general policy and operating direction over the facility to maintain a system that assured a full and complete accounting of clients A, B, C, D, E and		finances monthly for three months and will re-evaluate continued need for monthly audits thereafter. · Training with Program Director/QIDP regarding immediately reporting to the administrator or to other officials in accordance with State law allegations of mistreatment, neglect or abuse as well as injuries of unknown source. · Training with Program Director/QIDP regarding incidents requiring investigation. · Training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, and injuries of unknown origin). · Training with Program Coordinator and Program Director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, and injuries of unknown origin). · Area Director will review thorough and timely completion of investigations as well as immediate reporting of incidents to administrator or to other officials in accordance with State law through established procedures. · Training with Program Director/QIDP regarding completing investigations thoroughly as well as incidents requiring investigations. · Training with staff regarding	

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	G's personal funds. Please see W140. 4. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure allegations of abuse, neglect and/or injuries of unknown source reviewed for clients A, B, E, F and G were immediately reported to the administrator, and/or reported to state officials when management and/or administrative staff were made aware of the allegations and/or injuries of unknown source. Please see W153. 5. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure allegations of abuse, neglect, mistreatment and/or injuries of unknown source reviewed, were thoroughly investigated and documented regarding clients B, C, D, F and G. Please see W154. 6. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure a staff was immediately suspended when an allegation of abuse was made involving client B. Please see W155. 7. The facility's governing body failed to exercise general policy and operating		completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Training with Program Coordinator and Program director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Program Director/QIDP and/or Area Director will ensure investigations are completed and reported to the administration within 5 business days. · Training with Program Coordinator and Program Director/QIDP regarding policy on reporting abuse, neglect and exploitation, including removal/suspension of staff for client protection. · Any allegation of abuse, neglect and/or exploitation will result in immediate removal/suspension of staff for client protection. · Training with Program Director/QIDP regarding ensuring each client receives continuous, aggressive and consistent active treatment programs. · At a minimum twice weekly for one month, Program Director/QIDP will document via electronic documentation system	

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	direction over the facility to complete an investigation within 5 working days for client B. Please see W156. 8. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure its recommended corrective actions/measures in regard to medication errors prevented additional errors. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure its nursing services were involved in retraining staff and/or corrective actions. The governing body failed to exercise general policy and operating direction over the facility to take appropriate corrective action in regard to a pattern of medication errors made by the same facility staff to ensure clients' medications were administered without error for clients B, C, D, F and G. Please see W157. 9. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the Qualified Intellectual Disabilities Professional (QIDP) monitored the clients' programs in regard to ensuring each client received an aggressive active treatment program, addressed identified needs of clients, addressed basic training		(Therap) t-log/note on site observations at the facility to ensure integration and coordination of active treatment programming. After twice weekly for one month observations, Program Director/QIDP will document via Therap t-log at a minimum once weekly for one month, observations to ensure integration and coordination of active treatment programming. After once weekly for one month observations, Program Director/QIDP will complete at a minimum once monthly observations at the facility to ensure integration and coordination of active treatment programming. · The Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all clients in the home via monthly completion of data collection reports, which includes electronic documentation system data review. Area Director will comment on electronic documentation system data review report as reviewed. · Area Director will review Program Director/QIDP's Therap t-log regarding site observation of integration and coordination of active treatment programming twice weekly for one month, once weekly for one month and monthly thereafter and will address any concerns with the Program Director/QIDP within 48 hours of review. · Area Director will make unannounced visit to facility weekly for one month and monthly	

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	needs of clients and coordinated obtaining sensorimotor and/or communication assessments of clients. The governing body failed to exercise general policy and operating direction over the facility to ensure the QIDP monitored staff in regard to implementing clients' program plans when opportunities for training existed, and to ensure needed supports were incorporated into clients' program plans for clients B, C, D and G. Please see W159. 10. The facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure sufficient staff worked at the group home to meet the needs of the clients A, B, C, D, E, F and G. Please see W186. 11. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure each client received a continuous, aggressive and consistent active treatment program for clients C and D. Please see W196. 12. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure a client's sensorimotor/ambulation skills were assessed for client C. Please see		thereafter, to ensure the Program Director/QIDP has effectively integrated and coordinated the active treatment programs. · The Program Director/QIDP will ensure that programming is in place for all clients addressing their identified need at all times. · Staff will be retrained on the importance of ensuring active treatment at all times. · Training will be completed with the Program Coordinator and Program Director/QIDP regarding training of staff. · Staff will be re-trained on taking weekly weights and documenting weights as ordered by physician for Client C. · Nurse staff to obtain order for albumin level for Client C as recommended by dietary recommendation 1/15. · Nurse staff to clarify order for Client C's Ensure and update MAR as needed. · IDT to convene to discuss Client C's health status change related to weight loss. · Programming will be implemented for Client D addressing communication skill deficits as recommended by 5/30/14 Speech-Language evaluation. · Obtain physician order for Occupational Therapy/Physical Therapy evaluation to assess/reassess sensorimotor needs for Client C with regards to using the gait belt. · Revise risk plan, IPOP, MAR and train staff for Client C after	

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	W218. 13. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility assessed and/or re-assessed client C's communication skills. Please see W220. 14. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility addressed client G's identified training needs in regard to mealtime and privacy. Please see W227. 15. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure clients' Individual Support Plans included the needed supports to indicate how facility staff were to monitor/supervise client G to prevent self injury, to indicate how facility staff were to assist client C in regard to her gait belt, and/or indicate how facility staff were to restrain client B to prevent injuries. Please see W240. 16. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility addressed client C and D's basic training needs in regard to communication, toileting, bathing,		OT/PT evaluation, should OT/PT evaluation recommend continued use of gait belt. · Obtain physician order for Client C Speech assessment · Once speech assessment completed, Program Director/QIDP will implement formal programming to address speech assessment recommendations for communication skill development. · Programming will be implemented to address Client G's dining needs/slow pace when eating and encouraging fluid between bites and privacy. · Staff will be trained on Client G's ISP revision. · Behavior Analyst has revised Client B's Behavior Support plan to include how the staff were to restrain/hold Client B's arms/hands to assist with the applying protective mitts. · Behavior Analyst has re-trained staff regarding Client B's BSP revision, including how to restrain/hold Client B's arms/hands to assist with applying the protective mitts. · Behavior Analyst will continue to monitor monthly trends in behavior documentation for Client B regarding SIB and suggest to IDT revisions as needed. · Staff will be retrained on completing/documenting 15 minute checks for Client G. · IDT will convene to revise Client G's BSP to include how staff are to monitor/supervise to prevent	

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	dressing and/or oral hygiene. Please see W242. 17. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure clients B, C and D's Individual Program Plan objectives and/or behavior plans were implemented when formal and/or informal training opportunities existed. Please see W249. 18. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Human Rights Committee reviewed all restrictive plans for clients C and D. Please see W262. 19. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure clients C and D's guardian gave written informed consent in regard to the clients' restrictive programs. Please see W263. 20. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility allowed and/or encouraged clients to participate in all aspects of meal preparation, and to allow/encourage clients to feed themselves for clients A, B, C, D, E, F and G. Please see W488.		Client G's SIB. · Behavior Analyst will retrain staff on Client G's BSP including documentation of behavior events regarding Client G. · IDT will convene to discuss and implement plan involving Client G's skin picking/wound on top of head as well as outline/define high-risk monitoring as referenced in physical form from facility nurse on 2/18/15. · Nursing staff will include in risk plan for Client G description of high-risk monitoring as referenced in physical form from facility nurse on 2/18/15. · Program Director/QIDP will implement programming for Client G to promote activity engagement to discourage/help prevent SIB. · Programming will be implemented for Client C addressing personal hygiene, including toileting, dressing and oral hygiene. · Programming will be implemented for Client D addressing bathing and dressing. · Clients B, C and D will be placed on programming for them to assist with meal preparation/dining skills. · Clients C and D will be placed on programming to develop leisure skills. · Staff will be retrained on the importance of ensuring family style dining, active treatment during meal preparation and proper supervision of the client's needs during the meal. · Staff will be retrained on	

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	21. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure its nursing services met the health care needs of clients. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's health care services monitored and supervised staff in regard to medication errors/medication administration, to ensure clients' physicians were contacted in regard to clients' medication errors, updated and/or developed needed risk plans. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure facility staff were trained in regard to wound care and documentation. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's health care services ensured staff repositioned clients, monitored/assessed a client's health care need, addressed a client's dietary recommendations, addressed a client's weight loss and/or ensured facility staff weighed the client weekly as ordered for clients B, C and G. Please see W331. 22. The facility's governing body failed to exercise general policy and operating		client's meal time objectives, communication objectives and dining plans. · Programming will be implemented for Client C regarding hand washing. · Programming will be implemented for Client C regarding dining skills including use of a utensil and wiping mouth. · Staff will be retrained on Client Ds BSP regarding interventions when Client D engages in self-injury/biting. · Staff will be retrained on Client B's BSP regarding redirection to visual schedule. · Obtain legal guardian consent for restrictive measures for hazardous materials for Clients C and D as well as for bite protective sleeves for Client D. · Program Director/QIDP will be retrained regarding obtaining informed consent from guardians regarding restrictive measures. · The Program Director/QIDP will ensure at all times that programming is in place for all clients addressing their identified needs. · Area Director and Program Director/QIDP will evaluate current staff patterns to ensure adequate staffing numbers present in the home at all times to meet client needs. · Program Coordinator and Program Director/QIDP will ensure there are adequate staffing numbers present in the home at all times to meet client needs.	

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	direction over the facility to ensure facility staff were initially trained and demonstrated competency in wound care and on using a Hoyer Lift for clients B and G. Please see W342. 23. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure staff followed doctor's orders in regard to medication administration for clients B, C, D, F and G. Please see W368. 24. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure client G's medication was administered without error. Please see W369. This federal tag relates to complaint #IN00171811. 9-3-1(a)		· Prior to working with the clients in the home, staff will complete client specific training. · Staff will be trained on how to access client programming information and documentation needs in Therap (ISP, risk plans, goals, BSP, etc). · Staff will be retrained on client's meal time objectives, communication objectives and dining plans. · Staff will be retrained on Client Ds BSP regarding interventions when Client D engages in self-injury/biting. · Staff will be retrained on Client Bs BSP regarding redirection to visual schedule. · Human Rights Committee will review and/or approve restrictive measures regarding hazardous materials for Clients C and D as well as bite protective sleeves for Client D. · Programming will be implemented for Clients A, E, F and G for them to assist with meal preparation/dining skills. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication	

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			practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth medication error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one	

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			random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will review the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will review the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors. · Home Manager's (Program Coordinator) employment relationship with facility has been severed. · Client F's Behavior Support Plan will be revised to include descriptions of restrictions/consequences to ensure facility staff do not restrict Client F unfairly and/or appear as disciplinary/punitive for client's actions. · Staff will be retrained on client right restrictions and on Client F's Behavior Support Plan. · Program Coordinator and Program Director will be retrained on client right restrictions as well as not implementing right restrictions until IDT has convened, plans have been updated, staff training has occurred and Human rights committee has reviewed and/or approved restrictions (with consideration given to emergency restrictions for client's safety). ·	

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			Training with Program Director/QIDP regarding incidents requiring investigation. · Program Director/QIDP will revise Client A's ISP and IPOP to indicate Client A giving money away. · IDT will convene to discuss client 'allowance' and approval will be obtained from IDT for any 'allowance' moving forward. · Program Director/QIDP will update ISPs and IPOPs as required regarding any IDT concluded money handling limit. · Program Director/QIDP will discuss with IDT any client request for shopping/spending that does not appear to be in client's best interest. · Program Coordinator and Program Director/QIDP will be retrained regarding facility policy and procedure regarding maintaining a full and complete accounting of client finances. · Program Director/QIDP will audit client finances weekly for one month and thereafter monthly. · Area Director will audit finances monthly for three months and will re-evaluate continued need for monthly audits thereafter. · Training with Program Director/QIDP regarding immediately reporting to the administrator or to other officials in accordance with State law allegations of mistreatment, neglect or abuse as well as injuries of unknown source · Training with Program Director/QIDP regarding incidents	

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			requiring investigation. · Training with staff, Program Coordinator and Program Director/QIDP regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Area Director will review thorough and timely completion of investigations as well as immediate reporting of incidents to administrator or to other officials in accordance with State law through established procedures. · Training with Program Director/QIDP regarding incidents requiring investigation as well as completing investigations thoroughly. · Program Director/QIDP and/or Area Director will ensure investigations are completed and reported to the administration within 5 business days. · Training with Program Coordinator and Program Director/QIDP regarding policy on reporting abuse, neglect and exploitation, including removal/suspension of staff for client protection. · Any allegation of abuse, neglect and/or exploitation will result in immediate removal/suspension of staff for client protection. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient**	

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			practice does not recur: · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth medication error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will monitor the MAR daily for accurate	

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			completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will review the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will review the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors. · Home Manager's (Program Coordinator) employment relationship with facility has been severed. · Client F's Behavior Support Plan will be revised to include descriptions of restrictions/consequences to ensure facility staff do not restrict Client F unfairly and/or appear as disciplinary/punitive for client's actions. · Staff will be retrained on client right restrictions and on Client F's Behavior Support Plan. · Program Coordinator and Program Director will be retrained on client right restrictions as well as not implementing right restrictions until IDT has convened, plans have been	

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			updated, staff training has occurred and Human rights committee has reviewed and/or approved restrictions (with consideration given to emergency restrictions for client's safety). · Training with Program Director/QIDP regarding incidents requiring investigation. · Program Director/QIDP will revise Client A's ISP and IPOP to indicate Client A giving money away. · IDT will convene to discuss client 'allowance' and approval will be obtained from IDT for any 'allowance' moving forward. · Program Director/QIDP will update ISPs and IPOPs as required regarding any IDT concluded money handling limit. · Program Director/QIDP will discuss with IDT any client request for shopping/spending that does not appear to be in client's best interest. · Program Coordinator and Program Director/QIDP will be retrained regarding facility policy and procedure regarding maintaining a full and complete accounting of client finances. · Program Director/QIDP will audit client finances weekly for one month and thereafter monthly. · Area Director will audit finances monthly for three months and will re-evaluate continued need for monthly audits thereafter. · Training with Program Director/QIDP regarding immediately reporting to the administrator or to other officials	

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			in accordance with State law allegations of mistreatment, neglect or abuse as well as injuries of unknown source · Training with Program Director/QIDP regarding incidents requiring investigation. · Training with staff, Program Coordinator and Program Director/QIDP regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Area Director will review thorough and timely completion of investigations as well as immediate reporting of incidents to administrator or to other officials in accordance with State law through established procedures. · Training with Program Director/QIDP regarding incidents requiring investigation as well as completing investigations thoroughly. · Program Director/QIDP and/or Area Director will ensure investigations are completed and reported to the administration within 5 business days. · Training with Program Coordinator and Program Director/QIDP regarding policy on reporting abuse, neglect and exploitation, including removal/suspension of staff for client protection. · Any allegation of abuse, neglect and/or exploitation will result in	

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			immediate removal/suspension of staff for client protection. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth medication error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via emai	

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W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 3 of 4 sampled clients, (B, C and D) and for 3 additional clients (E, F and G). The facility failed to implement its written policy and procedures to ensure clients were not neglected due to medication errors, and in regard to putting corrective measures/actions in place to prevent medication errors which could cause potential harm to the clients. This non-compliance resulted in an Immediate Jeopardy as the facility failed to address a pattern of medication errors and to ensure monitoring and oversight of the group home to prevent errors from occurring. The Immediate Jeopardy was identified on 4/22/15 at 6:00 PM. The Regional Director and the Program Director were notified of the Immediate Jeopardy on 4/22/15 at 6:19 PM. The Immediate Jeopardy began on 4/5/15. The facility submitted a revised plan of removal for the Immediate Jeopardy on 4/23/15 at 1:23 PM. The facility's 4/23/15 plan of removal indicated the Group Home Manager/Program	W 0122	**W122 Client Protections** The facility must ensure that specific client protections requirements are met. **1. What corrective action will be accomplished?** · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth mediation error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes.	06/12/2015

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	Coordinator and staff #2 were suspended from work on 4/22/15. The Program Director was suspended from client contact and "direct line of staff supervision" on 4/22/15. The plan of removal indicated staff #6 was suspended on 4/14/15 and staff #5 was suspended on 4/22/15 from administering medications due to the number of medication errors from January 2015 to April 2015. The plan of removal indicated the remaining staff were retrained on medication administration on 4/23/15 by the facility group home nurse in regard to the following: "- Falsifying documentation, - 6 R's (rights) of administering medications, - Brother's keeper (staff checking the medication records behind the med passer), -What constitutes a medication error, - How to report a medication error. To decrease the risk of medication errors, only select staff (staff #7, #8, #9 and #10) will be designated medication passers only after attending the training with the nurse...." The facility's plan of removal indicated facility staff who did not participate in the training would not be allowed to administer medications until the training was completed with the facility's nurse, and the facility's nurse		· Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors. · Home Manager's (Program Coordinator) employment relationship with facility has been severed. · Client F's Behavior Support Plan will be revised to include descriptions of restrictions/consequences to ensure	

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	would do "medication practicums" to ensure competency of medication administration. The facility's plan of removal indicated the nurse would monitor a medication pass daily, and monitor the Medication Administration Record weekly. The 4/23/15 plan of removal indicated the Program Director and the Area Director would "monitor the completion of a medication practicum monthly." The facility also put in place a disciplinary procedure/process for staff who made medication errors. The facility submitted a revised plan of removal via e-mail on 4/23/15 at 1:23 PM. The Immediate Jeopardy was removed on 4/28/15 at 11:00 AM through observation, interview and record review. It was determined the facility implemented a plan of action to remove the Immediate Jeopardy, and the steps taken removed the immediacy of the problem. Observation of medication passes was completed on the following: -On 4/23/15 at 7:16 AM, staff #10 administered client C and F's 8:00 PM medications without error. -On 4/27/15 at 7:30 PM, staff #10 administered clients E, F and G their 8:00 PM medications. Staff #10 passed the medications without error.		facility staff do not restrict Client F unfairly and/or appear as disciplinary/punitive for client's actions. · Staff will be retrained on client right restrictions and on Client F's Behavior Support Plan. · Program Coordinator and Program Director will be retrained on client right restrictions as well as not implementing right restrictions until IDT has convened, plans have been updated, staff training has occurred and Human rights committee has reviewed and/or approved restrictions (with consideration given to emergency restrictions for client's safety). · Training with Program Director/QIDP regarding incidents requiring investigation as well as thorough completion of investigations. · IDT will convene to discuss Client A 'giving money away' and will revise plans as needed. · IDT will convene to discuss client 'allowance' and approval will be obtained from IDT for any 'allowance' moving forward. · Program Director/QIDP will update ISPs and IPOPs as required regarding any IDT concluded money handling limit. · Program Director/QIDP will discuss with IDT any client request for shopping/spending that does not appear to be in client's best interest. · Program Coordinator and Program Director/QIDP will be retrained regarding facility policy	

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	-On 4/28/15 at 7:00 AM, staff #8 administered clients B, C, D, E, F and G's 7:00 AM and 8:00 AM medications. Staff #8 administered oral medications and completed treatments without error. The facility's inservice records were reviewed on 4/28/15 at 10:43 AM. The facility's Inservice Training Reports indicated the nurse completed Core A training (state required medication administration training) and administering of medication were completed in 2 groups (one group on 4/23/15 and the second group on 4/24/15). The Inservice records indicated the training occurred from 10 AM to 1:00 PM. The facility's Medication Administration Checklist (Practicums) were reviewed on 4/28/15 at 10:50 AM. The facility's medication Practicums indicated the following Practicums were completed by the facility's nurse: -On 4/23/15, the facility's nurse (nurse staff #1, a registered nurse) conducted a medication administration practicum with staff #10 at the 4:00 PM medication pass. The checklist indicated staff #10's medication pass was "Satisfactory."		and procedure regarding maintaining a full and complete accounting of client finances. · Program Director/QIDP will audit client finances weekly for one month and thereafter monthly. · Area Director will audit finances monthly for three months and will re-evaluate continued need for monthly audits thereafter. · Quality Assurance will complete competency based training with Program Director/QIDP and Area Director regarding immediately reporting to the administrator or to other officials in accordance with State law allegations of mistreatment, neglect or abuse as well as injuries of unknown source. · Quality Assurance will complete competency based training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Quality Assurance will complete competency based training with Program Coordinator and Program Director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Area Director and/or Quality	

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	-On 4/24/15, the facility's nurse conducted a medication practicum with staff #8 at the 7 AM medication pass. The checklist indicated staff #8's medication pass was "Satisfactory." The checklist indicated "*[Staff #8] has a pharmacy background which is a great benefit. He understands the importance of accurate administration & (and) is knowledgeable about med(medication) practice." -On 4/25/15, the facility's nurse conducted a medication practicum with staff #9 at the 8 AM med pass. The checklist indicated staff #9's medication pass was "Satisfactory." The checklist indicated "*Asks very appropriate questions, very careful (with) doing meds correctly." -On 4/26/15, nurse staff #2 conducted a medication practicum with staff #7. The checklist indicated staff #7's medication pass was "Satisfactory." -On 4/27/15, the facility's nurse conducted a medication practicum with staff #8 at the 6 AM med pass. The checklist indicated staff #8's medication pass was "Satisfactory." Interview with staff #8 on 4/28/15 at 7:12 AM and 7:40 AM indicated the Area		Assurance will review investigations for thoroughness. · Area Director and/or Quality Assurance will supervise investigation recommendation(s) for completion, including corrective actions. · Quality Assurance will complete competency based training with Program Director/QIDP and Area Director regarding immediate removal/suspension of staff alleged to be abusive, neglectful and/or exploitive, for client protection. · Area Director will report weekly to Regional Director data regarding investigation timeliness. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing	

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	Director was overseeing the management of the group home. Staff #8 indicated he had been retrained on medication administration and documentation. Staff #8 indicated he was aware of three staff who could pass medications (#10 in the evening, #9 on the weekends and staff #8 in the mornings). While the Immediate Jeopardy was removed on 4/28/15, the facility remained out of compliance at the Condition level in that the facility needed to complete competency training with all staff in regard to medication administration. The facility needed to further monitor medication passes and staff to ensure the effectiveness of its plan of removal to ensure clients' medications were administered without error. Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients (E, F and G), the facility failed to implement its written policy and procedures to prevent neglect of client G in regard to her self-injurious behavior (SIB) which resulted in the client going to the wound care center, and/or abuse/mistreatment of clients B and F in regard to the clients' behaviors. The facility failed to ensure management and/or administrative staff immediately reported allegations of abuse, neglect,		medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth mediation error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly,	

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	mistreatment and/or injuries of unknown source to the administrator and/or to state officials. The facility failed to investigate all reported allegations of abuse, neglect, mistreatment and/or injuries of unknown source once reported to management/administrative staff. The facility failed to take appropriate corrective action with a staff who made repeated medication errors, to suspend staff immediately when an allegation was made, and to conduct its investigations/report the results of their investigations within 5 working days to the administrator. The facility failed to ensure the rights of a client in regard to money and/or going out into the community, and to ensure clients' funds held by the facility were accounted for. Findings include: 1. The facility failed to implement its policy and procedures to ensure clients were not neglected in regard to medication errors. The facility failed to ensure clients' medications were administered without error, and to prevent neglect in regard to a pattern of medication errors. The facility failed to ensure the facility implemented its corrective actions/measures and/or put in place corrective actions/measures to prevent medication errors. The facility		medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors. · Home Manager's (Program Coordinator) employment relationship with facility has been severed. · Client F's Behavior Support Plan will be revised to include descriptions of restrictions/consequences to ensure facility staff do not restrict Client F unfairly and/or appear as disciplinary/punitive for client's actions. · Staff will be retrained on client right restrictions and on Client F's Behavior Support Plan. · Program Coordinator and Program Director will be retrained on client right restrictions as well as not implementing right restrictions until IDT has convened, plans have been updated, staff training has occurred and Human rights committee has reviewed and/or approved restrictions (with consideration given to emergency restrictions for client's safety). · Training with Program Director/QIDP regarding incidents requiring investigation as well as thorough completion of investigations. · IDT will convene to discuss Client A 'giving money away' and will revise plans as needed. · IDT will convene to discuss client 'allowance' and approval will be obtained from IDT for any 'allowance' moving forward. · Program	

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	failed to ensure a staff, who made multiple errors with client B's medications, was not allowed to pass/administer clients' medications. The facility failed to implement its policy and procedures to conduct thorough investigations in regard to the medication errors to ensure the staff administered the medications as ordered. The facility failed to ensure its nursing services provided oversight/supervision of the group home, due to repeated medication errors to ensure facility staff administered medications without error to prevent potential harm to the clients who resided at the group home for clients A, B, C, D, E, F and G. Please see W149. 2. The facility failed to ensure client A and F's right to due process in regard to restricting the clients' monies and ability to go on outings/shopping in the community. Please see W125. 3. The facility failed to maintain a system that assured a full and complete accounting of clients A, B, C, D, E and G's personal funds. Please see W140. 4. The facility failed to ensure allegations of abuse, neglect and/or injuries of unknown source reviewed for clients A, B, E, F and G were immediately reported to the		Director/QIDP will update ISPs and IPOPs as required regarding any IDT concluded money handling limit. · Program Director/QIDP will discuss with IDT any client request for shopping/spending that does not appear to be in client's best interest. · Program Coordinator and Program Director/QIDP will be retrained regarding facility policy and procedure regarding maintaining a full and complete accounting of client finances. · Program Director/QIDP will audit client finances weekly for one month and thereafter monthly. · Area Director will audit finances monthly for three months and will re-evaluate continued need for monthly audits thereafter. · Training with Program Director/QIDP regarding immediately reporting to the administrator or to other officials in accordance with State law allegations of mistreatment, neglect or abuse as well as injuries of unknown source · Training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Training with Program Coordinator and Program Director/QIDP regarding timely review of internal incident/injury	

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	administrator, and/or reported to state officials when management and/or administrative staff were made aware of the allegations and/or injuries of unknown source. Please see W153. 5. The facility failed to ensure allegations of abuse, neglect, mistreatment and/or injuries of unknown source reviewed, were thoroughly investigated and documented regarding clients B, C, D, F and G. Please see W154. 6. The facility failed to ensure a staff was immediately suspended when an allegation of abuse was made involving client B. Please see W155. 7. The facility failed to complete an investigation within 5 working days for client B. Please see W156. 8. The facility failed to ensure its recommended corrective actions/measures in regard to medication errors prevented additional errors. The facility failed to ensure its nursing services were involved in retraining staff and/or corrective actions. The facility failed to take appropriate corrective action in regard to a pattern of medication errors made by the same facility staff to ensure clients'		reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Area Director will monitor thorough and timely completion of investigations as well as immediate reporting of incidents to administrator or to other officials in accordance with State law through established procedures. · Any allegation of abuse, neglect and/or exploitation will result in immediate removal/suspension of staff for client protection. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning,	

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	medications were administered without error for clients B, C, D, F and G. Please see W157. This federal tag relates to complaint #IN00171811. 9-3-2(a)		suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth mediation error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly	

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			investigating all incidents of medication errors. · Home Manager's (Program Coordinator) employment relationship with facility has been severed. · Client F's Behavior Support Plan will be revised to include descriptions of restrictions/consequences to ensure facility staff do not restrict Client F unfairly and/or appear as disciplinary/punitive for client's actions. · Staff will be retrained on client right restrictions and on Client F's Behavior Support Plan. · Program Coordinator and Program Director will be retrained on client right restrictions as well as not implementing right restrictions until IDT has convened, plans have been updated, staff training has occurred and Human rights committee has reviewed and/or approved restrictions (with consideration given to emergency restrictions for client's safety). · Training with Program Director/QIDP regarding incidents requiring investigation as well as thorough completion of investigations. · IDT will convene to discuss Client A 'giving money away' and will revise plans as needed. · IDT will convene to discuss client 'allowance' and approval will be obtained from IDT for any 'allowance' moving forward. · Program Director/QIDP will update ISPs and IPOPs as required regarding any IDT concluded money handling limit. · Program	

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			Director/QIDP will discuss with IDT any client request for shopping/spending that does not appear to be in client's best interest. · Program Coordinator and Program Director/QIDP will be retrained regarding facility policy and procedure regarding maintaining a full and complete accounting of client finances. · Program Director/QIDP will audit client finances weekly for one month and thereafter monthly. · Area Director will audit finances monthly for three months and will re-evaluate continued need for monthly audits thereafter. · Training with Program Director/QIDP regarding immediately reporting to the administrator or to other officials in accordance with State law allegations of mistreatment, neglect or abuse as well as injuries of unknown source · Training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Training with Program Coordinator and Program Director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication	

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			errors and injuries of unknown origin). · Area Director will monitor thorough and timely completion of investigations as well as immediate reporting of incidents to administrator or to other officials in accordance with State law through established procedures. · Any allegation of abuse, neglect and/or exploitation will result in immediate removal/suspension of staff for client protection. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure	

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			competency. · A fourth mediation error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors. · Home Manager's (Program Coordinator) employment relationship with facility has been severed. · Client	

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			F's Behavior Support Plan will be revised to include descriptions of restrictions/consequences to ensure facility staff do not restrict Client F unfairly and/or appear as disciplinary/punitive for client's actions. · Staff will be retrained on client right restrictions and on Client F's Behavior Support Plan. · Program Coordinator and Program Director will be retrained on client right restrictions as well as not implementing right restrictions until IDT has convened, plans have been updated, staff training has occurred and Human rights committee has reviewed and/or approved restrictions (with consideration given to emergency restrictions for client's safety). · Training with Program Director/QIDP regarding incidents requiring investigation as well as thorough completion of investigations. · IDT will convene to discuss Client A 'giving money away' and will revise plans as needed. · IDT will convene to discuss client 'allowance' and approval will be obtained from IDT for any 'allowance' moving forward. · Program Director/QIDP will update ISPs and IPOPs as required regarding any IDT concluded money handling limit. · Program Director/QIDP will discuss with IDT any client request for shopping/spending that does not appear to be in client's best interest. · Program Coordinator	

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			and Program Director/QIDP will be retrained regarding facility policy and procedure regarding maintaining a full and complete accounting of client finances. · Program Director/QIDP will audit client finances weekly for one month and thereafter monthly. · Area Director will audit finances monthly for three months and will re-evaluate continued need for monthly audits thereafter. · Training with Program Director/QIDP regarding immediately reporting to the administrator or to other officials in accordance with State law allegations of mistreatment, neglect or abuse as well as injuries of unknown source · Training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Training with Program Coordinator and Program Director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Area Director will monitor thorough and timely completion of investigations as well as immediate reporting of	

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			incidents to administrator or to other officials in accordance with State law through established procedures. · Any allegation of abuse, neglect and/or exploitation will result in immediate removal/suspension of staff for client protection. **1.What is the date by which the systemic changes will be completed?** · **June 12, 2015**	
W 0125 Bldg. 00	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. Based on observation, interview and record review for 1 of 4 sampled clients (A) and for 1 additional client (F), the facility failed to ensure the clients' right to due process in regard to restricting the clients' money and ability to go on outings/shopping in the community. Findings include: During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the group home, client F asked for more toast. Staff #1 stated "What do you have to do to get seconds? Client F then stood and went into the kitchen and cleaned off	W 0125	**W125 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. **1. What corrective action will be accomplished?** · Home Manager's (Program Coordinator) employment relationship with facility has been severed. · Client F's Behavior Support Plan will be revised to include descriptions of	06/12/2015

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	the counters and returned to the dining room table. Client F poured himself a second bowl of cereal and took 2 more toasts. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/21/15 at 1:42 PM and on 4/23/15 at 6:20 PM. The facility's 4/23/15 reportable incident report indicated "Staff members made allegations that Program Coordinator has imposed unapproved restrictions on client (client F). Program Coordinator is currently suspended pending investigation. Follow all recommendations of investigation." The facility's 4/23/15 internal Incident Report (IR) indicated "It was brought to the attention that [client F] could have been subject to unauthorized restrictions. The program coordinator was suspended due to another incident.-it appears the program coordinator is the one that imposed or gave directive to impose the possible restrictions." The facility's End of Shift Reports (EOS) were reviewed on 4/23/15 at 10:45 AM. Client F's 2/24/15 EOS indicated client F "...did his laundry, but didn't fold it. Refused a shower because HM (home manager) said he couldn't have money to		restrictions/consequences to ensure facility staff do not restrict Client F unfairly and/or appear as disciplinary/punitive for client's actions. · Staff will be retrained on client right restrictions and on Client F's Behavior Support Plan. · Program Coordinator and Program Director will be retrained on client right restrictions as well as not implementing right restrictions until IDT has convened, plans have been updated, staff training has occurred and Human rights committee has reviewed and/or approved restrictions (with consideration given to emergency restrictions for client's safety). · For Client F, Human Rights Committee will review and/or approve restrictive measures regarding any rights restrictions included in Behavior Support plan. · Training with Program Director/QIDP regarding incidents requiring investigation. · IDT will convene to discuss Client A 'giving money away,' and will revise plans as needed. · IDT will convene to discuss client 'allowance' and approval will be obtained from IDT for any 'allowance' moving forward. · Program Director/QIDP will update ISPs and IPOPs as required regarding any IDT concluded money handling limit. · Program Director/QIDP will discuss with IDT any client request for shopping/spending that does not	

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	go shopping tonight due to not holding up his end of their agreement. Said he wasn't going to do anything for HM anymore...." The EOS report indicated the PD (Program Director) read the report on 2/24/15. The facility's 2/15 to 4/15 reportable incident reports and/or investigations indicated the facility did not look at the 2/24/15 incident as a possible rights restriction. Client F's record was reviewed on 4/30/15 at 11:06 AM. Client F's 4/20/15 Individual Support Plan (ISP) indicated client F had an objective to recognize when there is inappropriate staffing (home alone, staff leaves in middle of shift, one staff on duty and/or if a staff is sleeping). Client F's 3/19/15 Behavior Support Plan (BSP) indicated "...Teaching Method 12 Please explain to [client F] the natural consequences of non compliant behavior. ie (example), he will miss out on opportunities to go to the convenience store with staff. Give him real life examples. (If staff does not do what they are asked to do then they have consequences but if they do what they are required to do then they get a paycheck)." Client F's 3/15 BSP did not specifically indicate what restrictions/consequences were to be used with client F to ensure		appear to be in client's best interest. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Home Manager's (Program Coordinator) employment relationship with facility has been severed. · Client F's Behavior Support Plan will be revised to include descriptions of restrictions/consequences to ensure facility staff do not restrict Client F unfairly and/or appear as disciplinary/punitive for client's actions. · Staff will be retrained on client right restrictions and on Client F's Behavior Support Plan. · Program Coordinator and Program Director will be retrained on client right restrictions as well as not implementing right restrictions until IDT has convened, plans have been updated, staff training has occurred and Human rights committee has reviewed and/or approved restrictions (with consideration given to emergency restrictions for client's safety). · For Client F, Human Rights Committee will review and/or approve restrictive measures regarding any rights restrictions included in Behavior Support plan.	

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	facility staff did not restrict client F unfairly and/or appear as disciplinary/punitive for the client's actions. Client F's 3/19/15 BSP did not indicate the client had any right restrictions in regard to going out into community, in regard to his money/finances and/or in regard to getting seconds by doing chores. Client F's BSP and/or 4/20/15 Individual Support Plan did not indicate the facility's Human Rights Committee (HRC) reviewed the client's BSP and/or reviewed any rights' restriction for client F as the HRC representative signature section was blank. Client A's record was reviewed on 4/28/15 at 3:00 PM. Client A's 12/18/14 ISP did not indicate client A's money and/or community access should be restricted due to the client's giving away money. Interview with client F on 4/20/15 at 5:46 PM stated he did not like "some" staff at the group home. Client F indicated staff #1 would not take him shopping for clothes. When asked why, client F stated "I don't know. She has my money. I need underwear." Client F also indicated he needed clothes. Client F indicated staff #1 would hide things from him.		· Training with Program Director/QIDP regarding incidents requiring investigation. · IDT will convene to discuss Client A 'giving money away,' and will revise plans as needed. · IDT will convene to discuss client 'allowance' and approval will be obtained from IDT for any 'allowance' moving forward. · Program Director/QIDP will update ISPs and IPOPs as required regarding any IDT concluded money handling limit. · Program Director/QIDP will discuss with IDT any client request for shopping/spending that does not appear to be in client's best interest. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Home Manager's (Program Coordinator) employment relationship with facility has been severed. · Client F's Behavior Support Plan will be revised to include descriptions of restrictions/consequences to ensure facility staff do not restrict Client F unfairly and/or appear as disciplinary/punitive for client's actions. · Staff will be retrained on client right restrictions and on Client F's Behavior Support Plan. · Program Coordinator and Program Director will be retrained on client right restrictions as well as	

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	Confidential interview A indicated clients' rights were being violated. Confidential interview A stated "[Staff #1] was refusing to give [client A] and [client F] money on weekends." Confidential interview A indicated client F needed clothes due to the client's weight gain. Confidential interview A stated staff #1 would call client F "a child" and state the client could not go shopping until he "acted like an adult." Confidential interview A indicated they did not like how the clients were being treated and reported their concerns/allegations regarding staff #1 to the PD and the Area Director. Interview with staff #2 on 4/21/15 at 9:49 AM indicated she did not think client F was on a diet. Staff #2 indicated client F was able to get seconds at meals if he completed a chore first. When asked if getting seconds based on chores was a part of the client's behavior plan, staff #2 stated "Not sure in plan. He gets upset when redirected." Interview with the PD (Program Director) on 4/21/15 at 3:00 PM indicated when asked if the PD was aware of any concerns/allegations of the HM withholding funds of clients and/or talking down to clients, the PD stated "Yes. I looked at it right away." The PD		not implementing right restrictions until IDT has convened, plans have been updated, staff training has occurred and Human rights committee has reviewed and/or approved restrictions (with consideration given to emergency restrictions for client's safety). · For Client F, Human Rights Committee will review and/or approve restrictive measures regarding any rights restrictions included in Behavior Support plan. · Training with Program Director/QIDP regarding incidents requiring investigation. · IDT will convene to discuss Client A 'giving money away,' and will revise plans as needed. · IDT will convene to discuss client 'allowance' and approval will be obtained from IDT for any 'allowance' moving forward. · Program Director/QIDP will update ISPs and IPOPs as required regarding any IDT concluded money handling limit. · Program Director/QIDP will discuss with IDT any client request for shopping/spending that does not appear to be in client's best interest. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Home Manager's (Program Coordinator) employment relationship with facility has been severed. · Client F's Behavior Support Plan will be revised to include	

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	stated the PD spoke with client F and "Conclusion was he (client F) had funds there and access to money." The PD indicated she did not see the concern as an allegation of possible abuse, neglect and/or mistreatment so she did not report it. The PD indicated she investigated the incident but did not document her investigation. Interview with staff #1 on 4/22/15 at 7:55 AM stated client F had "Plenty of underwear. He will wash them and not put them away." When asked when was the last time client F went shopping, staff #1 stated "Last week for a pop." Staff #1 indicated clients A and F received an allowance. Staff #1 stated client F got $1 "on request" and client A received $5 a week. Staff #1 stated client A is "still giving money away." Staff #1 indicated client A's ISP did not address client A's identified need, and there was no documentation in regard to client A giving money to others. Staff #1 indicated clients A and F could get their money when they requested it. When asked how client F was to get seconds at a meal, staff #1 stated "He has to do a chore." Staff #1 indicated the behavior clinician put that in place, and client F was getting a new behavior plan. Interview with PD #2 on 4/23/15 at 10:30		descriptions of restrictions/consequences to ensure facility staff do not restrict Client F unfairly and/or appear as disciplinary/punitive for client's actions. · Staff will be retrained on client right restrictions and on Client F's Behavior Support Plan. · Program Coordinator and Program Director will be retrained on client right restrictions as well as not implementing right restrictions until IDT has convened, plans have been updated, staff training has occurred and Human rights committee has reviewed and/or approved restrictions (with consideration given to emergency restrictions for client's safety). · For Client F, Human Rights Committee will review and/or approve restrictive measures regarding any rights restrictions included in Behavior Support plan. · Training with Program Director/QIDP regarding incidents requiring investigation. · IDT will convene to discuss Client A 'giving money away,' and will revise plans as needed. · IDT will convene to discuss client 'allowance' and approval will be obtained from IDT for any 'allowance' moving forward. · Program Director/QIDP will update ISPs and IPOPs as required regarding any IDT concluded money handling limit. · Program Director/QIDP will discuss with IDT any client request	

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	AM indicated client F did not have a restriction in his behavior plan in regard to how client F was to get seconds and/or have a money restriction. 9-3-2(a)		for shopping/spending that does not appear to be in client's best interest. **1.What is the date by which the systemic changes will be completed?** a. June 12, 2015	
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on observation, record review and interview, the facility failed to maintain a system that assured a full and complete accounting of 4 of 4 sampled clients (clients A, B, C and D) and 2 of 3 (E and G) additional clients' personal funds. Findings include: The Personal Finance Transaction Reports for clients A, B, C, D, E and G were reviewed with the Program Director (PD) #1 on 4/22/15 at 2:24 P.M. Client A's ledger indicated a balance of $31.35 on 3/29/15. Client A had a total of cash on hand of $1.96. Client A's receipts for the month of April totaled $40.07. There was no accounting for how client A spent $8.73 more money than she had.	W 0140	**W140 Client Finances** The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. **1. What corrective action will be accomplished?** · Program Coordinator and Program Director/QIDP will be retrained regarding facility policy and procedure regarding maintaining a full and complete accounting of client finances. · Program Director/QIDP will audit client finances weekly for one month and thereafter monthly. · Area Director will audit finances monthly for three months and will re-evaluate continued need for monthly audits thereafter. **2. How will we identify other residents having the potential to be**	06/12/2015

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	Client B's ledger indicated a balance of $21.64 on 3/31/15. Client B had a total of cash on hand of $7.36. Client B's receipts for the month of April totaled $10.00. There was no accounting for how client B spent $11.64 more money than he had. Client C's ledger indicated a balance of $42.95 on 3/31/15. Client C had a total of cash on hand of $35.21. Client C's receipts for the month of April totaled $5.88. There was no accounting for how client C spent $1.86 more money than she had. Client D's ledger indicated a balance of $59.95 on 3/31/15. Client D had a total of cash on hand of $52.06. Client D's receipts for the month of April totaled $5.88. There was no accounting for how client D spent $2.01 more money than he had. Client E did not have a ledger. Client E had a total of cash on hand of $13.62. Client E's receipts for the month of April totaled $19.88. There was no accounting of client E's personal finances since his date of admission to the group home earlier this year. Client G's ledger indicated a balance of $21.24 on 3/29/15. Client G had a total of		**affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Program Coordinator and Program Director/QIDP will be retrained regarding facility policy and procedure regarding maintaining a full and complete accounting of client finances. · Program Director/QIDP will audit client finances weekly for one month and thereafter monthly. · Area Director will audit finances monthly for three months and will re-evaluate continued need for monthly audits thereafter. · Performance Audits, involving review of client finances will be completed annually by Quality Assurance. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Program Coordinator and Program Director/QIDP will be retrained regarding facility policy and procedure regarding maintaining a full and complete accounting of client finances. · Program Director/QIDP will audit client finances weekly for one month and thereafter monthly. · Area Director will audit finances monthly for three months and will re-evaluate continued need	

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	cash on hand of $13.62. Client G's receipts for the month of April totaled $11.97. There was no accounting for how client G spent $4.25 more money than she had. An interview was conducted with Program Director (PD) #1 on 4/22/15 at 3:09 P.M. When asked about an internal auditing system to ensure the clients' personal funds could be accounted for, PD #1 stated, " The home manager takes care of them through out the month. I am starting at the end of the month when they turn in the ledgers to check the cash on hand with the ledgers. The home manager is to count the money weekly. I count it at the end of the month. No, I have not started this new system at this time." 9-3-2(a)		for monthly audits thereafter. · Performance Audits, involving review of client finances will be completed annually by Quality Assurance. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Program Coordinator and Program Director/QIDP will be retrained regarding facility policy and procedure regarding maintaining a full and complete accounting of client finances. · Program Director/QIDP will audit client finances weekly for one month and thereafter monthly. · Area Director will audit finances monthly for three months and will re-evaluate continued need for monthly audits thereafter. · Performance Audits, involving review of client finances will be completed annually by Quality Assurance **1.What is the date by which the systemic changes will be completed?** 1.June 12, 2015	
W 0149 Bldg. 00	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 3 of 4 sampled clients, (B,	W 0149	**W149 Staff Treatment of Clients** The facility must develop	06/12/2015

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	C and D) and for 3 additional clients (E, F and G), the facility neglected to implement its policy and procedures to ensure clients were not neglected in regard to medication errors. The facility neglected to ensure clients' medications were administered without error, and to prevent neglect in regard to a pattern of medication errors. The facility neglected to ensure the facility implemented its corrective actions/measures and/or put in place corrective actions/measures to prevent medication errors. The facility neglected to ensure a staff, who made multiple errors with client B's medications, was not allowed to pass/administer clients' medications. The facility neglected to implement its policy and procedures to conduct thorough investigations in regard to the medication errors to ensure the staff administered the medications as ordered. The facility neglected to ensure its nursing services provided oversight/supervision of the group home, due to repeated medication errors to ensure facility staff administered medications without error to prevent potential harm to the clients who resided at the group home. Based on observation, interview and record review for 2 of 4 sampled clients (A and B) and for 3 additional clients (E, F and G), the facility neglected to		and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. **1. What corrective action will be accomplished?** · **Staff training has been completed by facility nurse regarding medication administration procedures.** · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth mediation error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members.	

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	implement its written policy and procedures to prevent neglect of client G in regard to her self-injurious behavior (SIB) which resulted in the client going to the wound care center, and/or abuse/mistreatment of clients B and F in regard to the clients' behaviors. The facility neglected to implement its written policy and procedures to ensure its system for reporting all allegations of abuse, neglect, mistreatment and/or injuries of unknown source immediately to the administrator and to state officials was followed when appropriate management and/or administrative staff were made aware of the allegations and/or injuries of unknown source. The facility neglected to implement its written policy and procedures to investigate all reported allegations of abuse, neglect, mistreatment and/or injuries of unknown source management/administrative staff were aware of. The facility neglected to implement its written policy and procedures in regard to taking appropriate corrective action with a staff who made repeated medication errors, to suspend staff immediately when an allegation was made, and to conduct its investigations/report the results of their investigations within 5 working days to the administrator. Findings include:		· The IDT will convene to discuss identified needs as necessary. · Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will supervise the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Quality Assurance will complete competency based training with Program Director/QIDP regarding thoroughly investigating all incidents of medication errors. · Quality Assurance will complete competency based training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Quality Assurance will	

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	A. During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the group home, client G ate her breakfast at 6:49 AM. Staff #1 indicated she was going to pass medications on 4/21/15 and give staff #2 a "break." Client G came to the medication room to get her morning medications at 7:25 AM. Client G assisted staff in administering her own medications as staff #1 would hold a pill bottle (one at a time) and hand it to client G to get a pill out of the bottle. Client G received Omeprazole 40 milligrams 1 tablet at the morning medication pass. Client G's Omeprazole DR (non erosive gastritis) bottle indicated the client was to receive the medication 20 minutes prior to meals. Interview with staff #1 on 4/21/15 at 7:50 AM indicated when asked why client G's Omeprazole was administered after breakfast, staff #1 stated "If she does not take with other meds she will not take it. Our nurse gave us permission to give it after meals versus before meals." During the 4/22/15 observation period between 6:25 AM and 7:38 AM, at the group home, client B was sitting at the dining room table having breakfast upon arrival to the group home. Client B sat in his wheelchair until the client left for the day program. The client did not get any		complete competency based training with Program Coordinator and Program Director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Area Director and/or Quality Assurance will review investigations for thoroughness. · Area Director and/or Quality Assurance will supervise investigation recommendation(s) for completion, including corrective actions. · Area Director will report weekly to Regional Director data regarding investigation timeliness. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing	

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	medications (8 AM medications). Staff #2 passed clients' medications in the group home on 4/22/15. Interview with staff #1 on 4/22/15 at 7:40 AM by phone indicated client B received his 8 AM morning medications Oxcarbazepine 600mg tablet (for seizures) and Reno Caps Softgel 1 mg (for ulcer healing) after client B got up on 4/22/15 around 6 AM. Staff #1 indicated client B would have behaviors if they gave him the medications before he left for work. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/21/15 at 1:45 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following medication errors: 1. On 2/14/15, "It was reported on Sunday February 15, 2015 at 8pm (sic) that the 8am medications at Selma on February 14, 2015 were not passed. This med (medication) error occurred due to new staff and that this med pass was to occur during a shift change. All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR (medication administration record) at the beginning of their shift. No side effects were seen after this med error. The prescribing		medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth mediation error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication	

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	doctor was not contacted. Nurse and Program Director (PD) were contacted about this med error. As of 3pm on Monday February 16, 2015, there were still no side effects from this med error." The facility's 2/14/15 reportable incident reports indicated clients B, C, D, F and G did not receive their medications. The facility's 2/14/15 reportable incident reports indicated the facility was not aware of the medication error until 2/15/15 at 8:00 PM. The facility's 2/18/15 Investigation Summaries for clients B, C, D, F and G indicated staff #2 made the 2/14/15 medication errors. The facility's 2/18/15 investigations indicated in the Factual Findings section "Interview with [staff #2] (DSP) (Direct Support Professional) on February 17, 2015 -Stated that this consumer (clients C, D, F and G on 4 separate summaries) didn't have a med error. -Stated that she (staff #2) doesn't have Therap (facility computerized record system) access and couldn't record on the M.A.R...." The facility's 2/18/15 investigations indicated staff #3 and #4 indicated the clients did not receive their medications, and were not present when staff #2 administered the medications. The facility's investigations indicated clients C, D, F and G were not		practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015 **2. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth mediation error will result in severing the	

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	interviewed. The facility's investigation indicated client F was "...Able to verbally communicate wants and needs-may not recall details accurately...." Client G's 2/18/15 investigative summary indicated client G was "...Deaf-able to communication (sic) some wants and needs thru (sic) little signing-unable to recall details accurately...." Client C and D's 2/18/15 investigation summary indicated "...Non-verbal; doesn't know all of her medications and is unable to communicate to staff if they did a med error....." Client B's 2/18/15 Investigation Summary under the section entitled Factual Findings, indicated "Interview with [staff #2] (DSP) on February 17, 2015 -Stated this consumer didn't get his medications because she (staff #2) was waiting to do it when the next staff came in to assist her. -Stated that she forgot to do it when the next staff came in. -Stated that she doesn't have Therap access and couldn't record on the MAR...." The facility's investigation indicated client B was "... Semi-verbal to communicate wants and needs to regular daily staff; May not recall details accurately...." The facility's 2/18/15 investigation summaries		employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors.	

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	indicated the facility neglected to conduct a thorough investigation as no client interviews were conducted, no additional staff were interviewed, and the facility's investigation did not indicate what records were reviewed, and/or indicate how the facility was assured the clients' medications had been administered. The facility's investigation and/or reportable incident report neglected to indicate what medications did not get administered at the 8 AM medication pass. The facility's 2/18/15 investigation neglected to indicate if any corrective actions/measures were recommended and/or put in place to prevent to similar errors in the future. 2. On 2/18/15, "It was reported to the HM (home manager) on Wednesday February 18, 2015 at 8:15pm that [client C] was accidentally given her 8am medications (due on 2-19-15) at the 4pm med pass on 2-18-15. This med error occurred due staff not have her full concentration and focus on this med error at the time (sic). All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR at the beginning of their shift. No side effects were seen after this med error. The prescribing doctor was not contacted. Nurse and Program Director were contacted about this med error on			

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	2-18-15 right (sic) the HM learned of this error...This certain staff will be retrained over how to properly pass medications." The facility's 2/24/15 Investigation Summary indicated staff #5 made the medication error. The facility's investigation indicated client C was not interviewed as the client was non-verbal and did not know all of her medications. The facility's 2/18/15 investigation indicated staff #5 "...Stated that she would be willing to go thru (sic) additional training for med passes...." 3. On 2/26/15, "It was reported that on Thursday February 26, 2015 at 8pm that staff (staff #5) completed a med error with [client G] (client G). Staff forgot to give [client G] one of her medications. This med error occurred due to staff not realizing that [client G] had this medication. This medication is new to [client G]. All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR and their messages at the beginning of their shift. The home manager was reminded to inform all staff about any changes in the consumers' medications. No side effects were seen after this med error. The prescribing doctor was not contacted. Nurse and Program Director were contacted about this med error. As of 4:30pm on Friday			

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	February 27, 2015, there were still no side effects from this med error." The facility's 3/3/15 follow-up to the 2/26/15 reportable incident report indicated client G did not receive her ordered Xanax .25 milligrams (controlled substance-skin picking). 4. On 3/1/15, "It was reported that on Sunday March 1, 2015 at 8pm that staff (staff #4) completed a med error with [client G]. Staff forgot to give [client G] her Xanax (Alprazolam) .25mg tablet. [Client G] is to receive this medication 2 times a day. All staff are reminded to follow the 6 rights of medication administration. All staff are reminded to check the MAR and their messages at the beginning of their shift. The home manager was reminded to inform all staff about any changes in the consumer's medications. No side effects were seen after this med error. The prescribing doctor was not contacted. Nurse and Program Director were contacted about this med error...At house meeting on Wednesday all staff (including the staff who made the error) will be retrained by the HM and PD (Program Director)." The facility's 3/3/15 Investigation Summary indicated staff #4 "...Stated that she thought she passed all of [client G's]			

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	medications and didn't know about this med error until now. -Stated that she will remember next time to pass it and will work slower with med pass...." The facility's 3/3/15 Incident Management Quality Review indicated "Nurse Recommendations (if applicable):" was blank. 5. On 3/14/15, "It was discovered that at 11am on Saturday March 14, 2015 that [client B] had a med error. [Client B's] Oxcarbazepine 600mg tablet (for seizures) and Reno Caps Softgel 1 mg (for ulcer healing) were not passed. The weekend day staff discovered this med error. Normally the 3rd (third) shift staff (staff #2) passes the morning 8am medications. [Client B] was the only consumer in this house that 3rd shift staff forgot to pass the medications for...The staff was reminded to follow the 6 rights of medication administration. This staff was reminded to check the MAR at the beginning of the med pass, during the med pass, and after the med pass. No side effects were seen after this med error. The prescribing doctor was not contacted. Home Manager and Program Director was (sic) contacted about this med error. As of 8pm that day, there still were no side effects from this med error...."			

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	The facility's 3/20/15 Investigation Summary indicated the investigator (PD) looked at the BDDS (Bureau of Developmental Disabilities Services) report and the client's 3/14/15 MAR. The facility's investigation indicated staff #2 "...Stated that she left [client B's] medications to be completed by the following staff. - Stated that she completed everyone else's med passes. Interview with [staff #7] (DSP) (Direct Support Professional) on March 14, 2015 - Stated that when she came in for the start of her shift, [staff #2] was already hurrying out of the door. - Stated that she assumed all of the medications were already passed. - Stated that she called the PD as soon as she noticed this med error...." The facility's investigation summary indicated "...This staff was reminded to not be in a hurry to leave at the end of your shift, but be patient and to give a summary to the next staff on duty...." The facility's 3/20/15 Incident Management Quality Assurance Review indicated the facility's nurse did not review and/or make any recommendations in regard to 3/14/15 medication error as the nurse's section was blank. 6. On 3/23/15, "It was reported on			

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	Monday March 23, 2015 at 8pm that [client F] didn't receive his 8am medications that morning. Those missed medications include (Chlorhexidine 0.12% Rinse-15ml (milliliters) (Gingivitis); Invega ER 9 MB tablet (psychosis); Lisinopril 10 mg-(Hypertension); and Topiramate 50 MG tablet (Mood stabilizer). Staff was reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR at the beginning of their shift. No side effects were seen after this med error. The prescribing doctor was not contacted. Home Manager and Program Director was (sic) contacted about this med error. As of 3-25-15, there were still no side effects from this med error...." The facility's 3/27/15 Investigation Summary indicated staff #6 had made the error on 3/23/15. The facility's investigation indicated staff #6 "...Stated that she followed her normal routine of passing medication and doesn't know how she forgotten (sic) to pass [client F] those medications.- Stated that it was a busy morning trying to get all of the consumers ready for their Day Programs and ready for transport...." The facility's 3/27/15 Incident Management Quality Assurance Review			

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	indicated the facility's nurse did not make any recommendations as the Nurse's area was blank. 7. On 4/5/15, "It was reported on Sunday April 5, 2015 at 4pm that the 8am medications for [client B] were not passed earlier that day...This med error occurred due to confusion of who was going to pass his medications. All staff were reminded to communicate with each other during shift changes. All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR at the beginning of their shift. No side effects were seen after this med error. The prescribing doctor was not contacted. Nurse and Program Director were contacted about this med error." The facility's 4/14/15 follow-up report to the 4/5/15 reportable incident report indicated client B did not receive his 8 AM Oxcarbazepine and Reno Softgel medications. The facility's 4/14/15 Investigation Summary indicated staff #2 had left client B's medications to be administered by the day shift staff "...per the day shift's request...." The facility's investigation indicated the facility neglected to conduct a thorough investigation in regard to why			

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	staff #2 could/would not administer client B's medication as this was the third incident/pattern of staff #2 not administering the client's morning medications. The facility's 4/14/15 Incident Management Quality Assurance Review indicated recommendation by the facility's Area Director (AD) of "Follow MAR & (and) med pass protocol. Med Practicum with staff." 8. On 4/12/15, "It was reported that [client B] was not given his 8am on Sunday April 12th. [Client B] did not receive the following medications. OXCARBAZEPINE 600 MG TABLET for seizures & RENO CAPS SOFTGEL 1mg for Ulcer Healing. Late reporting of this BDDS report due to staff late reporting to the Program Director. The med error occurred due (sic) confusion between the 3rd shift staff and the day shift staff who was going to pass [client B's] medications. All staff were reminded to communicate with each other during shift changes. All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR at the beginning of their shift. Record of discussion was completed with the staff. No side effects were seen after this med			

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	error. The prescribing doctor was not contacted. This med error was reported late to the Nurse and the Program Director." The facility's 4/14/15 Investigation Summary indicated staff #2 was the staff who made the medication error. The facility's investigation indicated staff #2 "...Stated that she left [client B's] medications to be done by the following staff per the day shift's request. - Stated that she completed everyone else's med passes...." The facility's 4/14/15 investigation indicated staff #7 stated that when she came in for her shift she forgot that she wanted to pass [client B's] medications...." The facility's 4/14/15 investigation neglected to indicate why the day shift passed client B's medication versus the third shift. The facility's 4/14/15 Incident Management Review indicated the AD recommended on 4/15/15 to complete a medication practicum with staff (#2). The 4/14/15 incident form indicated the facility's nurse did not review the incidents and/or make any recommendations. The facility's incident review form and/or 4/14/15 investigation indicated the facility neglected to address staff #2's pattern of medication errors (4) with client B.			

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	The facility's above mentioned reportable incident reports/medication errors indicated the facility neglected to notify clients B, C, D, F and G's physicians in regard to the medication errors. The facility neglected to have its nursing services monitor and/or provide oversight of the staff when passing medications to ensure staff were competent to pass medications without error. The facility neglected to ensure its corrective actions/measures prevented medication errors. The facility neglected to address the pattern of medication errors with staff #2 which involved client B. Client G's record was reviewed on 4/22/15 at 5:05 PM. Client G's 3/31/15 physician's orders indicated client G received Omeprazole 40 milligrams 20 minutes before breakfast daily for 3 months. Client G's April's 2015 MAR indicated client G received Alprazolam (skin picking) 0.25 milligrams, Artificial tears (dry eyes) daily at 8:00 Baclofen (Cerebral Palsy) 10 milligrams, Calcium 500+D (Menopause) two times a day, Citalopram HBR(hydrobromide) 40 milligrams (Depressive Disorder), Cranberry Juice three times a day, Divalproex Sod DR (delayed release) 500			

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	milligrams (Seizure Control), Ocala (stool softener)100 milligrams daily, Loratadine (allergy) 10 milligrams, Oxybutynin CL (chloride-incontinence) ER (extended release) 5 milligrams and Santyl (wound care dressing) dressing. Client G's April, 2015 MAR indicated client G did not receive her morning medications at the 8 AM medication pass on 4/22/15 as there was no documentation/initials for the medication pass. Client B's record was reviewed on 4/23/15 at 10:35 AM. Client B's 2/13/15 Quarterly physical (physician's order) indicated client B received Oxcarbazepine 600 milligrams in the morning and 1 Reno Caps daily. Client B's April 2015 MAR indicated client B received the Reno Capsule in the morning at 8 AM. Client B's 2/13/15 Quarterly Physical indicated client B's diagnosis included, but was not limited to, Epilepsy Unspecified. Client C's April 2015 MAR was reviewed on 4/23/15 at 7:15 AM. Client C's April 2015 MAR indicated client C received the following medications at the 8:00 AM medication pass: Calcium Carb/D 500-400 (supplement) chew three times a day, Polyethylene Glycol (constipation) daily at 8 AM, Primidone			

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	(Seizures) 250 and milligrams two times a day. Client D's April 2015 MAR was reviewed on 4/23/15 at 7:15 AM. Client D's April 2015 MAR indicated client D received the following medications at 8:00 AM: Calcium Carb (nutritional supplement) 500 milligrams, Carnation Instant Breakfast (supplement) and Chlorhexidine Rinse 0.12% for periodontal disease. Client F's April 2015 MAR was reviewed on 4/23/15 7:15 AM. Client F's April 2015 MAR indicated client F received the following 7:00 AM and 8:00 AM medications: Chlorhexidine Rinse (gingivitis), Invega (Psychosis) ER 9 milligrams, Lisinopril (Hypertension) once daily and Topiramate (mood) 50 milligrams two times a day. The facility's End of Shift (EOS) reports were reviewed on 4/23/15 at 10:45 AM. The facility's 3/1/15 report indicated "...I (staff #7) came across [client E's] medication that is on hold was passed this morning. there (sic) is (sic) only supposed to be 56 left and there is (sic) 50 left. The hole for this morning was also marked on the MAR. I called the HM (home manager) and informed her of what I had found. She said she would			

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	handle it...." Review of the facility's reportable incident reports from February 2015 to the present indicated the HM neglected to report client E's medication error. The facility's Inservice records were reviewed on 4/22/15 at 10:55 AM. The facility's inservice records indicated facility staff were retrained in regard to Medication Pass/administration on 3/4/15 and on 4/1/15. The facility's 4/1/15 Inservice Meeting record indicated staff #2 was retrained in medication administration on 4/1/15. Staff #2 did not attend the 3/4/15 training. Staff #2's personnel record was reviewed on 4/22/15 at 4:05 PM. Staff #2's personnel record indicated staff #2 Core A and B (state training to pass medications) was A-88% and B-88%. Staff #2's personnel record indicated Staff #2 received a Record of Discussion Form on 4/1/15. The form indicated "90 Day check up; Discuss Med Pass, MARs, Documentation...[Staff #2] is having difficulties w/ (with) passing meds, documenting, following orders, etc. DSP (staff #2) will contact HM/PD if needs additional training. DSP to correct these issues/concerns." Review of the facility's reportable incident reports indicated staff #2 continued to have medication errors			

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	after her 4/1/15 record of discussion. Confidential interview A indicated facility staff documented medications were given when clients' medications had not been administered. Confidential interview A indicated there had been more medication errors at the group home than had been reported. Confidential interview A indicated when meds were not given, they would be returned to the pharmacy. Confidential interview E indicated the third shift staff would make medication errors on the weekend. Interview with the Area Director (AD) and the Program Director (PD) on 4/21/15 at 3:00 PM indicated the facility's nurse would conduct the core A and B training. The PD and the AD indicated the group home manager would do the medication Practicum which would initially be done before staff could actually pass medications. The PD and the AD indicated they were aware the home was having problems with medication errors. The PD indicated they had discussed and retrained staff in regard to the medication administration policy at staff meetings and by doing medication practicums. The PD and the AD stated the group home manager was			

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	15G364		05/13/2015

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	doing one "random" medication practicum a week. The PD stated if there was a medication error, the staff would receive a "Record of Discussion before you get a written warning." The PD and AD indicated the facility's nurse did not participate in staff meetings and did not conduct any medication practicums. The PD and the AD indicated the staff continued to have medication errors. The AD indicated their corrective action had not been working in regard to retraining staff. The PD indicated they were aware of the issues with staff #2. The PD stated they were working with HR (Human Resources) "to do a final warning. We tried retraining and that's why we are going to HR." The PD indicated staff #2 was still allowed to pass medication. The PD stated "She is unsure how to help him (client B)." The PD and AD indicated staff #2 was not sure how to administer client B's medication to the client as he would get upset at times. The PD and the AD indicated they had not provided any additional training with staff #2 to assist the staff to be able to handle and/or pass medications to client B. The PD indicated the facility had retrained staff in regard to the 6 rights of medication and medication administration. The PD and the AD indicated they were not aware of any false documentation in the group home. The PD indicated no clients			

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	and/or additional staff were interviewed in regard to the medication errors. Interview with staff #1 on 4/22/15 at 8:55 AM stated she completed med practicums "1 time a month and as needed as they tell me to do so." Staff #1 stated "Every med error gets a practicum up to 3 and then a verbal write up." Interview with the PD on 4/22/15 at 11:01 AM stated the facility just started doing the "random" Medication Practicums one to one and a half weeks ago. The PD indicated the manager had only done 1 random practicum and that was on 3/4/15. The other medication practicums were done last week with different staff. When asked if client G received her AM medications on 4/22/15, the PD indicated she had asked the manager and the manager indicated staff #2 did administer client G's medications but did not sign the MAR. When asked how they knew she administered the medications, the PD indicated the medication sticker/label was in the book which came off the medication packet. The PD indicated the manager stated staff #2 passed the medications. The PD indicated it did not appear the manager was with staff #2 when staff #2 passed the medications.			

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	Interview with the State Director on 4/22/15 at 11:55 AM indicated she was told the facility was monitoring staff #2 and she was not to pass medications unless the manager was present with her. The State Director indicated this was to have started a week ago. Interview with nurse staff #1 on 4/22/15 at 4:26 PM, by phone, stated if there is a medication error, "They should contact the the doctor immediately." Nurse staff #1 indicated the client's doctor should still be contacted even if it the error was discovered at a later date. Nurse staff #1 indicated she was not always informed when a medication error occurred. Nurse staff #1 stated "Only if informed of med errors." Nurse staff #1 stated she was aware of a medication error with client B in April, but "it was after the fact." Nurse staff #1 indicated client B did not get his medications on a Saturday and a Sunday. Nurse staff #1 indicated she would check the MARs when she was in the group home. Nurse staff #1 indicated there may have been some medication errors in the group home in March 2015. Nurse staff #1 indicated the group home's medication errors were due to staff signing/initialing the MAR as if the medications were given, but they had not been given. Nurse staff #1 indicated she did not monitor the group home in regard to			

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	medication errors. Nurse staff #1 indicated the HM and the PD trained and/or retrained staff. Nurse staff #1 stated "I do not monitor med passes unless I am asked to do so." Nurse staff #1 indicated if medications are not given, the pills would be returned to the pharmacy. Nurse staff #1 indicated there was no tracking/documentation to show how much medication was being returned to the pharmacy. When asked when client G should take her Omeprazole, Nurse staff #1 indicated it would probably be before she ate breakfast, but it would depend how it was written on the physician's orders. When asked if she gave staff permission to give client G the Omeprazole after breakfast when she had an order to be administered 20 minutes before her meal, nurse staff #1 stated "No." Nurse staff #1 indicated there would have to be an order to do that. Nurse staff #1 indicated she may have given permission one time for them to do that, but it would have been for that one time. Nurse staff #1 indicated she could not remember doing that. The facility's Medication Practicums (Medication Administration Skills Checklist) were reviewed on 4/22/15 at 10:55 AM. The checklists indicated the Home Manager completed the checklists. The checklists indicated the manager did			

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	a medication practicum with staff #2 on 4/14/15. The 4/14/15 practicum/checklist indicated staff #2 had check marks in the "Satisfactory" column. Review of the Medication skills checklist from 10/14 to 4/15 indicated the facility did not conduct any additional checklists. Review of the facility's Medication Practicums indicated the Home Manager conducted one random checklist prior to April 2015 on 3/4/15 with staff #8. The facility's policy and procedures were reviewed on 4/21/15 2:55 PM and on 4/22/15 at 12:35 PM. The facility's April 2011 policy entitled Operating Practices-Supervised Group Living Services indicated "Staff who are trained and certified according to state regulations, may administer prescription medication to any individual in accordance with a written medication order from the individual's physician...." The policy indicated "...9. Proper administration is critical. All medication errors are serious. Due to potential health implications, medication errors will result in retraining and/or disciplinary action as indicated by the frequency and severity of the error(s)...d. The staff person designated on the schedule as responsible for medication administration for each shift will:			

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	(5) Check the Medication Administration Record (MAR) at the beginning of his shift to ensure medication administration was completed correctly on the previous shift, and at the end if his shift to ensure medication administration was completed correctly for his shift. (6) If an actual medication error is discovered, the staff person will notify the on-call supervisor. The on-call supervisor will determine any action to be taken at that time, and will notify the individual's nurse and physician if required...d. The Area Director will compile a list of all medication errors made each month to determine trends in each team that may indicate the need for investigation, evaluation, training, and/or discipline. The Nursing Supervisor and Quality Assurance Director will review all medication errors to determine company wide trends that may indicate the need for retraining, policy revision or other interventions...." The facility's April 2011 policy entitled Operating Practices-Supervised Group Living Services indicated "...It is the policy of Indiana Mentor to protect the individuals being served who, because of physical or mental disabilities, are particularly vulnerable to abuse, exploitation, or neglect. It is also the intent of the company to take steps			

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	needed to ensure the health, safety, and welfare of the individuals served in cases where their safety may be compromised...." B. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, at the group home, client B had 2 gloves/mitts attached to the handles of his wheelchair. Client B had two open areas on the back of his right hand. The smaller area was raised, open with a scab starting to form. The larger area was red and open with swollen tissue surrounding the area. The larger area was about the size of an eraser tip and the smaller area was slightly smaller than an eraser tip. Interview with client F on 4/20/15 at 5:46 PM stated he did not like "some" staff at the group home. Client F indicated staff #1 would not take him shopping for clothes. When asked why, client F stated "I don't know. She has my money. I need underwear." Client F also indicated he needed clothes. Client F indicated staff #1 would hide things from him. Interview with client B's mother on 4/21/15 at 9:29 AM, by phone, indicated she had reported a bruise on client B's right forearm about two to two and a half weeks ago. Client B's mother indicated she saw the bruise when client B came to			

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	visit that weekend. Client B's mother stated "Weekend staff filled out paper work and [staff #1] knew of paper but said she (staff #1) did not see bruise." Client B's mother indicated client B's injury of unknown source was not reported to the Bureau of Developmental Disabilities Services (BDDS-state licensing and reporting agency) as client B's mother had spoken with the BDDS Coordinator. Client B's mother stated the bruise on client B's arm "looked like a thumb print." Client B's mother indicated she found out staff were holding client B's arm down when he started to bite his arm. Client B's mother stated client B called her last Monday (4/13/15) stating "Mom help." Client B's mother indicated client B was upset. Client B's mother indicated client A got on the phone and tried to explain what client B was trying to tell her. Client B's mother indicated client A indicated they were having waffles for breakfast but client A wanted eggs and started biting his arm. Client B's mother stated client A stated staff #8 told the client he was having waffles and not eggs when "staff #6 got involved and held [client B's] arms down and [staff #8] took him (client B) to his room." Client B's mother indicated staff #8 did not know he (staff #8) was not allowed to put client B in his room when he was having a behavior of biting his arm. Client B's			

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	mother indicated she called staff #1 and reported the allegation of abuse/neglect to staff #1. Client B's mother indicated staff #1 stated "She (staff #1) would make phone calls and take care of it." Client B's mother indicated on 4/14/15 in the morning, she called the group home to speak with client B when staff #6 answered the phone. Client B's mother indicated she asked staff #1 why [staff #6] was answering the phone, and staff #1 stated "Because she (staff #6) works here." Client B's mother stated staff #1 did not report "the allegation of abuse/neglect" as staff #6 was still working on 4/14/15. Client B's mother indicated she then called the main office and spoke with the Regional Director and the Area Director. Client B's mother indicated the facility's investigation was not started until Friday (4/17/15) when administrative staff called to interview her. Client B's mother stated she asked for a copy of the client B's Medication Administration Records (MARs) as the client had not been given his morning medication "3 to 4 times." Client B's mother indicated staff were signing the MARs as if the client's medications had been passed/given. Interview with client A on 4/21/15 at 11:00 AM indicated staff #6 had held client B's arms down. Client A indicated			

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	she saw/witnessed staff #6 holding the client's arms. Client A indicated she (client A) would sleep in the living room at night in her sleeping bag. Client A stated staff #2 would be on the phone "texting." Client A stated staff #2 was "sleeping part time in the living room." When asked if she had told anyone about staff #2's sleeping, client A stated "I told [staff #1]. Not sure how long ago." During the 4/21/15 interview, client A indicated client F had aggressed against her. Client A stated "[Client F] pushed me at office." Client A indicated client F had done that before and pushed client D. Interview with client B on 4/21/15 at 12:05 PM, with the day program manager (DPM) present, indicated client B could answer yes and no questions with some verbalization of words. Client B indicated he did not like the group home and/or staff. During the interview client B pointed to and looked at his arm. When asked if client B had any bruising on his arm, client B stated "Yes." The day program supervisor checked client B's arm, shoulder and back and did not find a bruise at that time. When asked if client B had a bruise on his arm before, client B stated "Yes." When asked if a client caused the bruise, client B stated "No." When asked if staff caused the bruise, client B stated "Yeah." Client B			

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	indicated facility staff would also yell at him. Interview with the DPM on 4/21/15 at 12:20 PM indicated the DPM was on call a couple of weeks ago when the weekend staff called on call and indicated client B did not get his 8 AM medications and to report a bruise on client B's arm. The DPM produced an "Program Coordinator On Call Book Summary of Calls." The On call book was reviewed on 4/21/15 at 12:20 PM which indicated client B did not receive his 8 AM medications on 4/5/15. The on-call book indicated "...Staff reported [client B] has bruising on right forearm that mom is concerned about. Reported to [PD] instructed staff to do GER on both." The DPM indicated the DPM spoke with facility staff from "5:40 to 5:55" on 4/21/15. The DPM indicated the PD was her supervisor and the PD was responsible for making a BDDS report for the medication error and for client B's injury/concern. Confidential interview A stated they had told staff #6 "to stop" as staff #6 had "grabbed" client B when restraining his arms. Confidential interview A stated they were to hold client B's arms down with "open hands." Confidential interview A stated they reported staff #6 for "yelling at clients and grabbing [client			

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	B's] arm" to staff #1 and to the Program Director (PD). Confidential interview A stated staff #1 had also "grabbed" client B's arms using an "inappropriate hold with a closed hand." Confidential interview A stated holding client B's arms with a "closed hand" would "leave marks"on the client. Confidential interview A stated client B had a bruise on his right arm which looked like a "thumb print." Confidential interview A indicated they reported the bruise on a "GER" (General Events Report-internal incident report) three to four days after confidential interview A realized the bruise had not been reported, and documented the bruise in an End of Shift (EOS) report. Confidential interview A indicated clients' rights were being violated. Confidential interview A stated "[Staff #1] was refusing to give [client A] and [client F] money on weekends." Confidential interview A indicated client F needed clothes due to the client's weight gain. Confidential interview A stated staff #1 would call client F "a child" and state the client could not go shopping until he "acted like an adult." Confidential interview A indicated they did not like how the clients were being treated and reported their concerns/allegations regarding staff #1 to the PD and the Area Director. Confidential interview A indicated they			

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	had reported clients B and F of being incontinent of bowel and/or bladder when they returned from the day program. Confidential interview A stated "this had been reported several times" to the HM and the PD. Confidential interview A also indicated the Area Director was also aware of the concern. Confidential interview A indicated staff #2 had been sleeping while on duty and was smoking in the bathroom. Confidential interview A indicated client A reported to staff about staff #2's sleeping while working on the night shift. Confidential interview A indicated they reported the allegation of neglect to the PD. Confidential interview A stated they "by passed [staff #1]." When asked when the allegation was reported, confidential interview A stated "Reported initially 1 month ago when [client A] told me." Confidential interview A indicated some staff were concerned about retaliation as the home manager had retaliated against a staff person before. When asked if they had been interviewed in regard to any allegations of abuse/mistreatment and/or injuries of unknown source regarding client B, confidential interview A stated "I'm not aware of any staff being interviewed." Confidential interview A indicated client B's bruise on his right arm, and the allegation of staff holding client #6's arm due to an incident over			

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	eggs, were 2 separate incidents. Confidential interview B stated when asked how facility staff treated clients, "Staff [staff #6] rude to me and clients." Confidential interview B stated "She yelled a lot at [client F]. He would get upset when she was here." When asked how client B got the bruise on his arm, confidential interview B stated "From [staff #6] restraining him in morning." Confidential interview B indicated they saw/witnessed staff #6 restraining client B. Confidential interview B stated "She (staff #6) holds too tight with a closed hand." When asked if the facility had interviewed them in regard to client B's bruise, confidential interview B stated "No." When asked if confidential interview B had reported these allegations of abuse/mistreatment, confidential interview B stated "No. Staff on weekend know as we talked about it. I did not report." Confidential interview D indicated client B bit the areas open on his hands. Confidential interview D stated facility staff were to put his mitts on when the client started biting himself. Confidential interview D indicated they did not have any problems with redirecting client B when he became upset. Confidential interview D indicated stated "I do well			

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	with him. I talk with him and calm him down. I feel you should not have to do that (restrain him). You can talk to him." Confidential interview D indicated client B recently had a bruise on his right wrist/forearm area. Confidential interview D indicated she was not sure how client B received the bruise. Confidential interview D stated client B's bruise was documented on Therap (facility's computer system) on the client's "skin and wound form." Confidential interview E indicated client B had open areas on his right hand due to client B's biting his hands when upset. Confidential interview E indicated client B required physical redirection/restraints of arms when the client demonstrated SIB (self-injurious behavior) of biting his arm. Confidential interview E indicated facility staff would have to hold client B's arms down to put on the client's gloves/mitts when he attempted to bite himself. Confidential interview E stated "Staff to put hands flat to not leave marks." Confidential interview E stated "I seen bruises a couple of weekends ago. Looked like thumb print." Confidential interview E indicated facility staff called the on-call person (DPM) and reported client B's medications not being given that morning and the bruise on client B's arm. Confidential interview E indicated			

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	the on call instructed facility staff to fill out a GER. Confidential interview E stated "Approximately five minutes later," the PD called group home and instructed staff to not fill out the GER indicating the PD would take care of it. Confidential interview E stated "Company is not reporting. Brush things under rug to have shift covered. When meds are not given, do not fill out paper work." Confidential E indicated the group home had been having problems since at least February. Confidential interview E indicated client A had told staff the third shift staff (staff #2) was sleeping when she worked. Confidential interview E indicated staff #1 and the PD had been made aware of staff's sleeping. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/21/15 at 1:45 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following regarding client B (not all inclusive): -4/14/15 "It was reported on April 14, 2015 that [client B] (consumer) may have been put into an inappropriate restraint. [Client B] has bite mitts that are to be put on when he is biting and hurting himself. It is suspected that staff [staff #6] held his			

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	arms down when applying the bite mitts during a behavior. [Staff #6] was suspended on April 14th and will remain suspended while an investigation is being conducted." The facility's 4/21/15 follow-up report to the 4/14/15 reportable incident report indicated "Investigation is still ongoing." The facility neglected to start/initiate its investigation timely as facility staff indicated they have not been interviewed as of 4/20/15 in regard to the 4/14/15 allegation of abuse/investigation. -4/16/15 "[Name of BDDS Coordinator] received call from consumer's mother wanting to report issues with treatment and care of consumer by staff in the group home. Mother (name of client B's mother) reported several issues that consumer has been having with staff at the group home for several months. -Consumer being held down during behaviors causing bruising to his person. -Consumer being put in his room for 'not behaving like an adult.' -Consumer not being given his medicine but staff signing off on MAR as if he has received it. -No coat all winter, was given someone else's coat to wear instead. -No incident reports completed for the			

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	times when consumer has had behaviors including self mutilation. -Staff not putting consumer's bite gloves on his hands to prevent him from self mutilation. -Mother also alleges that Consumer has attempted to write notes to give to workshop staff telling them things that house staff have done but house staff intercept his notes and take them away. Investigation will be completed into these allegations. BDDS will follow up with provider and consumer." The 4/16/15 reportable incident report was completed by the BDDS Coordinator. The facility's 4/21/15 follow-up report to the 4/16/15 reportable incident report indicated the facility's PD answered the following questions asked by BDDS (not all inclusive): "1. Please provide the outcome of the investigation. Investigation is still ongoing (sic) 2. Has the investigation been substantiated or unsubstantiated? Investigations still ongoing (sic) 3. Was the individual being put in his room as a punishment? No the consumer was not being put into his bedroom as a punishment. Consumer			

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	was being very disruptive to the other housemates and cussing at the staff. Staff was instructed that when the consumer is being disruptive that they should ask him if he wants to go to a quiet room. According to the staff, this consumer said he wanted to go to his bedroom and listen to music. 4. Was the individual held/locked in the room or was be (sic) able to come and go freely from the room? The consumer was not held/locked in the room. The consumer is in a wheelchair. Since this incident occurred, staff were informed that they are not to put this consumer in his bedroom unless he wants to go there and then a staff needs to stay in there with him. If this consumer doesn't want to go to his bedroom than (sic) staff are to stay with him in the current room and ask the other house mates to exit the room. 5. What emotional support has been provided to the individual? The Program Coordinator and other staff are available to listen to this consumer when needed. This consumer calls and talks with his mother on the phone about every night. 6. Were staff suspended pending an investigation? A couple of these issues in			

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	this BDDS report were already brought to our attention and a BDDS report (#685689) was already filed for those issues. It was thru BDDS report (#685689) that the staff was already suspended. 7. Please provide the name of the staff being accused. [Staff #6] was suspended on 4-14-15 due to the issues reported in BDDS report (#685689)." The facility's End of Shift Reports (EOS) were reviewed on 4/23/15 at 10:45 AM. The EOS indicated the following (not all inclusive): -4/18/15 "...While putting [client B] to bed he started biting himself and trying to bite staff. Staff put bite gloves on make (sic) sure to keep a flat palm. HM (home manager) [staff #11] was called and informed...Filled out behavior and GER report." Review of the facility's February 2015 to April 2015 reportable incident reports indicated the PD neglected to fill out a BDDS report in regard to the use of physical intervention. -On 4/8/15, "[Client B] started biting self during breakfast for no reason. Client was cussing staff when I (staff #6) was getting him up. Client was placed in his			

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	room and when checked on had blood all over his face and hands. He ate all of his eggs and about three bites of toast." The 4/8/15 EOS report indicated it was sent to all the staff who worked at the group home, staff #1, the PD and the nurse for the group home. The 4/8/15 EOS report indicated the PD read the report on 4/8/15 at 1:09 PM. The facility's reportable incident reports and/or investigations reviewed from February 2015 to April 2015 indicated the facility neglected to look at the incident as possible neglect, neglected to report the incident to BDDS and/or conduct an investigation in regard to the 4/8/15 incident of possible neglect (why the client was placed in his bedroom as the client demonstrated SIB with injury, gloves/mitts were not placed on the client, and/or why the client was not monitored). -On 4/6/15 Client B "...talked to mother on phone. was (sic) excited. very (sic) pleasant. has (sic) small bruise that looks similar to thumb print on Right forearm very light." The 4/6/15 EOS report indicated the PD read the EOS on 4/8/15 at 1:03 PM. The facility's 2/15 to 4/15 reportable incident reports and/or investigations indicated the facility's administrative staff neglected to report client B's injury of unknown source/possible abuse/mistreatment to			

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	BDDS/state officials, and/or to conduct an investigation in regard to the 4/6/15 allegation of possible abuse/injury of unknown source. -On 3/28/15, "[Client B] was upset because we had oatmeal instead of eggs. Went back to take meds and started biting his hands. Wound on right hand was broken open. He couldn't tell me why he was mad or upset. He didn't eat any am meal. Refused liquids also." The EOS report indicated staff #6 wrote the EOS report. The EOS report indicated the PD read the EOS note on 3/24/15. The EOS note neglected to indicate if client B's behavior plan was implemented in regard to applying the client's gloves/mitts. -On 3/8/15, Client F "...cooked 5 frozen hamburgers after eating a whole family size of popcorn puffs he purchased at the store. Staff reminded him that they were about to start dinner but he said that it was his snack time and he was hungry. After eating his hamburgers he came into the kitchen while staff was cooking and drank 3 cokes he also purchased. They were the glass bottles with metal tops. He went to go recycle them in a bag and to place them on the back porch. Staff asked him to please not place them on the back porch and to place them in the trash. He became upset, coming in from the			

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	back porch and threw the 3 metal tops at [client A] who was sitting at the table helping peel potatoes with another client and staff. 1 cap did hit [client A] in the face and staff notified HM right away...." The facility's 2/15 to 4/15 reportable incident reports and/or investigations indicated the HM neglected to report the allegation of client to client abuse immediately to the administrator. -On 3/5/15, "[Client B] refused to eat breakfast I guess because it wasn't eggs. Started to show out when taking meds (medications) but staff reminded him that he couldn't go to work shop unless he took meds and acted appropriately." The 3/5/15 EOS report was written by staff #6. The report indicated the PD read the report on 3/7/15. The facility's reportable incident reports/investigations indicated the facility neglected to look at the 3/5/15 incident as mistreatment and/or punishment. -On 3/1/15, "...I (staff #7) came across [client E's] medication that is on hold (sic) was passed this morning. there (sic) is (sic) only supposed to be 56 left and there is (sic) 50 left. The hole for this morning was also marked on the MAR. I called the HM (home manager) and informed her of what I had found. She said she would handle it...." Review of			

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	the facility's reportable incident reports from February 2015 to the present indicated the HM neglected to report client E's medication error. -On 2/24/15, Client F "...did his laundry, but didn't fold it. Refused a shower because HM said he couldn't have money to go shopping tonight due to not holding up his end of their agreement. Said he wasn't going to do anything for HM anymore...." The EOS report indicated PD read the report on 2/24/15. The facility's 2/15 to 4/15 reportable incident reports and/or investigations indicated the facility did not look at the 2/24/15 incident as a possible rights restriction. The facility's 2/14 to 4/15 reportable incident reports and/or investigations indicated the facility's management and/or administrative staff neglected to follow/implements its system for monitoring, reporting to state officials, and investigating all allegations of abuse, neglect, mistreatment and/or injuries of unknown source, as reported, to ensure the protection of clients A, B, E and F against, abuse, neglect and/or mistreatment. The facility neglected to ensure its management staff and/or administrative staff was able to recognize and/or identify allegations of neglect, abuse, mistreatment and/or injuries of			

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	unknown source to ensure the protection of clients who resided in the facility. Client B's record was reviewed on 4/23/15 at 10:25 AM and on 4/27/15 at 2:41 PM. Client B's May 2014 Behavior Plan (BP) indicated client B demonstrated "Self-injurious behavior: biting himself, typically on the arms/hands without breaking the skin. 1. Staff should verbally prompt [client B] to stop biting himself. 2. Staff should immediately redirect [client B] to his replacement behaviors. 3. If [client B] continues to self-harm, staff should explain to [client B] that they are putting his protective hand mitts on. Staff should put the mitts on so that his hands and fingers are covered. Staff should say, '[Client B] I did not want you to hurt yourself. You need to stop biting yourself. Adults do not behave this way'...5. Staff should document all incidents of self-injurious behaviors and provide any necessary medical care...." Client B's May 2014 BP indicated facility staff were to utilize a "visual daily schedule" with the client as his replacement behavior. Client B's BP did not indicate facility staff were to take the client to his bedroom, and/or indicate how facility staff were to restrain/hold client B's arms/hands to get the client's			

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	mitts on to prevent injury/harm to the client. Client F's record was reviewed on 4/30/15 at 11:06 AM. Client F's 4/20/15 Individual Support Plan (ISP) indicated client F had an objective to recognize when there is inappropriate staffing (home alone, staff leaves in middle of shift, one staff on duty and/or if a staff is sleeping). Client F's 3/19/15 Behavior Support Plan (BSP) indicated "...Teaching Method 12 Please explain to [client F] the natural consequences of non compliant behavior. ie (example), he will miss out on opportunities to go to the convenience store with staff. Give him real life examples. (If staff does not do what they are asked to do then they have consequences but if they do what they are required to do then they get a paycheck)." Client F's 3/15 BSP neglected to specifically indicate what restrictions/consequences were to be used with client F to ensure facility staff did not restrict client F unfairly and/or appear as disciplinary/punitive for the client's actions. Staff #6's 4/12/15 to 4/22/15 Time card was reviewed on 4/22/15 at 3:07 PM. Staff #6's time card indicated staff #6			

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	worked on Monday 4/13/15 from 12:22 AM to 8:32 AM and on Tuesday 4/14/15 from 12:32 AM to 9:13 AM. Staff #6's time card indicated staff #6 was not immediately suspended after client B's mother called the HM on 4/13/15 regarding an allegation of abuse/mistreatment as staff #6 was allowed to work her shift on 4/14/15 before the staff was suspended. Interview with the PD and the Area Director (AD) on 4/21/15 at 3:00 PM indicated they visited the group home. The PD indicated she was at the group home once a week and the AD indicated she was at the group home once a month. The PD later indicated she was at the group home once a month as well. The PD and the AD indicated they were not aware of any staff sleeping while working. The PD and the AD also indicated they were not aware of any staff being rude or yelling at clients. When asked if the PD had received any reports on 4/5/15 of client B's bruising to his arm, the PD stated "Was reported to me. Sent by S-com (secure email). It was one small bruise smaller than a quarter." The PD indicated the bruise was not reported to BDDS as it did not meet the reporting requirements. When asked when staff #6 was suspended for the 4/14/15 allegation, the PD stated "[Client B's] mom			

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	contacted us (Regional Director) about it that morning. Met as a team to discuss. She was suspended immediately." The PD stated staff #6 was putting the mitts on client B "the way she normally did it." When asked if there was an investigation for client B's 4/5/15 bruising/injury of unknown source to the client's arm, the PD and the AD stated "No." When asked if there had been any peer to peer aggression/allegations of abuse, the PD indicated there had been past altercations between clients F and A. The PD indicated the incidents occurred months ago. When asked if the PD was aware of any concerns/allegations of the HM withholding funds of clients and/or talking down to clients, the PD stated "Yes. I looked at it right away." The PD stated the PD spoke with client F and "Conclusion was he (client F) had funds there and access to money." The PD indicated she did not see the concern as an allegation of possible abuse, neglect and/or mistreatment so she did not report it. The PD indicated she investigated the incident but did not document her investigation. Interview with staff #1 on 4/22/15 at 8:55 AM stated client F had "Plenty of underwear. He will wash them and not put them away." When asked when was the last time client F went shopping, staff			

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	#1 stated "Last week for a pop." When asked if staff #1 was aware of any staff yelling at clients, staff #1 stated "No." Staff #1 stated she was aware one staff "speaks loud." Staff #1 stated the staff person had a "hearing loss-compensates for speaking loud." Staff #1 indicated clients A and F received an allowance. Staff #1 stated client F got $1 "on request" and client A received $5 a week. Staff #1 stated client A is "still giving money away." Staff #1 indicated client A's ISP did not address client A's identified need, and there was no documentation in regard to client A giving money to others. Interview with the PD on 4/22/15 at 11:01 AM indicated when asked if the PD had been aware of any bruising with client B's arm prior to 4/14/15, the PD stated "No." The PD then stated "I think staff was told that weekend and they made out a report. We were notified 4/14/15. Mom called BDDS and made more allegations and BDDS made out report dated 4/16/15." When asked if the investigation was completed for the 4/14/15 allegation, the PD indicated the investigation was not done by 4/21/15 as the investigation was still being done. When asked if any staff were interviewed, the PD stated "I'm not doing the investigation."			

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	Interview with Human Resource (HR) staff #1 on 4/22/15 at 1:40 PM indicated she did not know when the facility suspended staff #6. HR staff #1 stated "There is no documentation or form from HR on when staff is suspended." HR staff #1 indicated the Quality Assurance (QA) staff would have that information. Interview with QA staff #1 on 4/22/15 at 2:35 PM and at 2:45 PM indicated she did not have the information on when staff #6 was suspended but was trying to find out herself. At 2:45 PM, QA staff #1 indicated staff #6 was suspended on the morning of 4/14/15 after client B's mother called the Regional Director, who called the AD and the AD informed the PD to suspend staff #6. QA staff #1 indicated staff #6 was not immediately removed from client contact when the allegation was made. QA staff #1 indicated she had received an email from the Regional Director on 4/14/15 in regard to an allegation of staff #6 using an inappropriate restraint. QA staff #1 stated "We (Regional Director and QA staff #1) could not connect until Friday (4/17/15) morning." QA staff #1 indicated she did not start the investigation into the 4/14/15 allegation of abuse until 4/17/15. QA staff #1 indicated she interviewed client B's			

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	mother on 4/17/15, and started interviewing staff on 4/21/15. QA staff #1 stated " Still doing investigation." QA staff #1 indicated the investigation would not be completed within 5 working days. Interview with the Regional Director and the State Director on 4/22/15 at 4:00 PM indicated the home manager had been suspended from work on 4/22/15. The Regional Director indicated the PD was still working but would not have any client contact. The State Director reminded the Regional Director, the PD had been named in some of the reported allegations made to them (4/22/15 at 11:20 AM). The Regional Director indicated the PD would not oversee any management aspects of the group home as well as have any contact with the clients. Interview with PD #2 on 4/23/15 at 10:30 AM indicated GERs are not to be filled out by staff anymore. PD #2 indicated the staff are to call the PD with any concerns, incidents and/or allegations and the PD fills out the REM internal incident report. When asked who read the EOS logs/reports, PD #2 stated "Program Coordinator (HM), PD and who ever is on the recipient list." Interview with PD #2 on 4/28/15 at 5:10			

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	PM indicated allegations of abuse, neglect and/or injuries of unknown source were to be reported by the PDs to the Executive Director and to BDDS. PD #2 indicated all allegations should be reported and investigated. When asked if the 3/17/15 client to client aggression/abuse with clients F and A was reported to state and investigated, PD #2 stated "I gave you everything I could locate." When asked if the 4/8/15 incident where client B was placed in his bedroom and the client ended up injuring himself was reported and/or investigated, PD #2 stated "It may be coupled with what [QA staff #1] is investigating." C. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, at the group home, client G spent the majority of her time in her bedroom except to take a shower, to eat and to get her night time medications. At 4:55 PM, when client G came out of her bedroom to the dining room, client G sat on a seater walker wearing a gait belt and an ace wrap/bandage around her head. The ace wrap/bandage went around each side of the client's face and under her chin. Client G had a hat over top of the ace wrap. At 6:18 PM, client G carried her dishes to the kitchen and she scooted her seat walker with her feet. Client G then went outside and smok			

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W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review for 12 of 22 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility to immediately report allegations of abuse, neglect, mistreatment and/or injuries of unknown source to the administrator, and/or to report allegations of abuse, neglect, mistreatment and/or injuries of unknown source to state officials when management and/or administrative staff were made aware of the allegations and/or injuries of unknown source for clients A, B, E, F and G. Findings include: 1. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, at the group home, client B had 2 gloves/mitts attached to the handles of his wheelchair. Client B had two open areas on the back of his right hand. The smaller area was raised, open with a scab starting to form. The larger area was red and open with swollen tissue surrounding the area. The larger area was about the size of an eraser	W 0153	**W153 Staff Treatment of Clients** The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. **1. What corrective action will be accomplished?** · Quality Assurance will complete competency based training with Program Director/QIDP and Area Director regarding immediately reporting to the administrator or to other officials in accordance with State law allegations of mistreatment, neglect or abuse as well as injuries of unknown source. · Quality Assurance will complete competency based training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Quality Assurance will complete competency based training with Program Coordinator and	06/12/2015

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	tip and the smaller area was slightly smaller than an eraser tip. Interview with client F on 4/20/15 at 5:46 PM states he did not like "some" staff at the group home. Client F indicated staff #1 would not take him shopping for clothes. When asked why, client F stated "I don't know. She has my money. I need underwear." Client F also indicated he needed clothes. Client F indicated staff #1 would hide things from him. Interview with client B's mother on 4/21/15 at 9:29 AM, by phone, indicated she had reported a bruise on client B's right forearm about two to two and a half weeks ago. Client B's mother indicated she saw the bruise when client B came to visit that weekend. Client B's mother stated "Weekend staff filled out paper work and [staff #1] knew of paper but said she (staff #1) did not see bruise." Client B's mother indicated client B's injury of unknown source was not reported to the Bureau of Developmental Disabilities Services (BDDS-state licensing and reporting agency) as client B's mother had spoken with the BDDS Coordinator. Client B's mother stated the bruise on client B's arm "looked like a thumb print." Client B's mother indicated she found out staff were holding client B's arm down when he		Program Director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Area Director and/or Quality Assurance will review investigations for thoroughness. · Area Director and/or Quality Assurance will supervise investigation recommendation(s) for completion, including corrective actions. · Quality Assurance will complete competency based training with Program Director/QIDP and Area Director regarding immediate removal/suspension of staff alleged to be abusive, neglectful and/or exploitive, for client protection. · Area Director will report weekly to Regional Director data regarding investigation timeliness. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Training with Program Director/QIDP regarding reporting to the administrator or to other officials in accordance with State law allegations of mistreatment, neglect or abuse as well as injuries of unknown	

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	started to bite his arm. Client B's mother stated client B called her last Monday (4/13/15) stating "Mom help." Client B's mother indicated client B was upset. Client B's mother indicated client A got on the phone and tried to explain what client B was trying to tell her. Client B's mother indicated client B indicated they were having waffles for breakfast but client A wanted eggs and started biting his arm. Client B's mother stated client A stated staff #8 told the client he was having waffles and not eggs when "[staff #6] got involved and held [client B's] arms down and [staff #8] took him (client B) to his room." Client B's mother indicated staff #8 did not know he (staff #8) was not allowed to put client B in his room when he was having a behavior of biting his arm. Client B's mother indicated she called staff #1 and reported the allegation of abuse/neglect to staff #1. Client B's mother indicated staff #1 stated "She (staff #1) would make phone calls and take care of it." Client B's mother indicated on 4/14/15 in the morning, she called the group home to speak with client B when staff #6 answered the phone. Client B's mother indicated she asked staff #1 why staff #6 was answering the phone, and staff #1 stated "Because she (staff #6) works here." Client B's mother stated staff #1 did not report "the allegation of		source. · Training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Training with Program Coordinator and Program Director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Area Director will review thorough and timely completion of investigations as well as immediate reporting of incidents to administrator or to other officials in accordance with State law through established procedures. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Training with Program Director/QIDP regarding reporting to the administrator or to other officials in accordance with State law allegations of mistreatment, neglect or abuse as well as injuries of unknown source. · Training with staff regarding completion of internal incident/injury reports as well as expectation regarding	

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	abuse/neglect" as staff #6 was still working on 3/14/15. Client B's mother indicated she then called the main office and spoke with the Regional Director and the Area Director. Client B's mother stated she asked for a copy of the client B's Medication Administration Records (MARs) as the client had not been given his morning medication "3 to 4 times." Client B's mother indicated staff were signing the MARs as if the client's medications had been passed/given. Interview with client A on 4/21/15 at 11:00 AM indicated staff #6 had held client B's arms down. Client A indicated she saw/witnessed staff #6 holding the client's arms. Client A indicated she (client A) would sleep in the living room at night in her sleeping bag. Client A stated staff #2 would be on the phone "texting." Client A stated staff #2 was "sleeping part time in the living room." When asked if she had told anyone about staff #2's sleeping, client A stated "I told [staff #1]. Not sure how long ago." During the 4/21/15 interview, client A indicated client F had aggressed against her. Client A stated "[Client F] pushed me at office." Client A indicated client F had done that before and pushed client D. Interview with client B on 4/21/15 at 12:05 PM, with the day program manager		immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Training with Program Coordinator and Program Director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Area Director will review thorough and timely completion of investigations as well as immediate reporting of incidents to administrator or to other officials in accordance with State law through established procedures. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Training with Program Director/QIDP regarding reporting to the administrator or to other officials in accordance with State law allegations of mistreatment, neglect or abuse as well as injuries of unknown source. · Training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). ·	

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	(DPM) present, indicated client B could answer yes and no questions with some verbalization of words. Client B indicated he did not like the group home and/or staff. During the interview client B pointed to and looked at his arm. When asked if client B had any bruising on his arm, client stated "Yes." The day program supervisor checked client B's arm, shoulder and back and did not find a bruise at that time. When asked if client B had a bruise on his arm before, client B stated "Yes." When asked if a client caused the bruise, client B stated "No." When asked if staff caused the bruise, client B stated "Yeah." Client B indicated facility staff would also yell at him. Interview with the DPM on 4/21/15 at 12:20 PM indicated the DPM was on call a couple of weeks ago when the weekend staff called on call and indicated client B did not get his 8 AM medications and to report a bruise on client B's arm. The DPM produced an "Program Coordinator On Call Book Summary of Calls." The On call book was reviewed on 4/21/15 at 12:20 PM which indicated client B did not receive his 8 AM medications on 4/5/15. The on-call book indicated "...Staff reported [client B] has bruising on right forearm that mom is concerned about. Reported to [PD] instructed staff		Training with Program Coordinator and Program Director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Area Director will review thorough and timely completion of investigations as well as immediate reporting of incidents to administrator or to other officials in accordance with State law through established procedures. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015	

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	to do GER on both." The DPM indicated the DPM spoke with facility staff from "5:40 to 5:55" on 4/21/15. The DPM indicated the PD was her supervisor and the PD was responsible for making a BDDS report for the medication error and for client B's injury/concern. Confidential interview A stated they had told staff #6 "to stop" as staff #6 had "grabbed" client B when restraining his arms. Confidential interview A stated they were to hold client B's arms down with "open hands." Confidential interview A stated they reported staff #6 for "yelling at clients and grabbing [client B's] arm" to staff #1 and to the Program Director (PD). Confidential interview A stated staff #1 had also "grabbed" client B's arms using an "inappropriate hold with a closed hand." Confidential interview A stated holding client B's arms with a "closed hand" would "leave marks"on the client. Confidential interview A stated client B had a bruise on his right arm which looked like a "thumb print." Confidential interview A indicated they reported the bruise on a "GER" (General Events Report-internal incident report) three to four days after confidential interview A realized the bruise had not been reported, and documented the bruise in an End of Shift (EOS) report. Confidential interview A			

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	indicated clients' rights were being violated. Confidential interview A stated "[Staff #1] was refusing to give [client A] and [client F] money on weekends." Confidential interview A indicated client F needed clothes due to the client's weight gain. Confidential interview A stated staff #1 would call client F "a child" and state the client could not go shopping until he "acted like an adult." Confidential interview A indicated they did not like how the clients were being treated and reported their concerns/allegations regarding staff #1 to the PD and the Area Director. Confidential interview A indicated they had reported clients B and F of being incontinent of bowel and/or bladder when they returned from the day program. Confidential interview A stated "this had been reported several times" to the HM and the PD. Confidential interview A also indicated the Area Director was also aware of the concern. Confidential interview A indicated staff #2 had been sleeping while on duty and was smoking in the bathroom. Confidential interview A indicated client A reported to staff about staff #2's sleeping while working on the night shift. Confidential interview A indicated they reported the allegation of neglect to the PD. Confidential interview A stated they "by passed [staff #1]." When asked when the allegations			

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	were reported, confidential interview A stated "Reported initially 1 month ago when [client A] told me." Confidential interview B stated when asked how facility staff treated clients, "Staff [staff #6] rude to me and clients." Confidential interview B stated "She yelled a lot at [client F]. He would get upset when she was here." When asked how client B got the bruise on his arm, confidential interview B stated "From [staff #6] restraining him in morning." Confidential interview B indicated they saw/witnessed staff #6 restraining client B. Confidential interview B stated "She (staff #6) holds too tight with a closed hand." When asked if confidential interview B had reported these allegations of abuse/mistreatment, confidential interview B stated "No. Staff on weekend know as we talked about it. I did not report." Confidential interview E indicated client B had open areas on his right hand due to client B's biting his hands when upset. Confidential interview E indicated client B required physical redirection/restraints of arms when the client demonstrated SIB (self-injurious behavior) of biting his arm. Confidential interview E indicated facility staff would have to hold client B's arms down to put on the client's			

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	gloves/mitts when he attempted to bite himself. Confidential interview E stated "Staff to put hands flat to not leave marks." Confidential interview E stated "I seen bruises a couple of weekends ago. Looked like thumb print." Confidential interview E indicated facility staff called the on-call person (DPM) and reported client B's medications not being given that morning and the bruise on client B's arm. Confidential interview E indicated the on call instructed facility staff to fill out a GER. Confidential interview E stated "Approximately five minutes later," the PD called group home and instructed staff to not fill out the GER indicating the PD would take care of it. Confidential interview E stated "Company is not reporting. Brush things under rug to have shift covered. When meds are not given, do not fill out paper work." Confidential E indicated the group home had been having problems since at least February. Confidential interview E indicated client A had told staff the third shift staff (staff #2) was sleeping when she worked. Confidential interview E indicated staff #1 and the PD had been made aware staff's sleeping. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/21/15 at 1:45 PM. The facility's reportable			

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	incident reports, internal incident reports and/or investigations indicated the following regarding client B (not all inclusive): -4/14/15 "It was reported on April 14, 2015 that [client B] (consumer) may have been put into an inappropriate restraint. [Client B] has bite mitts that are to be put on when he is biting and hurting himself. It is suspected that staff [staff #6] held his arms down when applying the bite mitts during a behavior. [Staff #6] was suspended on April 14th and will remain suspended while an investigation is being conducted." -4/16/15 "[Name of BDDS Coordinator] received call from consumer's mother wanting to report issues with treatment and care of consumer by staff in the group home. Mother (name of client B's mother) reported several issues that consumer has been having with staff at the group home for several months. -Consumer being held down during behaviors causing bruising to his person. -Consumer being put in his room for 'not behaving like an adult.' -Consumer not being given his medicine but staff signing off on MAR as if he has received it. -No coat all winter, was given someone			

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	else's coat to wear instead. -No incident reports completed for the times when consumer has had behaviors including self mutilation. -Staff not putting consumer's bite gloves on his hands to prevent him from self mutilation. -Mother also alleges that Consumer has attempted to write notes to give to workshop staff telling them things that house staff have done but house staff intercept his notes and take them away. Investigation will be completed into these allegations. BDDS will follow up with provider and consumer." The 4/16/15 reportable incident report was completed by the BDDS Coordinator. The facility's End of Shift Reports (EOS) were reviewed on 4/23/15 at 10:45 AM. The EOS indicated the following (not all inclusive): -4/18/15 "...While putting [client B] to bed he started biting himself and trying to bite staff. Staff put bite gloves on make (sic) sure to keep a flat palm. HM (home manager) [staff #11] was called and informed...Filled out behavior and GER report." Review of the facility's February 2015 to April 2015 reportable incident reports indicated the PD did not report the physical intervention/restraint to BDDS.			

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	-On 4/8/15, "[Client B] started biting self during breakfast for no reason. Client was cussing staff when I (staff #6) was getting him up. Client was placed in his room and when checked on had blood all over his face and hands. He ate all of his eggs and about three bites of toast." The 4/8/15 EOS report indicated it was sent to all the staff who worked at the group home, staff #1, the PD and the nurse for the group home. The 4/8/15 EOS report indicated the PD read the report on 4/8/15 at 1:09 PM. The facility's reportable incident reports and/or investigations reviewed from February 2015 to April 2015 indicated the facility did not look at the incident as possible neglect and failed to report the incident to BDDS. -On 4/6/15 Client B "...talked to mother on phone. was (sic) excited. very (sic) pleasant. has (sic) small bruise that looks similar to thumb print on Right forearm very light." The 4/6/15 EOS report indicated the PD read the EOS on 4/8/15 at 1:03 PM. The facility's 2/15 to 4/15 reportable incident reports and/or investigations indicated the facility's administrative staff did not report client B's injury of unknown source/possible abuse/mistreatment to the administrator and/or to BDDS/state officials.			

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	-On 3/8/15, Client F "...cooked 5 frozen hamburgers after eating a whole family size of popcorn puffs he purchased at the store. Staff reminded him that they were about to start dinner but he said that it was his snack time and he was hungry. After eating his hamburgers he came into the kitchen while staff was cooking and drank 3 cokes he also purchased. They were the glass bottles with metal tops. He went to go recycle them in a bag and to place them on the back porch. Staff asked him to please not place them on the back porch and to place them in the trash. He became upset, coming in from the back porch and threw the 3 metal tops at [client A] who was sitting at the table helping peel potatoes with another client and staff. 1 cap did hit [client A] in the face and staff notified HM right away...." The facility's 2/15 to 4/15 reportable incident reports and/or investigations indicated the HM did not report the allegation of client to client abuse immediately to the administrator. -On 3/1/15, "...I (staff #7) came across [client E's] medication that is on hold (sic) was passed this morning. there (sic) is (sic) only supposed to be 56 left and there is (sic) 50 left. The hole for this morning was also marked on the MAR. I called the HM (home manager) and			

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	informed her of what I had found. She said she would handle it...." Review of the facility's reportable incident reports from February 2015 to the present indicated the HM failed to report client E's medication error. -On 2/24/15, Client F "...did his laundry, but didn't fold it. Refused a shower because HM said he couldn't have money to go shopping tonight due to not holding up his end of their agreement. Said he wasn't going to do anything for HM anymore...." Interview with the PD and the Area Director (AD) on 4/21/15 at 3:00 PM indicated they were not aware of any staff sleeping while working. The PD and the AD also indicated they were not aware of any staff being rude or yelling at clients. When asked if the PD had received any reports on 4/5/15 of client B's bruising to his arm, the PD stated "Was reported to me. Sent by S-com (secure email). It was one small bruise smaller than a quarter." The PD indicated the bruise was not reported to BDDS as it did not meet the reporting requirements. When asked if there had been any peer to peer aggression/allegations of abuse, the PD indicated there had been past altercations between clients F and A. The PD indicated the incidents occurred months			

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	ago. When asked if the PD was aware of any concerns/allegations of the HM withholding funds of clients and/or talking down to clients, the PD stated "Yes. I looked at it right away." The PD stated the PD spoke with client F and "Conclusion was he (client F) had funds there and access to money." The PD indicated she did not see the concern as an allegation of possible abuse, neglect and/or mistreatment so she did not report it. Interview with the PD on 4/22/15 at 11:01 AM indicated when asked if the PD had been aware of any bruising with client B's arm prior to 4/14/15, the PD stated "No." The PD then stated "I think staff was told that weekend and they made out a report. We were notified 4/14/15. Mom called BDDS and made more allegations and BDDS made out report dated 4/16/15." Interview with PD #2 on 4/23/15 at 10:30 AM indicated GERs are not to be filled out by staff anymore. PD #2 indicated the staff are to call the PD with any concerns, incidents and/or allegations and the PD fills out the REM internal incident report. When asked who read the EOS logs/reports, PD #2 stated "Program Coordinator (HM), PD and who ever is on the recipient list."			

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	Interview with PD #2 on 4/28/15 at 5:10 PM indicated allegations of abuse, neglect and/or injuries of unknown source are reported by the PDs to the Executive Director and to BDDS. PD #2 indicated allegations should be reported and investigated. When asked if the 3/17/15 client to client aggression/abuse with clients F and A was reported to state, PD #2 stated "I gave you everything I could locate." When asked if the 4/8/15 incident where client B was placed in his bedroom and the client ended up injuring himself was reported, PD #2 stated "It may be coupled with what [QA staff #1] is investigating." 2. The facility's End of Shift (EOS) reports were reviewed on 4/23/15 at 10:45 AM. The EOS reports indicated the following (not all inclusive): -2/23/15 "[Client G] had been picking her scalp as there was blood all over her mattress...." -2/24/15 "Client G] was picking at scalp today. I pulled her bed sheet so she will need to make her bed when she gets home. Sheet had lots of blood on it...." Client G's record was reviewed on 4/22/15 at 5:05 PM and on 4/27/15 at			

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	2:30 PM. Client G's Skin/Wound Assessments documented by Direct Support Professionals (DSPs) indicated the following (not all inclusive): -2/4/15 "client (sic) picked head during the night as there was blood on the bed." Client G's 4/20/15 ISP indicated client G was on 15 minute checks for "Safeguards." The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/21/15 at 1:45 PM. The facility's reportable incident reports and/or internal incident reports indicated the facility did not look at the above mentioned incidents as possible neglect as the client was to be on 15 minute checks. The facility did not report the allegations of possible neglect to the administrator and/or to state officials. Interview with staff #4 on 4/20/15 8:22 PM indicated client G would pick the wound at the top of her head. Staff #4 indicated client G was on 15 minute checks. Interview with staff #1 on 4/22/15 at 8:55 AM stated client G was to have her ace bandage on her head "All day, every day.			

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	Lately has not been tolerating it. Hates it." When asked how facility staff were monitoring the client to prevent her from picking, staff #1 stated "She is on 15 minutes checks and she stay out (of room) with us." Interview with PD #1 on 4/23/15 at 10:30 AM indicated when asked who reads the End of Shift reports stated "the PC/HM& PD and who ever is on the recipient list." Interview with PD #2 and the AD on 4/28/15 on 5:10 PM PD #2 indicated the PDs did not always look at the EOS in a timely manner. PD #2 indicated all allegations of abuse, neglect and/or injuries of unknown source were to be reported by the PDs to the Executive Director and to BDDS. This federal tag relates to complaint #IN00171811. 9.3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on observation, interview and record review for 13 of 22 allegations of	W 0154	**W154 Staff Treatment of Clients** The facility must have evidence that all alleged	06/12/2015

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	abuse, neglect, mistreatment and/or injuries of unknown source reviewed, the facility failed to ensure all allegations of abuse, neglect, mistreatment and/or injuries of unknown source reviewed were thoroughly investigated and documented regarding clients B, C, D, F and G. Findings include: 1. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/21/15 at 1:45 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following: -On 2/14/15, "It was reported on Sunday February 15, 2015 at 8pm (sic) that the 8am medications at Selma on February 14, 2015 were not passed. This med (medication) error occurred due to new staff and that this med pass was to occur during a shift change...." The facility's 2/14/15 reportable incident reports indicated clients B, C, D, F and G did not receive their medications. The facility's 2/18/15 Investigation Summaries for clients B, C, D, F and G indicated staff #2 made the 2/14/15 medication errors. The facility's 2/18/15		violations are thoroughly investigated. **1. What corrective action will be accomplished?** · **Quality Assurance will complete competency based training with Program Director/QIDP regarding incidents requiring investigation as well as timely completion of investigations.** · Quality Assurance will complete competency based training with Program Director/QIDP and Area Director regarding immediately reporting to the administrator or to other officials in accordance with State law allegations of mistreatment, neglect or abuse as well as injuries of unknown source. · Quality Assurance will complete competency based training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Quality Assurance will complete competency based training with Program Coordinator and Program Director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Area Director and/or Quality	

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	investigations indicated in the Factual Findings section "Interview with [staff #2] (DSP) (Direct Support Professional) on February 17, 2015 -Stated that this consumer (clients C, D, F and G on 4 separate summaries) didn't have a med error. -Stated that she (staff #2) doesn't have Therap (facility computerized record system) access and couldn't record on the M.A.R...." The facility's 2/18/15 investigations indicated staff #3 and #4 indicated the clients did not receive their medications, and were not present when staff #2 administered the medications. The facility's investigations indicated clients C, D, F and G were not interviewed. The facility's investigation indicated client F was "...Able to verbally communicate wants and needs-may not recall details accurately...." Client G's 2/18/15 investigative summary indicated client G was "...Deaf-able to communication (sic) some wants and needs thru (sic) little signing-unable to recall details accurately...." Client C and D's 2/18/15 investigation summary indicated "...Non-verbal; doesn't know all of her medications and is unable to communicate to staff if they did a med error....." Client B's 2/18/15 Investigation Summary under the section entitled		Assurance will review investigations for thoroughness. · Area Director and/or Quality Assurance will supervise investigation recommendation(s) for completion, including corrective actions. · Quality Assurance will complete competency based training with Program Director/QIDP and Area Director regarding immediate removal/suspension of staff alleged to be abusive, neglectful and/or exploitive, for client protection. · Area Director will report weekly to Regional Director data regarding investigation timeliness. · Training with staff regarding medication administration procedures. · IDT will convene to discuss Client A 'giving money away,' and will revise plans as needed. · Program Director/QIDP and/or Area Director will ensure investigations are completed and reported to the administration within 5 business days. · Program Director/QIDP and/or Area Director will ensure Quality Assurance is notified of incidents timely to allow sufficient time for incidents to be thoroughly investigated. 2.. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Training with Program Director/QIDP regarding incidents	

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	Factual Findings, indicated "Interview with [staff #2] (DSP) on February 17, 2015 -Stated this consumer didn't get his medications because she (staff #2) was waiting to do it when the next staff came in to assist her. -Stated that she forgot to do it when the next staff came in. -Stated that she doesn't have Therap access and couldn't record on the MAR...." The facility's investigation indicated client B was "... Semi-verbal to communicate wants and needs to regular daily staff; May not recall details accurately...." The facility's 2/18/15 investigation summaries indicated the facility failed to conduct a thorough investigation as no client interviews were conducted, no additional staff were interviewed, and the facility's investigation did not indicate what records were reviewed, and/or indicate how the facility was assured the clients' medications had been administered. The facility's investigation and/or reportable incident report failed to indicate what medications did not get administered at the 8 AM medication pass. The facility's 2/18/15 investigation failed to indicate if any corrective actions/measures were recommended and/or put in place to prevent to similar errors in the future.		requiring investigation as well as timely completion of investigations. · Training with staff regarding medication administration procedures. · Training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Training with Program Coordinator and Program director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · IDT will convene to discuss Client A 'giving money away,' and will revise plans as needed. · Program Director/QIDP and/or Area Director will ensure investigations are completed and reported to the administration within 5 business days. · Program Director/QIDP and/or Area Director will ensure Quality Assurance is notified of incidents timely to allow sufficient time for incidents to be thoroughly investigated. **1.What is the date by which the systemic changes will be completed?** ·June 12, 2015 **How will we identify other**	

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	-On 2/18/15, "It was reported to the HM (home manager) on Wednesday February 18, 2015 at 8:15pm that [client C] was accidentally given her 8am medications (due on 2-19-15) at the 4pm med pass on 2-18-15. This med error occurred due staff not have her full concentration and focus on this med error at the time (sic). All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR at the beginning of their shift...." The facility's 2/24/15 Investigation Summary indicated staff #5 made the medication error. The facility's investigation indicated client C was not interviewed as the client was non-verbal and did not know all of her medications. -On 3/14/15, "It was discovered that at 11am on Saturday March 14, 2015 that [client B] had a med error. [Client B's] Oxcarbazepine 600mg tablet (for seizures) and Reno Caps Softgel 1 mg (for ulcer healing) were not passed. The weekend day staff discovered this med error. Normally the 3rd (third) shift staff (staff #2) passes the morning 8am medications. [Client B] was the only consumer in this house that 3rd shift staff forgot to pass the medications for...The staff was reminded to follow the 6 rights of medication administration. This staff was reminded to check the MAR at the		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Training with Program Director/QIDP regarding incidents requiring investigation as well as timely completion of investigations. · Training with staff regarding medication administration procedures. · Training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Training with Program Coordinator and Program director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · IDT will convene to discuss Client A 'giving money away,' and will revise plans as needed. · Program Director/QIDP and/or Area Director will ensure investigations are completed and reported to the administration within 5 business days. · Program Director/QIDP and/or Area Director will ensure Quality Assurance is notified of	

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	beginning of the med pass, during the med pass, and after the med pass...." The facility's 3/20/15 Investigation Summary indicated the investigator (PD) looked at the BDDS (Bureau of Developmental Disabilities Services) report and the client's 3/14/15 MAR. The facility's investigation indicated staff #2 "...Stated that she left [client B's] medications to be completed by the following staff. - Stated that she completed everyone else's med passes. Interview with [staff #7] (DSP) (Direct Support Professional) on March 14, 2015 - Stated that when she came in for the start of her shift, [staff #2] was already hurrying out of the door. - Stated that she assumed all of the medications were already passed. - Stated that she called the PD as soon as she noticed this med error...." The facility's investigation summary indicated "...This staff was reminded to not be in a hurry to leave at the end of your shift, but be patient and to give a summary to the next staff on duty...." The facility's 3/20/15 Incident Management Quality Assurance Review indicated the facility's nurse did not review and/or make any recommendations in regard to 3/14/15 medication error as the nurse's section		incidents timely to allow sufficient time for incidents to be thoroughly investigated. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Training with Program Director/QIDP regarding incidents requiring investigation as well as timely completion of investigations. · Training with staff regarding medication administration procedures. · Training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Training with Program Coordinator and Program director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · IDT will convene to discuss Client A 'giving money away,' and will revise plans as needed. · Program Director/QIDP and/or Area Director will ensure investigations are completed and reported to the administration within 5 business days. · Program Director/QIDP and/or Area Director will ensure	

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	was blank. -On 4/5/15, "It was reported on Sunday April 5, 2015 at 4pm that the 8am medications for [client B] were not passed earlier that day...This med error occurred due to confusion of who was going to pass his medications. All staff were reminded to communicate with each other during shift changes. All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR at the beginning of their shift...." The facility's 4/14/15 follow-up report to the 4/5/15 reportable incident report indicated client B did not receive his 8 AM Oxcarbazepine and Reno Softgel medications. The facility's 4/14/15 Investigation Summary indicated staff #2 had left client B's medications to be administered by the day shift staff "...per the day shift's request...." The facility's investigation indicated the facility failed to conduct a thorough investigation in regard to why staff #2 could/would not administer client B's medication as this was the third incident/pattern of staff #2 not administering the client's morning medications.		Quality Assurance is notified of incidents timely to allow sufficient time for incidents to be thoroughly investigated.	

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	The facility's 4/14/15 Incident Management Quality Assurance Review indicated recommendation by the facility's Area Director (AD) of "Follow MAR & (and) med pass protocol. Med Practicum with staff." -On 4/12/15, "It was reported that [client B] was not given his 8am on Sunday April 12th. [Client B] did not receive the following medications. OXCARBAZEPINE 600 MG TABLET for seizures & RENO CAPS SOFTGEL 1mg for Ulcer Healing. Late reporting of this BDDS report due to staff late reporting to the Program Director. The med error occurred due (sic) confusion between the 3rd shift staff and the day shift staff who was going to pass [client B's] medications. All staff were reminded to communicate with each other during shift changes. All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR at the beginning of their shift...." The facility's 4/14/15 Investigation Summary indicated staff #2 was the staff who made the medication error. The facility's investigation indicated staff #2 "...Stated that she left [client B's] medications to be done by the following staff per the day shift's request. - Stated			

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	that she completed everyone else's med passes...." The facility's 4/14/15 investigation indicated staff #7 stated that when she came in for her shift she forgot that she wanted to pass [client B's] medications...." The facility's 4/14/15 investigation failed to indicate why the day shift passed client B's medication versus the third shift. The facility failed to investigate staff #2's pattern of medication errors involving client B. Staff #2's personnel record was reviewed on 4/22/15 at 4:05 PM. Staff #2's personnel record indicated staff #2 Core A and B (state training to pass medications) was A-88% and B-88%. Staff #2's personnel record indicated Staff #2 received a Record of Discussion Form on 4/1/15. The form indicated "90 Day check up; Discuss Med Pass, MARs, Documentation...[Staff #2] is having difficulties w/ (with) passing meds, documenting, following orders, etc. DSP (staff #2) will contact HM/PD if needs additional training. DSP to correct these issues/concerns." Review of the facility's reportable incident reports indicated staff #2 continued to have medication errors after her 4/1/15 record of discussion. Confidential interview A indicated facility staff documented medications were given when clients' medications had			

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	not been administered. Confidential interview A indicated there had been more medication errors at the group home than had been reported. Confidential interview A indicated when meds were not given, they would be returned to the pharmacy. Confidential interview E indicated the third shift staff would make medication errors on the weekend. Interview with the Area Director (AD) and the Program Director (PD) on 4/21/15 at 3:00 PM indicated they were aware the home was having problems with medication errors. The PD stated "She is unsure how to help him (client B)." The PD and AD indicated staff #2 was not sure how to administer client B's medication to the client as he would get upset at times. The PD and the AD indicated they were not aware of any false documentation in the group home. The PD indicated no clients and/or additional staff were interviewed in regard to the medication errors. 2. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, at the group home, client B had 2 gloves/mitts attached to the handles of his wheelchair. Client B had two open areas on the back of his right hand. The smaller area was			

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	raised, open with a scab starting to form. The larger area was red and open with swollen tissue surrounding the area. The larger area was about the size of an eraser tip and the smaller area was slightly smaller than an eraser tip. Interview with client F on 4/20/15 at 5:46 PM states he did not like "some" staff at the group home. Client F indicated staff #1 would not take him shopping for clothes. When asked why, client F stated "I don't know. She has my money. I need underwear." Client F also indicated he needed clothes. Client F indicated staff #1 would hide things from him. Interview with client B's mother on 4/21/15 at 9:29 AM, by phone, indicated she had reported a bruise on client B's right forearm about two to two and a half weeks ago. Client B's mother indicated she saw the bruise when client B came to visit that weekend. Client B's mother stated "Weekend staff filled out paper work and [staff #1] knew of paper but said she (staff #1) did not see bruise." Client B's mother stated the bruise on client B's arm "looked like a thumb print." Client B's mother indicated she found out staff were holding client B's arm down when he started to bite his arm. Client B's mother stated client B called her last Monday (4/13/15) stating			

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	"Mom help." Client B's mother indicated client B was upset. Client B's mother indicated client A got on the phone and tried to explain what client B was trying to tell her. Client B's mother indicated client A indicated they were having waffles for breakfast but client B wanted eggs and started biting his arm. Client B's mother stated client A stated staff #8 told the client he was having waffles and not eggs when "[staff #6] got involved and held [client B's] arms down and [staff #8] took him (client B) to his room." Client B's mother indicated staff #8 did not know he (staff #8) was not allowed to put client B in his room when he was having a behavior of biting his arm. Client B's mother indicated she called staff #1 and reported the allegation of abuse/neglect to staff #1. Client B's mother indicated staff #1 stated "She (staff #1) would make phone calls and take care of it." Client B's mother indicated on 4/14/15 in the morning, she called the group home to speak with client B when staff #6 answered the phone. Client B's mother indicated she asked staff #1 why staff #6 was answering the phone, and staff #1 stated "Because she (staff #6) works here." Client B's mother stated staff #1 did not report "the allegation of abuse/neglect" as staff #6 was still working on 4/14/15. Client B's mother indicated she then			

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	called the main office and spoke with the Regional Director and the Area Director. Client B's mother indicated the facility's investigation was not started until Friday (4/17/15) when administrative staff called to interview her. Client B's mother stated she asked for a copy of the client B's Medication Administration Records (MARs) as the client had not been given his morning medication "3 to 4 times." Client B's mother indicated staff were signing the MARs as if the client's medications had been passed/given. Interview with client A on 4/21/15 at 11:00 AM indicated staff #6 had held client B's arms down. Client A indicated she saw/witnessed staff #6 holding the client's arms. Client A indicated she (client A) would sleep in the living room at night in her sleeping bag. Client A stated staff #2 would be on the phone "texting." Client A stated staff #2 was "sleeping part time in the living room." When asked if she had told anyone about staff #2's sleeping, client A stated "I told [staff #1]. Not sure how long ago." During the 4/21/15 interview, client A indicated client had aggressed against her. Client A stated "[Client F] pushed me at office." Client A indicated client F had done that before and pushed client D. Interview with client B on 4/21/15 at			

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	12:05 PM, with the day program manager (DPM) present, indicated client B could answer yes and no questions with some verbalization of words. Client B indicated he did not like the group home and/or staff. During the interview client B pointed to and looked at his arm. When asked if client B had any bruising on his arm, client stated "Yes." The day program supervisor checked client B's arm, shoulder and back and did not find a bruise at that time. When asked if client B had a bruise on his arm before, client B stated "Yes." When asked if a client caused the bruise, client B stated "No." When asked if staff caused the bruise, client B stated "Yeah." Client B indicated facility staff would also yell at him. Interview with the DPM on 4/21/15 at 12:20 PM indicated the DPM was on call a couple of weeks ago when the weekend staff called on call and indicated client B did not get his 8 AM medications and to report a bruise on client B's arm. The DPM produced an "Program Coordinator On Call Book Summary of Calls." The On call book was reviewed on 4/21/15 at 12:20 PM which indicated client B did not receive his 8 AM medications on 4/5/15. The on-call book indicated "...Staff reported [client B] has bruising on right forearm that mom is concerned			

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	about. Reported to [PD] instructed staff to do GER on both." The DPM indicated the DPM spoke with facility staff from "5:40 to 5:55" on 4/21/15. The DPM indicated the PD was her supervisor. Confidential interview A stated they had told staff #6 "to stop" as staff #6 had "grabbed" client B when restraining his arms. Confidential interview A stated they were to hold client B's arms down with "open hands." Confidential interview A stated they reported staff #6 for "yelling at clients and grabbing [client B's] arm" to staff #1 and to the Program Director (PD). Confidential interview A stated staff #1 had also "grabbed" client B's arms using an "inappropriate hold with a closed hand." Confidential interview A stated holding client B's arms with a "closed hand" would "leave marks"on the client. Confidential interview A stated client B had a bruise on his right arm which looked like a "thumb print." Confidential interview A indicated they reported the bruise on a "GER" (General Events Report-internal incident report) three to four days after confidential interview A realized the bruise had not been reported, and documented the bruise in an End of Shift (EOS) report. Confidential interview A indicated clients' rights were being violated. Confidential interview A stated			

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	"[Staff #1] was refusing to give [client A] and [client F] money on weekends." Confidential interview A indicated client F needed clothes due to the client's weight gain. Confidential interview A stated staff #1 would call client F "a child" and state the client could not go shopping until he "acted like an adult." Confidential interview A indicated they did not like how the clients were being treated and reported their concerns/allegations regarding staff #1 to the PD and the Area Director. Confidential interview A indicated they had reported clients B and F of being incontinent of bowel and/or bladder when they returned from the day program. Confidential interview A stated "this had been reported several times" to the HM and the PD. Confidential interview A also indicated the Area Director was also aware of the concern. Confidential interview A indicated staff #2 had been sleeping while on duty and was smoking in the bathroom. Confidential interview A indicated client A reported to staff about staff #2's sleeping while working on the night shift. Confidential interview A indicated they reported the allegation of neglect to the PD. Confidential interview A stated they "by passed [staff #1]." When asked when the allegation was reported, confidential interview A stated "Reported initially 1 month ago			

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	when [client A] told me." Confidential interview A indicated some staff were concerned about retaliation as the home manager had retaliated against a staff person before. When asked if they had been interviewed in regard to any allegations of abuse/mistreatment and/or injuries of unknown source regarding client B, confidential interview A stated "I'm not aware of any staff being interviewed." Confidential interview A indicated client B's bruise on his right arm, and the allegation of staff holding client #6's arm due to an incident over eggs, were 2 separate incidents. Confidential interview B stated when asked how facility staff treated clients, "Staff [staff #6] rude to me and clients." Confidential interview B stated "She yelled a lot at [client F]. He would get upset when she was here." When asked how client B got the bruise on his arm, confidential interview B stated "From [staff #6] restraining him in morning." Confidential interview B indicated they saw/witnessed staff #6 restraining client B. Confidential interview B stated "She (staff #6) holds too tight with a closed hand." When asked if the facility had interviewed them in regard to client B's bruise, confidential interview B stated "No."			

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	Confidential interview D indicated client B bit the areas open on his hands. Confidential interview D stated facility staff were to put his mitts on when the client started biting himself. Confidential interview D indicated they did not have any problems with redirecting client B when he became upset. Confidential interview D indicated stated "I do well with him. I talk with him and calm him down. I feel you should not have to do that (restrain him). You can talk to him." Confidential interview D indicated client B recently had a bruise on his right wrist/forearm area. Confidential interview D indicated she was not sure how client B received the bruise. Confidential interview D stated client B's bruise was documented on Therap (facility's computer system) on the client's "skin and wound form." Confidential interview E indicated client B had open areas on his right hand due to client B's biting his hands when upset. Confidential interview E indicated client B required physical redirection/restraints of arms when the client demonstrated SIB (self-injurious behavior) of biting his arm. Confidential interview E indicated facility staff would have to hold client B's arms down to put on the client's gloves/mitts when he attempted to bite himself. Confidential interview E stated			

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	"Staff to put hands flat to not leave marks." Confidential interview E stated "I seen bruises a couple of weekends ago. Looked like thumb print." Confidential interview E indicated facility staff called the on-call person (DPM) and reported client B's medications not being given that morning and the bruise on client B's arm. Confidential interview E indicated the on call instructed facility staff to fill out a GER. Confidential interview E stated "Approximately five minutes later," the PD called group home and instructed staff to not fill out the GER indicating the PD would take care of it. Confidential interview E stated "Company is not reporting. Brush things under rug to have shift covered. When meds are not given, do not fill out paper work." Confidential E indicated the group home had been having problems since at least February. Confidential interview E indicated client A had told staff the third shift staff (staff #2) was sleeping when she worked. Confidential interview E indicated staff #1 and the PD had been made aware staff's sleeping. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/21/15 at 1:45 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the			

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	following regarding client B (not all inclusive): -4/14/15 "It was reported on April 14, 2015 that [client B] (consumer) may have been put into an inappropriate restraint. [Client B] has bite mitts that are to be put on when he is biting and hurting himself. It is suspected that staff [staff #6] held his arms down when applying the bite mitts during a behavior. [Staff #6] was suspended on April 14th and will remain suspended while an investigation is being conducted." The facility's 4/21/15 follow-up report to the 4/14/15 reportable incident report indicated "Investigation is still ongoing." The facility failed to start/initiate its investigation timely as facility staff indicated they have not been interviewed as of 4/20/15 in regard to the 4/14/15 allegation of abuse/investigation. -4/16/15 "[Name of BDDS Coordinator] received call from consumer's mother wanting to report issues with treatment and care of consumer by staff in the group home. Mother (name of client B's mother) reported several issues that consumer has been having with staff at the group home for several months. -Consumer being held down during			

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	behaviors causing bruising to his person. -Consumer being put in his room for 'not behaving like an adult.' -Consumer not being given his medicine but staff signing off on MAR as if he has received it. -No coat all winter, was given someone else's coat to wear instead. -No incident reports completed for the times when consumer has had behaviors including self mutilation. -Staff not putting consumer's bite gloves on his hands to prevent him from self mutilation. -Mother also alleges that Consumer has attempted to write notes to give to workshop staff telling them things that house staff have done but house staff intercept his notes and take them away. Investigation will be completed into these allegations. BDDS will follow up with provider and consumer." The 4/16/15 reportable incident report was completed by the BDDS Coordinator. The facility's 4/21/15 follow-up report to the 4/16/15 reportable incident report indicated the facility's PD answered the following questions asked by BDDS (not all inclusive): "1. Please provide the outcome of the investigation. Investigation is still ongoing (sic)			

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	2. Has the investigation been substantiated or unsubstantiated? Investigations still ongoing (sic) 3. Was the individual being put in his room as a punishment? No the consumer was not being put into his bedroom as a punishment. Consumer was being very disruptive to the other housemates and cussing at the staff. Staff was instructed that when the consumer is being disruptive that they should ask him if he wants to go to a quiet room. According to the staff, this consumer said he wanted to go to his bedroom and listen to music. 4. Was the individual held/locked in the room or was be (sic) able to come and go freely from the room? The consumer was not held/locked in the room. The consumer is in a wheelchair. Since this incident occurred, staff were informed that they are not to put his consumer in his bedroom unless he wants to go there and then a staff needs to stay in there with him. If this consumer doesn't want to go to his bedroom than (sic)staff are to stay with him in the current room and ask the other house mates to exit the room...." The facility's End of Shift Reports (EOS)			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	10311 E JACKSON SELMA, IN 47383

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	were reviewed on 4/23/15 at 10:45 AM. The EOS indicated the following (not all inclusive): -On 4/8/15, "[Client B] started biting self during breakfast for no reason. Client was cussing staff when I (staff #6) was getting him up. Client was placed in his room and when checked on had blood all over his face and hands. He ate all of his eggs and about three bites of toast." The 4/8/15 EOS report indicated it was sent to all the staff who worked at the group home, staff #1, the PD and the nurse for the group home. The 4/8/15 EOS report indicated the PD read the report on 4/8/15 at 1:09 PM. The facility's reportable incident reports and/or investigations reviewed from February 2015 to April 2015 indicated the facility failed to conduct an investigation in regard to 4/8/15 incident of possible neglect (why the client was placed in his bedroom as the client demonstrated SIB with injury, gloves/mitts were not placed on the client, and/or why the client was not monitored). -On 4/6/15 Client B "...talked to mother on phone. was (sic) excited. very (sic) pleasant. has (sic) small bruise that looks similar to thumb print on Right forearm very light." The 4/6/15 EOS report indicated the PD read the EOS on 4/8/15			

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	at 1:03 PM. The facility's 2/15 to 4/15 reportable incident reports and/or investigations indicated the facility's administrative staff failed to conduct an investigation in regard to the 4/6/15 allegation of possible abuse/injury of unknown source. Client B's record was reviewed on 4/23/15 at 10:25 AM and on 4/27/15 at 2:41 PM. Client B's May 2014 Behavior Plan (BP) indicated client B demonstrated "Self-injurious behavior: biting himself, typically on the arms/hands without breaking the skin. 1. Staff should verbally prompt [client B] to stop biting himself. 2. Staff should immediately redirect [client B] to his replacement behaviors. 3. If [client B] continues to self-harm, staff should explain to [client B] that they are putting his protective hand mitts on. Staff should put the mitts on so that his hands and fingers are covered. Staff should say, '[Client B] I did not want you to hurt yourself. You need to stop biting yourself. Adults do not behave this way'...5. Staff should document all incidents of self-injurious behaviors and provide any necessary medical care...." Client B's May 2014 BP indicated facility staff were to utilize a "visual daily schedule" with the client as his			

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	replacement behavior. Client B's BP did not indicate facility staff were to take the client to his bedroom, and/or indicate how facility staff were to restrain/hold client B's arms/hands to get the client's mitts on to prevent injury/harm to the client. Client F's record was reviewed on 4/30/15 at 11:06 AM. Client F's 4/20/15 Individual Support Plan (ISP) indicated client F had an objective to recognize when there is inappropriate staffing (home alone, staff leaves in middle of shift, one staff on duty and/or if a staff is sleeping). Client F's 3/19/15 Behavior Support Plan (BSP) indicated "...Teaching Method 12 Please explain to [client F] the natural consequences of non compliant behavior. ie (example), he will miss out on opportunities to go to the convenience store with staff. Give him real life examples. (If staff does not do what they are asked to do then they have consequences but if they do what they are required to do then they get a paycheck)." Interview with the PD and the Area Director (AD) on 4/21/15 at 3:00 PM indicated they visited the group home. The PD indicated she was at the group home once a week and the AD indicated			

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	she was at the group home once a month. The PD later indicated she was at the group home once a month as well. The PD and the AD indicated they were not aware of any staff sleeping while working. The PD and the AD also indicated they were not aware of any staff being rude or yelling at clients. When asked if the PD had received any reports on 4/5/15 of client B's bruising to his arm, the PD stated "Was reported to me. Sent by S-com (secure email). It was one small bruise smaller than a quarter." When asked if there was an investigation for client B's 4/5/15 bruising/injury of unknown source to the client's arm, the PD and the AD stated "No." When asked if there had been any peer to peer aggression/allegations of abuse, the PD indicated there had been past altercations between clients F and A. The PD indicated the incidents occurred months ago. When asked if the PD was aware of any concerns/allegations of the HM withholding funds of clients and/or talking down to clients, the PD stated "Yes. I looked at it right away." The PD stated the PD spoke with client F and "Conclusion was he (client F) had funds there and access to money." The PD indicated she investigated the incident but did not document her investigation. Interview with staff #1 on 4/22/15 at 8:55			

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	AM stated client F had "Plenty of underwear. He will wash them and not put them away." When asked when was the last time client F went shopping, staff #1 stated "Last week for a pop." When asked if staff #1 was aware of any staff yelling at clients, staff #1 stated "No." Staff #1 stated she was aware one staff "speaks loud." Staff #1 stated the staff person had a "hearing loss-compensates for speaking loud." Staff #1 indicated clients A and F received an allowance. Staff #1 stated client F got $1 "on request" and client A received $5 a week. Staff #1 sta ted client A is "still giving money away." Staff #1 indicated client A's ISP did not address client A's identified need, and there was no documentation in regard to client A giving money to others. Interview with the PD on 4/22/15 at 11:01 AM indicated when asked if the PD had been aware of any bruising with client B's arm prior to 4/14/15, the PD stated "No." The PD then stated "I think staff was told that weekend and they made out a report." When asked if any staff were interviewed, the PD stated "I'm not doing the investigation." Interview with QA staff #1 on 4/22/15 at 2:35 PM and at 2:45 PM indicated QA staff #1 indicated she had received an			

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	email from the Regional Director on 4/14/15 in regard to an allegation of staff #6 using an inappropriate restraint. QA staff #1 stated "We (Regional Director and QA staff #1) could not connect until Friday (4/17/15) morning." QA staff #1 indicated she did not start the investigation into the 4/14/15 allegation of abuse until 4/17/15. QA staff #1 indicated she interviewed client B's mother on 4/17/15, and started interviewing staff on 4/21/15. QA staff #1 stated " Still doing investigation." Interview with PD #2 on 4/28/15 at 5:10 PM indicated all allegations should be reported and investigated. When asked if the 3/17/15 client to client aggression/abuse with client F and client A was investigated, PD #2 stated "I gave you everything I could locate." When asked if the 4/8/15 incident where client B was placed in his bedroom and the client ended up injuring himself was investigated, PD #2 stated "It may be coupled with what [QA staff #1] is investigating." This federal tag relates to complaint #IN00171811. 9-3-2(a)			
W 0155	483.420(d)(3)			

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Bldg. 00	STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. Based on 1 of 9 allegations of abuse, neglect, mistreatment and/or injuries of unknown source reviewed, the facility failed to ensure a staff was immediately removed from client contact when an allegation of abuse was made involving client B. Findings include: During the 4/20/15 observation period between 4:25 PM and 9:14 PM, at the group home, client B had 2 gloves/mitts attached to the handles of his wheelchair. Client B had two open areas on the back of his right hand. The smaller area was raised, open with a scab starting to form. The larger area was red and open with swollen tissue surrounding the area. The larger area was about the size of an eraser tip and the smaller area was slightly smaller than an eraser tip. Interview with client B's mother on 4/21/15 at 9:29 AM, by phone, indicated she had reported a bruise on client B's right forearm about two to two and a half weeks ago. Client B's mother indicated she saw the bruise when client B came to visit that weekend. Client B's mother stated "Weekend staff filled out paper	W 0155	**W155 Staff Treatment of Clients** The facility must prevent further potential abuse while the investigation is in process. **1. What corrective action will be accomplished?** · Quality Assurance will complete competency based training with Program Director/QIDP and Area Director regarding immediate removal/suspension of staff alleged to be abusive, neglectful and/or exploitive, for client protection. · Area Director and/or Quality Assurance will supervise investigation recommendation(s) for completion, including corrective actions. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Training with Program Coordinator and Program Director/QIDP regarding policy on reporting abuse, neglect and exploitation, including removal/suspension of staff for client protection. · Any allegation of abuse, neglect and/or exploitation will result in immediate removal/suspension of staff for client protection. **1.What measures will be put**	06/12/2015

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	work and [staff #1] knew of paper but said she (staff #1) did not see bruise." Client B's mother stated the bruise on client B's arm "looked like a thumb print." Client B's mother indicated she found out staff were holding client B's arm down when he started to bite his arm. Client B's mother stated client B called her last Monday (4/13/15) stating "Mom help." Client B's mother indicated client B was upset. Client B's mother indicated client A got on the phone and tried to explain what client B was trying to tell her. Client B's mother indicated client A indicated they were having waffles for breakfast but client B wanted eggs and started biting his arm. Client B's mother stated client A stated staff #8 told the client he was having waffles and not eggs when "[staff #6] got involved and held [client B's] arms down and [staff #8] took him (client B) to his room." Client B's mother indicated staff #8 did not know he (staff #8) was not allowed to put client B in his room when he was having a behavior of biting his arm. Client B's mother indicated she called staff #1 and reported the allegation of abuse/neglect to staff #1. Client B's mother indicated staff #1 stated "She (staff #1) would make phone calls and take care of it." Client B's mother indicated on 4/14/15 in the morning, she called the group home to speak with		**into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ·Training with Program Coordinator and Program Director/QIDP regarding policy on reporting abuse, neglect and exploitation, including removal/suspension of staff for client protection ·Any allegation of abuse, neglect and/or exploitation will result in immediate removal/suspension of staff for client protection. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** ·Training with Program Coordinator and Program Director/QIDP regarding policy on reporting abuse, neglect and exploitation, including removal/suspension of staff for client protection. ·Any allegation of abuse, neglect and/or exploitation will result in immediate removal/suspension of staff for client protection. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015	

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	client B when staff #6 answered the phone. Client B's mother indicated she asked staff #1 why staff #6 was answering the phone, and staff #1 stated "Because she (staff #6) works here." Client B's mother stated staff #1 did not report "the allegation of abuse/neglect" as staff #6 was still working on 4/14/15. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/21/15 at 1:45 PM. The facility's 4/14/15 reportable incident report indicated "It was reported on April 14, 2015 that [client B] (consumer) may have been put into an inappropriate restraint. [Client B] has bite mitts that are to be put on when he is biting and hurting himself. It is suspected that staff [staff #6] held his arms down when applying the bite mitts during a behavior. [Staff #6] was suspended on April 14th and will remain suspended while an investigation is being conducted." Staff #6's 4/12/15 to 4/22/15 Time card was reviewed on 4/22/15 at 3:07 PM. Staff #6's time card indicated staff #6 worked on Monday 4/13/15 from 12:22 AM to 8:32 AM and on Tuesday 4/14/15 from 12:32 AM to 9:13 AM. Staff #6's time card indicated staff #6 was not immediately suspended after client B's			

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	mother called the HM on 4/13/15 regarding an allegation of abuse/mistreatment as staff #6 was allowed to work her shift on 4/14/15 before the staff was suspended. Interview with the PD and the Area Director (AD) on 4/21/15 at 3:00 PM indicated client B's mother had made an allegation of abuse against a staff person. When asked when staff #6 was suspended for the 4/14/15 allegation, the PD stated "[Client B's] mom contacted us (Regional Director) about it that morning. Met as a team to discuss. She was suspended immediately." Interview with Human Resource (HR) staff #1 on 4/22/15 at 1:40 PM indicated she did not know when the facility suspended staff #6. HR staff #1 stated "There is no documentation or form from HR on when staff is suspended." HR staff #1 indicated the Quality Assurance (QA) staff would have that information. Interview with QA staff #1 on 4/22/15 at 2:35 PM and at 2:45 PM indicated she did not have the information on when staff #6 was suspended but was trying to find out herself. At 2:45 PM, QA staff #1 indicated staff #6 was suspended on the morning of 4/14/15 after client B's mother called the Regional Director, who			

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	called the AD and the AD informed the PD to suspend staff #6. QA staff #1 indicated staff #6 was not immediately removed from client contact when the allegation was made. This federal tag relates to complaint #IN00171811. 9-3-2(a)			
W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on interview and record review for 1 of 9 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to complete investigations within 5 working days for client B. Findings include: The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/21/15 at 1:45 PM. The facility's 4/14/15 reportable incident report indicated "It was reported on April 14, 2015 that [client B] (consumer) may have been put into an inappropriate restraint. [Client B] has bite mitts that are to be put on when	W 0156	**W156 Staff Treatment of Clients** The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. **1. What corrective action will be accomplished?** · Quality Assurance will complete competency based training with Program Director/QIDP regarding incidents requiring investigation as well as timely completion of investigations. · Quality Assurance will complete competency based training with Program Director/QIDP and Area Director regarding immediately reporting to the administrator or to	06/12/2015

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	he is biting and hurting himself. It is suspected that staff [staff #6] held his arms down when applying the bite mitts during a behavior...." Interview with client B's mother on 4/21/15 at 9:29 AM, by phone, indicated mother indicated she found out staff were holding client B's arm down when he started to bite his arm. Client B's mother stated client B called her last Monday (4/13/15) stating "Mom help." Client B's mother indicated client B was upset. Client B's mother indicated client A got on the phone and tried to explain what client B was trying to tell her. Client B's mother indicated client A indicated they were having waffles for breakfast but client B wanted eggs and started biting his arm. Client B's mother stated client A stated staff #8 told the client he was having waffles and not eggs when "[staff #6] got involved and held [client B's] arms down and [staff #8] took him (client B) to his room." Client B's mother indicated staff #8 did not know he (staff #8) was not allowed to put client B in his room when he was having a behavior of biting his arm. Client B's mother indicated she called staff #1 and reported the allegation of abuse/neglect to staff #1. Client B's mother indicated staff #1 stated "She (staff #1) would make phone calls and take care of it." Client B's		other officials in accordance with State law allegations of mistreatment, neglect or abuse as well as injuries of unknown source. · Quality Assurance will complete competency based training with staff regarding completion of internal incident/injury reports as well as expectation regarding immediately reporting incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Quality Assurance will complete competency based training with Program Coordinator and Program Director/QIDP regarding timely review of internal incident/injury reports as well as process for reported incidents (including abuse, neglect, exploitation, peer to peer incidents, medication errors and injuries of unknown origin). · Area Director will report weekly to Regional Director data regarding investigation timeliness. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Program Director/QIDP and/or Area Director will ensure investigations are completed and reported to the administration within 5 business	

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	mother indicated on 4/14/15 in the morning, she called the group home to speak with client B when staff #6 answered the phone. Client B's mother indicated she asked staff #1 why staff #6 was answering the phone, and staff #1 stated "Because she (staff #6) works here." Client B's mother indicated she then called the main office and spoke with the Regional Director and the Area Director. Client B's mother indicated the facility's investigation was not started until Friday (4/17/15) when administrative staff called to interview her. Interview with the PD on 4/22/15 at 11:01 AM stated when asked if the investigation was completed for the 4/14/15 allegation, the PD indicated the investigation was not done by 4/21/15 as the investigation was still being done. Interview with QA staff #1 on 4/22/15 at 2:35 PM and at 2:45 PM indicated she had received an email from the Regional Director on 4/14/15 in regard to an allegation of staff #6 using an inappropriate restraint. QA staff #1 stated "We (Regional Director and QA staff #1) could not connect until Friday (4/17/15) morning." QA staff #1 indicated she did not start the investigation into the 4/14/15 allegation		days. · Program Director/QIDP and/or Area Director will ensure Quality Assurance is notified of incidents timely to allow sufficient time for incidents to be thoroughly investigated **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Program Director/QIDP and/or Area Director will ensure investigations are completed and reported to the administration within 5 business days. · Program Director/QIDP and/or Area Director will ensure Quality Assurance is notified of incidents timely to allow sufficient time for incidents to be thoroughly investigated **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Program Director/QIDP and/or Area Director will ensure investigations are completed and reported to the administration within 5 business days. · Program Director/QIDP and/or Area Director will ensure Quality Assurance is notified of incidents timely to allow sufficient time for incidents to be thoroughly investigated **1.What is the date by which the systemic changes will be completed?** · June 12, 2015	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	10311 E JACKSON SELMA, IN 47383

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	of abuse until 4/17/15. QA staff #1 indicated she interviewed client B's mother on 4/17/15, and started interviewing staff on 4/21/15. QA staff #1 stated " Still doing investigation." QA staff #1 indicated the investigation would not be completed within 5 working days. This federal tag relates to complaint #IN00171811. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, interview and record review for 9 of 10 allegations of abuse, neglect, and/or injuries of unknown source reviewed, the facility failed to ensure its recommended corrective actions/measures in regard to medication errors prevented additional errors. The facility failed to ensure its nursing services were involved in retraining staff and/or corrective actions. The facility failed to take appropriate corrective action in regard to a pattern of medication errors made the same facility staff to ensure clients' medications were administered without error for clients B, C, D, F and G.	W 0157	**W157 Staff Treatment of Clients** If the alleged violation is verified, appropriate corrective action must be taken. **1. What corrective action will be accomplished?** · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will	06/12/2015

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	Findings include: During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the group home, client G ate her breakfast at 6:49 AM. Staff #1 indicated she was going to pass medications on 4/21/15 and give staff #2 a "break." Client G came to the medication room to get her morning medications at 7:25 AM. Client G assisted staff in administering her own medications as staff #1 would hold a pill bottle (one at a time) and hand it to client G to get a pill out of the bottle. Client G received Omeprazole 40 milligrams 1 tablet at the morning medication pass. Client G's Omeprazole DR (non erosive gastritis) bottle indicated the client was to receive the medication 20 minutes prior to meals. Interview with staff #1 on 4/21/15 at 7:50 AM indicated when asked why client G's Omeprazole was administered after breakfast, staff #1 stated "If she does not take with other meds she will not take it. Our nurse gave us permission to give it after meals versus before meals." During the 4/22/15 observation period between 6:25 AM and 7:38 AM, at the group home, client B was sitting at the dining room table having breakfast upon arrival to the group home. Client B sat in his wheelchair until the client left for the		result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth mediation error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will complete one random medication practicum monthly. · Program Director/QIDP will review the completion of a medication practicum monthly. · Area Director will monitor the completion of a medication practicum monthly. · Area Director and/or Quality Assurance will review investigations for thoroughness. · Area Director and/or Quality Assurance will supervise investigation recommendation(s) for completion, including corrective actions. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what**	

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	day program. The client did not get any medications (8 AM medications). Staff #2 passed clients' medications in the group home on 4/22/15. Interview with staff #1 on 4/22/15 at 7:40 AM by phone indicated client B received his 8 AM morning medications Oxcarbazepine 600mg tablet (for seizures) and Reno Caps Softgel 1 mg (for ulcer healing) after client B got up on 4/22/15 around 6 AM. Staff #1 indicated client B would have behaviors if they gave him the medications before he left for work. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/21/15 at 1:45 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following medication errors: 1. On 2/14/15, "It was reported on Sunday February 15, 2015 at 8pm (sic) that the 8am medications at Selma on February 14, 2015 were not passed. This med (medication) error occurred due to new staff and that this med pass was to occur during a shift change. All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR (medication administration record) at the beginning of their shift. No side effects were seen		**corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth mediation error will result in severing the employment relationship with that employee. · Program Coordinator will complete one random medication practicum monthly . · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Area Director will monitor the completion of a medication practicum monthly. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	

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	after this med error. The prescribing doctor was not contacted. Nurse and Program Director (PD) were contacted about this med error. As of 3pm on Monday February 16, 2015, there were still no side effects from this med error." The facility's 2/14/15 reportable incident reports indicated clients B, C, D, F and G did not receive their medications. The facility's 2/18/15 Investigation Summaries for clients B, C, D, F and G indicated staff #2 made the 2/14/15 medication errors. The facility's 2/18/15 investigations indicated in the Factual Findings section "Interview with [staff #2] (DSP) (Direct Support Professional) on February 17, 2015 -Stated that this consumer (clients C, D, F and G on 4 separate summaries) didn't have a med error. -Stated that she (staff #2) doesn't have Therap (facility computerized record system) access and couldn't record on the M.A.R...." The facility's 2/18/15 investigations indicated staff #3 and #4 indicated the clients did not receive their medications, and were not present when staff #2 administered the medications. Client B's 2/18/15 Investigation Summary under the section entitled Factual Findings, indicated "Interview with [staff #2] (DSP) on February 17,		· All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth mediation error will result in severing the employment relationship with that employee. · Program Coordinator will complete one random medication practicum monthly . · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Area Director will monitor the completion of a medication practicum monthly. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · All new staff will have 3 medication practicums before passing medications independently. · One medication	

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	2015 -Stated this consumer didn't get his medications because she (staff #2) was waiting to do it when the next staff came in to assist her. -Stated that she forgot to do it when the next staff came in. -Stated that she doesn't have Therap access and couldn't record on the MAR...." The facility's 2/18/15 investigation indicated the facility failed to put in place any corrective actions/measures e to prevent to similar errors in the future. 2. On 2/18/15, "It was reported to the HM (home manager) on Wednesday February 18, 2015 at 8:15pm that [client C] was accidentally given her 8am medications (due on 2-19-15) at the 4pm med pass on 2-18-15. This med error occurred due staff not have her full concentration and focus on this med error at the time (sic). All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR at the beginning of their shift. No side effects were seen after this med error. The prescribing doctor was not contacted. Nurse and Program Director were contacted about this med error on 2-18-15 right (sic) the HM learned of this error...This certain staff will be retrained over how to properly pass medications."		error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth mediation error will result in severing the employment relationship with that employee. · Program Coordinator will complete one random medication practicum monthly . · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Area Director will monitor the completion of a medication practicum monthly. **1.What is the date by which the systemic changes will be completed?** ·June 12, 2015	

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	The facility's 2/24/15 Investigation Summary indicated staff #5 made the medication error. The facility's 2/18/15 investigation indicated staff #5 "...Stated that she would be willing to go thru (sic) additional training for med passes...." 3. On 2/26/15, "It was reported that on Thursday February 26, 2015 at 8pm that staff (staff #5) completed a med error with [client G] (client G). Staff forgot to give [client G] one of her medications. This med error occurred due to staff not realizing that [client G] had this medication. This medication is new to [client G]. All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR and their messages at the beginning of their shift. The home manager was reminded to inform all staff about any changes in the consumers' medications...." The facility's 3/3/15 follow-up to the 2/26/15 reportable incident report indicated client G did not receive her ordered Xanax .25 milligrams (controlled substance-skin picking). 4. On 3/1/15, "It was reported that on Sunday March 1, 2015 at 8pm that staff (staff #4) completed a med error with [client G]. Staff forgot to give [client G]			

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	her Xanax (Alprazolam) .25mg tablet. [Client G] is to receive this medication 2 times a day. All staff are reminded to follow the 6 rights of medication administration. All staff are reminded to check the MAR and their messages at the beginning of their shift. The home manager was reminded to inform all staff about any changes in the consumer's medications...At house meeting on Wednesday all staff (including the staff who made the error) will be retrained by the HM and PD (Program Director)." The facility's 3/3/15 Investigation Summary indicated staff #4 "...Stated that she thought she passed all of [client G's] medications and didn't know about this med error until now. -Stated that she will remember next time to pass it and will work slower with med pass...." The facility's 3/3/15 Incident Management Quality Review indicated "Nurse Recommendations (if applicable):" was blank. 5. On 3/14/15, "It was discovered that at 11am on Saturday March 14, 2015 that [client B] had a med error. [Client B's] Oxcarbazepine 600mg tablet (for seizures) and Reno Caps Softgel 1 mg (for ulcer healing) were not passed. The weekend day staff discovered this med error. Normally the 3rd (third) shift staff			

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	(staff #2) passes the morning 8am medications. [Client B] was the only consumer in this house that 3rd shift staff forgot to pass the medications for...The staff was reminded to follow the 6 rights of medication administration. This staff was reminded to check the MAR at the beginning of the med pass, during the med pass, and after the med pass...." The facility's 3/20/15 Investigation Summary indicated the investigator (PD) looked at the BDDS (Bureau of Developmental Disabilities Services) report and the client's 3/14/15 MAR. The facility's investigation indicated staff #2 "...Stated that she left [client B's] medications to be completed by the following staff. - Stated that she completed everyone else's med passes. Interview with [staff #7] (DSP) (Direct Support Professional) on March 14, 2015 - Stated that when she came in for the start of her shift, [staff #2] was already hurrying out of the door. - Stated that she assumed all of the medications were already passed. - Stated that she called the PD as soon as she noticed this med error...." The facility's investigation summary indicated "...This staff was reminded to not be in a hurry to leave at the end of your shift, but be patient and to give a summary to the next staff on duty...."			

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	The facility's 3/20/15 Incident Management Quality Assurance Review indicated the facility's nurse did not review and/or make any recommendations in regard to 3/14/15 medication error as the nurse's section was blank. 6. On 3/23/15, "It was reported on Monday March 23, 2015 at 8pm that [client F] didn't receive his 8am medications that morning. Those missed medications include (Chlorhexidine 0.12% Rinse-15ml (milliliters) (Gingivitis); Invega ER 9 MB tablet (psychosis); Lisinopril 10 mg-(Hypertension); and Topiramate 50 MG tablet (Mood stabilizer). Staff was reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR at the beginning of their shift...." The facility's 3/27/15 Incident Management Quality Assurance Review indicated the facility's nurse did not make any recommendations as the Nurse's area was blank. 7. On 4/5/15, "It was reported on Sunday April 5, 2015 at 4pm that the 8am medications for [client B] were not passed earlier that day...This med error			

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	occurred due to confusion of who was going to pass his medications. All staff were reminded to communicate with each other during shift changes. All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR at the beginning of their shift...." The facility's 4/14/15 follow-up report to the 4/5/15 reportable incident report indicated client B did not receive his 8 AM Oxcarbazepine and Reno Softgel medications. The facility's 4/14/15 Investigation Summary indicated staff #2 had left client B's medications to be administered by the day shift staff "...per the day shift's request...." The facility's investigation indicated the facility failed to take appropriate corrective action in regard to staff #2 administering clients' medications as this was the third incident/pattern of staff #2 not administering the client's morning medications. The facility's 4/14/15 Incident Management Quality Assurance Review indicated recommendation by the facility's Area Director (AD) of "Follow MAR & (and) med pass protocol. Med Practicum with staff."			

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	8. On 4/12/15, "It was reported that [client B] was not given his 8am on Sunday April 12th. [Client B] did not receive the following medications. OXCARBAZEPINE 600 MG TABLET for seizures & RENO CAPS SOFTGEL 1mg for Ulcer Healing...The med error occurred due (sic) confusion between the 3rd shift staff and the day shift staff who was going to pass [client B's] medications. All staff were reminded to communicate with each other during shift changes. All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR at the beginning of their shift. Record of discussion was completed with the staff...." The facility's 4/14/15 Investigation Summary indicated staff #2 was the staff who made the medication error. The facility's investigation indicated staff #2 "...Stated that she left [client B's] medications to be done by the following staff per the day shift's request. - Stated that she completed everyone else's med passes...." The facility's 4/14/15 investigation indicated staff #7 stated that when she came in for her shift she forgot that she wanted to pass [client B's] medications...."			

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	The facility's 4/14/15 Incident Management Review indicated the AD recommended on 4/15/15 to complete a medication practicum with staff (#2). The 4/14/15 incident form indicated the facility's nurse did not review the incidents and/or make any recommendations. The facility's incident review form and/or 4/14/15 investigation indicated the facility failed to address staff #2's pattern of medication errors (4) with client B. The facility failed to have its nursing services monitor and/or provide oversight of the staff when passing medications to ensure staff were competent to pass medications without error. The facility failed to ensure its corrective actions/measures prevented medication errors. The facility failed to address the pattern of medication errors with staff #2 which involved client B. Client G's record was reviewed on 4/22/15 at 5:05 PM. Client G's 3/31/15 physician's orders indicated client G received Omeprazole 40 milligrams 20 minutes before breakfast daily for 3 months. Client G's April's 2015 MAR indicated client G received Alprazolam (skin picking) 0.25 milligrams, Artificial tears			

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	(dry eyes) daily at 8:00 Baclofen (Cerebral Palsy) 10 milligrams, Calcium 500+D (Menopause) two times a day, Citalopram HBR(hydrobromide) 40 milligrams (Depressive Disorder), Cranberry Juice three times a day, Divalproex Sod DR (delayed release) 500 milligrams (Seizure Control), Ocala (stool softener)100 milligrams daily, Loratadine (allergy) 10 milligrams, Oxybutynin CL (chloride-incontinence) ER (extended release) 5 milligrams and Santyl (wound care dressing) dressing. Client G's April, 2015 MAR indicated client G did not receive her morning medications at the 8 AM medication pass on 4/22/15 as there was no documentation/initials for the medication pass. Client B's record was reviewed on 4/23/15 at 10:35 AM. Client B's 2/13/15 Quarterly physical (physician's order) indicated client B received Oxcarbazepine 600 milligrams in the morning and 1 Reno Caps daily. Client B's April 2015 MAR indicated client B received the Reno Capsule in the morning at 8 AM. Client B's 2/13/15 Quarterly Physical indicated client B's diagnosis included, but was not limited to, Epilepsy Unspecified. The facility's Inservice records were			

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	reviewed on 4/22/15 at 10:55 AM. The facility's inservice records indicated facility staff were retrained in regard to Medication Pass/administration on 3/4/15 and on 4/1/15. The facility's 4/1/15 Inservice Meeting record indicated staff #2 was retrained in medication administration on 4/1/15. Staff #2 did not attend the 3/4/15 training. Staff #2's personnel record was reviewed on 4/22/15 at 4:05 PM. Staff #2's personnel record indicated staff #2 Core A and B (state training to pass medications) was A-88% and B-88%. Staff #2's personnel record indicated Staff #2 received a Record of Discussion Form on 4/1/15. The form indicated "90 Day check up ; Discuss Med Pass, MARs, Documentation...[Staff #2] is having difficulties w/ (with) passing meds, documenting, following orders, etc. DSP (staff #2) will contact HM/PD if needs additional training. DSP to correct these issues/concerns." Review of the facility's reportable incident reports indicated staff #2 continued to have medication errors after her 4/1/15 record of discussion. Interview with the Area Director (AD) and the Program Director (PD) on 4/21/15 at 3:00 PM indicated the facility's nurse would conduct the core A and B			

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	15G364		05/13/2015

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	training. The PD and the AD indicated the group home manager would do the medication Practicum which would initially be done before staff could actually pass medications. The PD and the AD indicated they were aware the home was having problems with medication errors. The PD indicated they had discussed and retrained staff in regard to the medication administration policy at staff meetings and by doing medication practicums. The PD and the AD stated the group home manager was doing one "random" medication practicum a week. The PD stated if there was a medication error, the staff would receive a "Record of Discussion before you get a written warning." The PD and AD indicated the facility's nurse did not participate in staff meetings and did not conduct any medication practicums. The PD and the AD indicated the staff continued to have medication errors. The AD indicated their corrective action had not been working in regard to retraining staff. The PD indicated they were aware of the issues with staff #2. The PD stated they were working with HR (Human Resources) "to do a final warning. We tried retraining and that's why we are going to HR." The PD indicated staff #2 was still allowed to pass medication. The PD stated "She is unsure how to help him (client B)." The PD and AD indicated			

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	staff #2 was not sure how to administer client B's medication to the client as he would get upset at times. The PD and the AD indicated they had not provided any additional training with staff #2 to assist the staff to be able to handle and/or pass medications to client B. The PD indicated the facility had retrained staff in regard to the 6 rights of medication and medication administration. Interview with nurse staff #1 on 4/22/15 at 4:26 PM, by phone, indicated she was not always informed when a medication error occurred. Nurse staff #1 stated "Only if informed of med errors." Nurse staff #1 stated she was aware of a medication error with client B in April, but "it was after the fact." Nurse staff #1 indicated she did not monitor the group home in regard to medication errors. Nurse staff #1 indicated the HM and the PD trained and/or retrained staff. Nurse staff #1 stated "I do not monitor med passes unless I am asked to do so." The facility's Medication Practicums (Medication Administration Skills Checklist) were reviewed on 4/22/15 at 10:55 AM. The checklists indicated the Home Manager completed the checklists. The checklists indicated the manager did a medication practicum with staff #2 on 4/14/15. The 4/14/15 practicum/checklist			

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	indicated staff #2 had check marks in the "Satisfactory" column. Review of the Medication skills checklist from 10/14 to 4/15 indicated the facility did not conduct any additional checklists. Review of the facility's Medication Practicums indicated the Home Manager conducted one random checklist prior to April 2015 on 3/4/15 with staff #8. This federal tag relates to complaint #IN00171811. 9-3-2(a)			
W 0159 Bldg. 00	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. Based on observation, interview and record review for 3 of 4 sampled clients (B, C and D) and for 1 additional client (G), the Qualified Intellectual Disabilities Professional (QIDP) failed to monitor the clients' programs in regard to ensuring each client received an aggressive active treatment program. The QIDP failed to ensure identified needs of clients were addressed, addressed basic training needs of clients and coordinated sensorimotor assessments and communication	W 0159	**W159 Qualified Mental Retardation Professional** Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. **1. What corrective action will be accomplished?** · **Quality Assurance (QIDP) will complete competency based training with Program Director/QIDP regarding ensuring each client receives continuous, aggressive and consistent active treatment programs.**	06/12/2015

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	assessments of clients. The QIDP failed to ensure clients' program plans were implemented when opportunities existed, and to ensure needed supports were incorporated into clients' program plans regarding a gait belt, how to monitor and supervise a client who was self-injurious, and how to restrain a client without causing injuries. Findings include: 1. During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the group home, client C refused to eat her breakfast except for a few bites of food. Client C's record was reviewed on 4/28/15 at 11:10 AM. Client C's 2/16/15 Consultation Form indicated indicated client C saw a speech therapist in regard to a swallow study. The 2/16/15 note indicated "Pt (patient) was able to tolerate small amounts of regular consistency foods if given small pieces. Staff is concerned (with) (decreased) intake and weight loss. Rec (recommend): "Upgrade to regular consistency (with) staff controlled bites and sips of thin liquids. 1:1 (One staff to one client) supervision at all times for meals. Staff to cut food at table." Client C's Health Tracking Monthly		· Quality Assurance will complete competency based training with staff on the importance of ensuring active treatment at all times. · Training will be completed with the Program Coordinator and Program Director/QIDP regarding training of staff. · At a minimum twice weekly for one month, Program Director/QIDP will document via electronic documentation system (Therap) t-log/note on site observations at the facility to ensure integration and coordination of active treatment programming. After twice weekly for one month observations, Program Director/QIDP will document via Therap t-log at a minimum once weekly for one month, observations to ensure integration and coordination of active treatment programming. After once weekly for one month observations, Program Director/QIDP will complete at a minimum once monthly observations at the facility to ensure integration and coordination of active treatment programming. · The Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all clients in the home via monthly completion of data collection reports, which includes electronic documentation system data review. Area Director will comment on electronic documentation system data review report as reviewed. · Area Director will review	

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	Report indicated the following weights: -October 2014 121 pounds -November 2014 115 pounds -December 2014 No weights documented -January 2015 No weights documented -February 2015 No weights documented -March 7, 2015 111.6 pounds -March 21, 2015 109 pounds -March 29, 2015 109 pounds -April 5, 2015 106.8 pounds Client C's 2/19/15 Quarterly Physical indicated client C was to be weighed weekly and to document in Therap (facility's computer record system). Client C's 1/13/15 Quarterly Nutrition Review indicated client C saw her doctor on 1/15/15 and the doctor office weighed the client at 106.7 pounds. Client C's nutrition review indicated weekly weights were started on 1/15/15 and Ensure (dietary supplement) three times a day was started on 12/14/14 at and emergency room visit to improve intake. The nutrition review indicated client C also saw her doctor on 1/28/15 for "eating issues, wt (weight) loss and CBC (blood lab work) abnormalities." The note indicated client C's doctor increased client C's Ensure up to 5 cans a day on 1/28/15 and ordered a swallow study. The nutrition assessment indicated		Program Director/QIDP's Therap t-log regarding site observation of integration and coordination of active treatment programming twice weekly for one month, once weekly for one month and monthly thereafter and will address any concerns with the Program Director/QIDP within 48 hours of review. · Area Director will make unannounced visit to facility weekly for one month and monthly thereafter, to ensure the Program Director/QIDP has effectively integrated and coordinated the active treatment programs. 2. **How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents have the potential to be affected by the same deficient practice. · Training with Program Director/QIDP regarding ensuring each client receives continuous, aggressive and consistent active treatment programs. · The Area Director will ensure that the Program Director/QIDP is monitoring treatment programs for all 8 clients in the home. · The Program Director/QIDP will ensure that programming is in place for all clients addressing their identified need at all times. · Staff will be retrained on the importance of ensuring active treatment at all times. · Training will be completed with the	

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	"...Weight decreased 8.3# (pounds) this quarter-wt down 14# x (times) 90 days-wt change down 12% (percent) which is significant. Wt is at lower end of AWR (average weight range) = 105-135#-would not further wt loss...would rec (recommend) an albumin to assess nutrition status...." Client C's nutritional review indicated recommendations to obtain weekly weights. The assessment also indicated "Request for Physician's Order (s) and Justification for Request 1. Clarify supplement order with MD (medical doctor) of giving Ensure Plus-MD order was for Ensure. 2. Request MD order for Albumin level to assess visceral protein stores (detects malnutrition)." Client C's 2/18/15 Physical Form (nurse assessment) indicated "...Intake remains poor). 0 (zero) weight available even though she is scheduled for weekly weights-Staff are not following protocol-PD/AD (Program Director/Area Director) are aware...." The note indicated client C's (4/1/15) risk plan for choking was updated to a regular diet. Client C's labs and/or records from 4/14 to 4/15 did not indicate the nurse addressed client C's 1/15 dietary recommendations as no albumin labs were present in the client's record/Therap.		Program Coordinator and Program Director/QIDP regarding training of staff. · Performance Audits, involving review of program data collection will be completed annually by Quality Assurance. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Training with Program Director/QIDP regarding ensuring each client receives continuous, aggressive and consistent active treatment programs. · The Area Director will ensure that the Program Director/QIDP is monitoring treatment programs for all 8 clients in the home. · The Program Director/QIDP will ensure that programming is in place for all clients addressing their identified need at all times. · Staff will be retrained on the importance of ensuring active treatment at all times. · Training will be completed with the Program Coordinator and Program Director/QIDP regarding training of staff. · Performance Audits, involving review of program data collection will be completed annually by Quality Assurance. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Training with Program Director/QIDP regarding ensuring	

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	Client C's consultation forms and/or record indicated the facility's nursing services did not clarify client C's Ensure order. Client C's 4/1/15 ISP (Individual Support Plan) indicated client C's IDT (interdisciplinary team) did not meet to discuss/review and/or address client C's weight loss. Client C's 4/1/15 ISP and/or risk plans did not specifically address client C's weight loss. Interview with PD #2 on 4/28/15 at 5:10 PM indicated client C had been taken to the doctor in regard to her weight loss. PD #2 indicated she could not locate any documentation where client C's IDT met to review and/or address the client's weight loss. Interview with nurse staff #1 on 4/29/15 at 10:47 AM, by phone, indicated client C had lost weight. Nurse staff #1 stated the group home had "Ensure and Ensure Complete" in the house as of 4/29/15. Nurse staff #1 indicated client C's recommendation to clarify the client's Ensure had not been done. Nurse staff #1 indicated she called client C's doctor office yesterday to see if the Albumin level had been done as client C had some labs done on 3/11/15. Nurse staff #1 indicated she did not know what labs had		each client receives continuous, aggressive and consistent active treatment programs. · The Area Director will ensure that the Program Director/QIDP is monitoring treatment programs for all 8 clients in the home. · The Program Director/QIDP will ensure that programming is in place for all clients addressing their identified need at all times. · Staff will be retrained on the importance of ensuring active treatment at all times. · Training will be completed with the Program Coordinator and Program Director/QIDP regarding training of staff. · Performance Audits, involving review of program data collection will be completed annually by Quality Assurance. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015	

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	been completed on 3/11/15. 2. Client D's record was reviewed on 4/28/15 at 3:56 PM. Client D's 5/30/14 Speech-Language Evaluation indicated client D was "...non-verbal and essentially non-vocal...." Client D's speech evaluation indicated client D had a current goal to "functionally use photo communication board remains an appropriate goal...." The assessment recommended the following (not all inclusive): -"...increasing his ability to functionally use 1-2 communication pictures to request a specific item/object...expand his choice making skills using eye gaze...Staff should encourage the client to participate in social activities which promote vocabulary and language skills. For example: listening to magazine/newspaper articles, pointing to pictures in books/magazines, simple object manipulation games (puzzles, shape sorters, pop-up objects, etc...)...." Client D's record and/or 3/29/15 ISP indicated the QIDP did not address the client's 5/14 speech recommendations. Interview with staff #2 on 4/21/15 at 9:49 AM indicated client D did not have any communication training in place.			

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	Interview with staff #1 on 4/22/15 at 8:55 AM indicated client D was not able to make his wants and needs known, and did not have any formal communication training objective. Interview with PD #2 on 4/28/15 at 5:10 PM indicated PD #2 did not know how client D's 5/30/14 speech assessment recommendations had been addressed as client D did not have a communication training objective in place. 3. The QIDP failed to ensure each client received a continuous, aggressive and consistent active treatment program for clients C and D. Please see W196. 4. The QIDP failed to ensure client C's sensorimotor/ambulation skills were assessed. Please see W218. 5. The QIDP failed to ensure client C's communication skills were assessed and/or re-assessed to increase the client's communication with others. Please see W220. 6. The QIDP failed to address client G's identified training needs in regard to mealtime and privacy. Please see W227. 7. The QIDP failed to ensure clients'			

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	Individual Support Plans included the needed supports to indicate how facility staff were to monitor/supervise client G to prevent self injury, to indicate how facility staff were to assist client C in regard to her gait belt, and/or indicate how facility staff were to restrain client B to prevent injuries. Please see W240. 8. The QIDP failed to address client C and D's basic training needs in regard to communication, toileting, bathing, dressing and/or oral hygiene. Please see W242. 9. The QIDP failed to ensure clients B, C and D's Individual Program Plan objectives and/or behavior plans were implemented when formal and/or informal training opportunities existed. Please see W249. 10. The QIDP failed to ensure the facility's Human Rights Committee reviewed all restrictive plans for clients C and D. Please see W262. 11. The QIDP failed to ensure clients C and D's guardian gave written informed consent in regard to the clients' restrictive programs. Please see W263. This federal tag relates to complaint #IN00171811.			

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	9-3-3(a)			
W 0186 Bldg. 00	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. 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. Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients (E, F and G), the facility failed to ensure sufficient staff worked at the group home to meet the needs of the clients. Findings include: During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the group home, there was 1 staff to 7 clients. Upon arrival to the home, client A answered the door and then returned to the kitchen with staff #2. Client C was in the living room rolled up into a fetal position on the couch with her eyes closed, and a gait belt around her waist. Client A was in the kitchen making coffee. Client G was in her bed without	W 0186	**W186 Direct Care Staff** The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. 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. **1. What corrective action will be accomplished?** · Area Director and Program Director/QIDP will evaluate current staff patterns to ensure adequate staffing numbers present in the home at all times to meet client needs. · Program Coordinator will develop and turn in schedule to Program Director one week prior to the week in question to reflect adequate staffing. Program Director/QIDP will ensure there are adequate staffing numbers present in the home to meet client needs on	06/12/2015

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	her ace bandage wrap on her head. Clients B, D, E and F were still in their bedrooms. At 5:55 AM staff #1 arrived at the group home. Client A handed staff #1 the lunch containers from the refrigerator and staff #1 sat them on the table as staff #2 started waking clients to get them dressed for the day. Client C remained in the living room on the couch in a fetal position. Client G utilized her seat walker and maneuvered herself to the bathroom. Client G sat on the toilet with the door open naked from the waist down and no ace wrap/bandage on her head. At 6:10 AM, client G continued to sit on the toilet and dress with the door open as client F walked down the back hallway looking for staff. Client G was naked from the waist up with exposed breasts. Client F walked past the open bathroom door. At 6:18 AM, client E went into the living room and sat in a rocker chair and rocked while client G remained on the couch in a fetal position with her eyes closed. Client D walked around the group home with his roller walker as staff #1 was in the kitchen dining room area and staff #2 continued to assist clients to get dressed. At 6:30 AM, client D walked into the laundry room at the back of the house which was also the medication room. Client D opened a pudding container and started to eat the pudding with his hands and got		scehdule. Program Coordinator will cover any open shifts that arise and would cause inadequate staffing numbers. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · In the event that an individual's needs become greater than the current staffing supports in the home, the IDT will meet to reevaluate the staffing pattern in the home and to develop a plan to meet the client's increased needs. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · In the event that an individual's needs become greater than the current staffing supports in the home, the IDT will meet to reevaluate the staffing pattern in the home and to develop a plan to meet the client's increased needs. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. **1.How will the corrective action be monitored to ensure the deficient practice will not**	

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	pudding on the counter in the medication room. Staff #1 was in the kitchen area preparing breakfast and staff #2 was in client B's bedroom assisting the client to get ready for the day. Client D then went to the front of the house while staff #1 went into client B's bedroom to assist staff #2 with client B. Client A was in the kitchen area watching the food as client D walked toward the stove/counter area in the kitchen. At 6:38 AM, Client D grabbed a slice of toast and took a bite out of it. Client A started yelling. Staff #1 returned to the kitchen and grabbed the toast out of client D's hand (client D is on a pureed diet). Client D swallowed what was in his mouth. Client G came into the dining room area dressed and transferred herself to a dining room chair from her seated walker. Client G did not have the ace wrap on her head. Staff made pancakes while clients A, G and client F were in the kitchen area. Staff #1 then left the kitchen area again to go into client B's room to assist staff #2 with client B. Client C remained on the couch in a fetal position with her eyes closed. At 6:49 AM, client D walked over to the kitchen counter and got into his pureed plate of food while staff #1 was cutting up client G's pancakes and staff #2 was wheeling client B to the dining room table. Client D ate some of the pureed food with his hands, before client A		**recur?** · In the event that an individual's needs become greater than the current staffing supports in the home, the IDT will meet to reevaluate the staffing pattern in the home and to develop a plan to meet the client's increased needs. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015	

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	15G364		05/13/2015

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	informed staff #1 client D was eating his food on the stove. Staff #1 brought client D's food to the table and staff #2 started feeding client D his pureed meal while staff #1 went to the living room to get client C. Client F started placing a large amount of butter on his bread. Staff #1 encouraged client F not to use all of the butter that was left in the container. As staff #1 was assisting client C to eat her breakfast and staff #2 was feeding client D, client F took 3 large scoops of sugar/sweetener from a bag and placed them into his bowl of cereal before staff could redirect him. Client F asked for more toast, staff #1 stated "What do you have to do to get seconds? Client F then stood and went into the kitchen and cleaned off the counters and returned to the dining room. Client F returned to the table and poured himself a second bowl of cereal and took 2 more toasts. At 7:17 AM, as staff #1 was preparing for the morning medication and staff #2 was feeding client B, client F took a small juice cup and placed it in the bag of sweetener and filled it to the top of the glass. Client F then poured the cup of sweetener onto his cereal and took large bites of his cereal with no redirection. After client C had left the dining room, client C returned to the living room couch without an activity and/or training. At 8:08 AM, client F could be heard			

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	slamming doors and hitting walls. Staff #1 was passing medications to client B while staff #2 dealt with client F's behavior and monitored/supervised the other clients (A, C, D, E and G). At 8:25 AM clients A, B,C, D and F were sitting in the van waiting to leave for the workshop/day program while client G was in the house in the bathroom, staff #2 was in the kitchen area and staff #1 was putting a blanket around client B to take the client to the van. Once client B was loaded on the van, client B became upset and started cursing staff #1 and tried to bite himself. Staff #1 called for staff #2 as staff #1 was attempting to try and put client B's mitts on his hands. Staff #1 held one arm/hand (opened handed) while staff #2 held one arm/hand as both staff were trying to get his mitts on. Staff #1 was telling client B he would have to go to the day program. During the above observation period client B had two open areas on the back of his right hand. The smaller area was raised, open with a scab starting to form. The larger area was red and open with swollen tissue surrounding the area. The larger area was about the size of an eraser tip and the smaller area was slightly smaller than an eraser tip. Client G had a large open area at the top of her head. The open area was about the size of a quarter with an irregular shape. The open area was surrounded by a larger			

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	area about the size of a half dollar. The larger area had hair missing. The open area was dry looking and the edges around the open area was dark red in color. The facility's End of Shift (EOS) reports were reviewed on 4/23/15 at 10:45 AM. The EOS reports indicated the following (not all inclusive): -2/23/15 "[Client G] had been picking her scalp as there was blood all over her mattress...." -2/24/15 "[Client G] was picking at scalp today. I pulled her bed sheet so she will to make her bed when she gets home. Sheet had lots of blood on it...." -2/27/15 "[Client G] kept taking off bandage and picking...." -3/6/15 "[Client G] had head wound uncovered today and it looked like she had been picking at it. re (sic) did wound care...." -3/11/15 "[Client G] started picking at the smaller wound on her head again...." -3/13/15 "[Client G] took wound cover off during the night and I replaced it. When went to ice foot she had taken it			

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	off again. Replaced it and while getting dressed again took off cover." -3/15/15 "...Keeps taking head wrap off...." -3/16/15 "[Client G] keeps picking at head...." -3/18/15 "[Client G] took wrap off twice this am. She had been picking at it and it looks red and wet." -3/19/15 "[Client G] took off her headwrap least 5 times...." -3/24/15 "[Client G] took wound cover off several times last night...." -3/30/15 "[Client G] took off her head wrap a couple of times. Picked at her wound...." -4/2/15 "[Client G] keeps taking off wrap...." -4/9/15 "[Client G] had head wrap off this am. Didn't see her picking at head...." -4/11/15 "...Keeps taking head wrap off and trying to pick head wounds...." -4/13/15 "[Client G] has head wrap off			

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	and staff caught client picking at scalp while in bathroom getting dressed...." -4/22/15 "[Client G] keeps taking off head wrap...." Client G's record was reviewed on 4/22/15 at 5:05 PM and on 4/27/15 at 2:30 PM. Client G's Skin/Wound Assessments documented by Direct Support Professionals (DSPs) indicated the following (not all inclusive): -2/4/15 "client (sic) picked head during the night as there was blood on the bed." -2/6/15 "scalp (sic) looks very red and irritated (sic) client (sic) was observed picking while getting dressed...." -2/9/15 "area (sic) looks larger and was red today. client (sic) seen picking at scalp in am." -2/10/15 "scalp (sic) wound looks bad, infection present and has been picking at it as it looks bigger today (sic)" -2/20/15 "client (sic) was picking at larger wound this am. Looks red and has a little infection in it." -2/24/15 "Scalp looks worse than yesterday. client was picking at head in			

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	the am...." -2/27/15 "was caught a couple times taking off her wrap and picking at her head...." -3/4/15 "I (staff #6) think she may be picking at the wound that isn't covered. Looked larger and red." -3/6/15 "Client had pulled of (sic) wound cover and has been picking at area on scalp (sic) Staff replied (sic) dressing to wound. Looks like it is trying to heal." -3/11/15 "Wound on head continues to heal and looks better. Has started to pick at her smaller wound again." -3/13/15 "Large wound is looking much better. Client won't leave the wrap on and is picking at the smaller wound. It was larger this am and looked runny." -3/13/15 "Large area looks much improved. Client left dressing on through the night. Client has been picking the smaller on it and it has doubled in size (sic). Put medication on as directed." -3/16/15 "Client had bandage off this am and area looked red...."			

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	-3/17/15 "Client has been picking at her head today. area (sic) was open and had been bleeding. Staff covered the area again and also put bandage on front area wound." -3/18/15 at 9:55 AM, "Client continued to take off wound wrap and had been picking at the larger area...." -3/23/15 "Wound on head have been picked at during the night as client won't keep wrap on them...." -3/26/15 "smaller (sic) wound look better and is drying up. The wound is red and looks infected. wound (sic) has several areas that are deep." -3/30/15 "Larger wound on head had been picked at. Smaller wound remains the same...." -4/8/15 "Larger wound on head has been picked at. Smaller one continues to heal." -4/14/15 "...Won't leave spots on head alone. Keeps trying to scratch them." -4/14/15 (PM note) "client (sic) took wrap off during the night. Scalp looks like it has a little blood on it...."			

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	Client G's 2/16/15 Internal Med Progress Note indicated client G's diagnoses included, but were not limited to, Mild Intellectual Disability, Cerebral Palsy, Scoliosis, and Epilepsy. Client G's 4/20/15 Individual Support Plan (ISP) indicated "...Within the past year, [client G's] abilities to independent have declined due to her CP (Cerebral Palsy) diagnosis. Through evaluations at [name of company], they believe that she will be utilizing her wheelchair on a full time basis soon due to the rapid decline of her abilities. [Client G] now requires staff assistance in getting in and out of the bathtub. She requires the use of her walker or staff assisting her when walking to ensure that she doesn't fall due to her unsteady gait...[Client G] is deaf...." Client G's ISP indicated the client had the following objectives (not all inclusive): independently assist with meal preparation, to pack a mechanical soft lunch for the day, point to a coin that facility staff asked her too, and an objective to "independently choose a leisure activity to engage in for at least 10 minutes with another housemate." Client G's 4/14/15 Individual Plan of Protective Oversight-Residential Information indicated client G required 15 minute checks for seizures and			

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	"...behavior concerns of hitting others when she cannot communicate what she wants...." Client G's 6/5/14 Behavior Plan (BP) indicated client G demonstrated SIB defined as "(slapping himself (sic) in his (sic) face leaving welts, red marks, bruising)." Client G's BP indicated when client G demonstrated SIB, staff was to "Ask [client G] to stop skin picking. 2. Counsel that she could cause herself harm. 3. Redirect [client G] to another activity." The BP indicated client G was to be redirected to "...an alternate activity using her hands (chore, writing, looking at a book or magazine, get a snack or a drink)...." Client B's record was reviewed on 4/23/15 at 10:35 AM and on 4/27/15 at 2:41 PM. Client B's 2/13/15 Quarterly Physical/Internal Med (Medicine) Progress Note indicated client B's diagnoses included, but were not limited to, Severe Intellectual Disability, Quadriplegia, Cerebral Palsy, Scoliosis, Epilepsy and "Biting self." Client B's 5/20/14 BSP indicated client B demonstrated "Self-injurious behavior: biting himself, typically on the arms/hands without breaking the skin.			

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	1. Staff should verbally prompt [client B] to stop biting himself. 2. Staff should immediately redirect [client B] to his replacement behaviors. 3. If [client B] continues to self-harm, staff should explain to [client B] that they are putting his protective hand mitts on. Staff should put the mitts on so that his hands and fingers are covered. Staff should say, '[Client B] I did not want you to hurt yourself. You need to stop biting yourself. Adults do not behave this way'...5. Staff should document all incidents of self-injurious behaviors and provide any necessary medical care...." Client B's May 2014 BP indicated facility staff were to utilize a "visual daily schedule" with the client as his replacement behavior. Client B's BSP indicated the client should be given choices on what is expected of him to complete/do. Client B's 4/20/15 ISP indicated "... [Client B] has a history of engaging in self-injurious behavior (biting his hand) when he gets agitated...." Client B's ISP indicated "...[Client B] requires total staff support for all of his daily living needs. He requires physical assistance and support for self-care needs including toileting, dressing, eating, bathing, oral care and hair care...." Client B's 4/20/15 ISP indicated client B had objectives to			

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	feed himself with verbal and physical prompts, identify and state the value of a quarter, tell staff a way he can cope with his frustrations instead of biting himself, independently state why he takes Lamotrigine ER (seizures), and an objective to independently prepare lunch using appropriate choices. Client A's record was reviewed on 4/28/15 at 3:00 PM. Client A's 12/18/14 Individual Support Plan (ISP) indicated client A had an objective to prepare a side dish and an objective to increase her leisure skills. Client C's record was reviewed on 4/28/15 at 11:10 AM. Client C's 2/19/15 Internal Med Progress Note indicated client C's diagnoses included, but were not limited to, Profound Intellectual Disabilities, Osteoporosis, Epilepsy and Recurrent Seizures. Client C's 4/1/15 Dining Plan indicated "Staff needs to sit next to [client C] while she is eating a meal. Staff assists her with scooping food onto her utensils with hand over hand assistance. Once the food is on her utensil, she is able to take the food to her mouth." The dining plan indicated client C was at risk for choking and aspiration.			

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	Client C's 4/1/15 Risk Plan for Falls indicated "Staff are to assist clients as needed with ambulation (walking)... [Client C] ambulates independently...She is very unsteady on uneven surfaces or steps...." Client C's 4/1/15 ISP indicated client C had objectives to sit in the same seat for 5 minutes "appropriately," feed herself hand over hand, identify a coin from a group of objects, gather her cup for her water and prepare her water for the med pass, and and objective to learn the sign for restroom. Client D's record was reviewed on 4/28/15 at 3:56 PM. Client D's 2/19/15 Quarterly Physical indicated client D's diagnoses included, but were not limited to, Profound Intellectual Disability, Epilepsy, Osteoporosis, and Scoliosis. Client D's 4/1/15 Risk Plans indicated client D had a risk plan for Falls. The risk plan indicated client D utilized a walker due to the client's "unsteady gait." The risk plan indicated "...3. Will walk holding on to walls or other objects. 4. Must be reminded to use his walker at all times...." Client D's 3/29/15 Dining Plan indicated "[Client D] requires hand over hand			

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	assistance from staff while eating. He is able to feed himself with his utensils (once staff have helped him scoop up the food) when he is willing to cooperate. Staff needs to sit by his side when they are assisting him with his meals." The risk plan indicated client D was at risk for choking and aspirating. Client D's 3/12/15 BP indicated client D had the targeted behaviors of attempting to drink "all liquids regardless of whether they are hazardous for him to drink," and to demonstrate SIB defined as "... (continued chewing on wrist,arm,hand,or (sic) fingers)." Client D's 3/29/15 ISP indicated client D had objectives to independently feed self (hand over hand may be needed), participate in group activities for 5 minutes, gather his pill crusher, identify a coin from a group of objects, and an objective to point to a hazmat when sitting next to other items. The facility's Medication Administration Skills Checklist was reviewed on 4/28/15 at 10:50 AM. The facility's 4/25/15 checklist indicated nurse staff #1 was observing staff #9 pass medications. A handwritten note at the bottom of the checklist indicated "*Med pass was very distracting (with) multiple interruptions.			

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	Only had 2 staff working." Interview with staff #1 on 4/21/15 at 5:55 AM stated "Typically another staff here (making 3 staff) but they are on vacation." Interview with client A on 4/21/15 at 11:00 AM indicated 2 to 3 staff worked at the group home in the evening. Client A stated "[Staff #2] worked today by her self. [Staff #1] came in the morning." Interview with staff #1 on 4/22/15 at 8:55 AM indicated client B required the use of a Hoyer Lift when transferring the client from his bed to the wheelchair. When asked how many staff did client B require when using the Hoyer Lift, staff #1 stated "Was 2 not 1. If need help ask staff." Confidential interview A indicated there used to be 2 staff who worked the morning and evening shifts. Confidential interview A indicated there should be 3 staff working. Confidential interview A stated it was "recently started." Confidential interview A stated "Three staff here until 8 PM to get showers." Confidential interview A stated "Done up about 1 to 2 weeks ago." Confidential interview B stated "There used to be 2 staff at night, now 1."			

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	Confidential interview B indicated client G was on 15 minute checks. Confidential interview D stated "2 or 3 staff worked until recently, now 3 mostly." Confidential interview E stated the group home was "very understaffed. Hard to get people to come in." Confidential interview E stated "Schedule 3 sometimes 2. Usually 2 technically on weekends. Hard to go anywhere." Confidential interview E stated clients B, C, D and G required "a lot staff attention." Interview with the Program Director (PD) and the Area Director (AD) on 4/21/15 at 3:00 PM indicated 1 staff worked at night and 3 staff were to work during the morning and evening shifts. 9-3-3(a)			
W 0195 Bldg. 00	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Active	W 0195	**W195 Active Treatment Services – CONDITION** The facility must ensure that specific active treatment services	06/12/2015

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	Treatment Services for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients (E, F and G). The facility failed to ensure each client received a continuous, aggressive active treatment program. The facility failed to ensure facility staff implemented clients' program plans across all environments/times of the day. The facility failed to ensure staff collected data per the clients' program plans, and failed to ensure clients participated in aspects of meal preparation and/or were allowed to assist in feeding themselves. The facility failed to address clients' basic training needs, to address clients' identified needs, to ensure needed supports were included in the clients' program plans, and to needed assessments were completed. The facility failed to ensure its Human Rights Committee reviewed and/or approved all restrictive programs and to ensure clients' guardians gave written informed consent for each restrictive program. Findings include: 1. The facility failed to ensure each client received a continuous, aggressive and consistent active treatment program for clients C and D. Please see W196. 2. The facility failed to ensure clients		requirements are met. 1. **What corrective action will be accomplished?** **·Programming will be implemented for Clients A, B, C, D, E, F and G to participate in dining skills and/or meal preparation** **·Staff will be retrained on the importance of ensuring family style dining, active treatment during meal preparation and proper supervision of the client's needs during the meal.** **·Staff will be retrained on client's meal time objectives and dining plans.** **·Staff will be trained on how to access client programming information and documentation needs in Therap (ISP, risk plans, goals, BSP, etc).** **· Staff will be retrained on the importance of ensuring active treatment at all times .** · Training will be completed with the Program Coordinator and Program Director/QIDP regarding training of staff. · Prior to working with the clients in the home, staff will complete client specific training. · Clients C and D will be placed on programming to develop leisure skills. · Staff will be retrained on client's communication objectives. · Programming will be implemented for Client C regarding hand washing. · Programming will be	

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	sensorimotor/ambulation skills were assessed for clients C and D. Please see W218. 3. The facility failed to ensure client C's communication skills were assessed and/or re-assessed to increase the client's communication with others. Please see W220. 4. The facility failed to address client G's identified training needs in regard to mealtime and privacy. Please see W227. 5. The facility failed to ensure clients' Individual Support Plans included the needed supports to indicate how facility staff were to monitor/supervise client G to prevent self injury, to indicate how facility staff were to assist client C in regard to her gait belt, and/or indicate how facility staff were to restrain client B to prevent injuries. Please see W240. 6. The facility failed to address client C and D's basic training needs in regard to communication, toileting, bathing, dressing and/or oral hygiene. Please see W242. 7. The facility failed to ensure clients B, C and D's Individual Program Plan objectives and/or behavior plans were implemented when formal and/or		implemented for Client C regarding dining skills including use of a utensil and wiping mouth. · Programming will be implemented for Client C addressing personal hygiene, including toileting, dressing and oral hygiene. · Programming will be implemented for Client D addressing communication skill deficits as recommended by 5/30/14 Speech-Language evaluation. · Programming will be implemented for Client D addressing bathing and dressing. · Quality Assurance (QIDP) will complete competency based training with Program Director/QIDP regarding ensuring each client receives continuous, aggressive and consistent active treatment programs. · Quality Assurance will complete competency based training with staff on the importance of ensuring active treatment at all times. · Training will be completed with the Program Coordinator and Program Director/QIDP regarding training of staff. · At a minimum twice weekly for one month, Program Director/QIDP will document via electronic documentation system (Therap) t-log/note on site observations at the facility to ensure integration and coordination of active treatment programming. After twice weekly for one month observations, Program Director/QIDP will document via Therap t-log at a minimum once	

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	informal training opportunities existed. Please see W249. 8. The facility failed to ensure the facility's Human Rights Committee reviewed all restrictive plans for clients C and D. Please see W262. 9. The facility failed to ensure clients C and D's guardian gave written informed consent in regard to the client's restrictive programs. W263. 10. The facility failed to allow and/or encourage clients to participate in all aspects of meal preparation, and to allow/encourage clients to feed themselves when skills demonstrated for clients A, B, C, D, E, F and G. Please see W488. 9-3-4(a)		weekly for one month, observations to ensure integration and coordination of active treatment programming. After once weekly for one month observations, Program Director/QIDP will complete at a minimum once monthly observations at the facility to ensure integration and coordination of active treatment programming. · The Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all clients in the home via monthly completion of data collection reports, which includes electronic documentation system data review. Area Director will comment on electronic documentation system data review report as reviewed. · Area Director will review Program Director/QIDP's Therap t-log regarding site observation of integration and coordination of active treatment programming twice weekly for one month, once weekly for one month and monthly thereafter and will address any concerns with the Program Director/QIDP within 48 hours of review. · Area Director will make unannounced visit to facility weekly for one month and monthly thereafter, to ensure the Program Director/QIDP has effectively integrated and coordinated the active treatment programs. · The Program Director/QIDP will ensure at all times that programming is in place for all clients addressing their identified	

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			needs via monthly evaluation of program data collection, including revisions to programs as needed. · Obtain physician order for Occupational Therapy/Physical Therapy evaluation to assess/reassess sensorimotor needs for Client C with regards to using the gait belt. · Client C's risk plan and IPOP will be updated to include when and/or how facility staff are to use a gait belt, should OT/PT evaluation recommend continued use of gait belt. · Staff will be retrained regarding the appropriate use of Client C's gait belt as well as Client C's revised risk plan and IPOP, should OT/PT evaluation recommend continued use of gait belt. · Obtain physician order for Client C Speech assessment · Once speech assessment completed, Program Director/QIDP will implement formal programming to address speech assessment recommendations for communication skill development. · Client G's ISP will be updated to include formal training to address dining needs and privacy. · Programming will be implemented to address Client G's dining needs/slow pace when eating and encouraging fluid between bites and privacy. · Staff will be trained on Client G's ISP revision. · Behavior Analyst has revised Client B's Behavior Support plan to	

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			include how the staff were to restrain/hold Client B's arms/hands to assist with the applying protective mitts. · Behavior Analyst has re-trained staff regarding Client B's BSP revision, including how to restrain/hold Client B's arms/hands to assist with applying the protective mitts. · Behavior Analyst will continue to monitor monthly trends in behavior documentation for Client B regarding SIB and suggest to IDT revisions as needed. · At a minimum twice weekly for one month, Program Director/QIDP will document via electronic documentation system (Therap) t-log/note on site observations at the facility to ensure training with Behavior Analyst regarding BSP revisions is implemented (as needed) correctly. After twice weekly for one month observations, Program Director/QIDP will document via Therap t-log at a minimum once weekly for one month. After once weekly for one month observations, Program Director/QIDP will complete at a minimum once monthly observations at the facility. · Behavior Analyst will continue at least monthly observations to assist in identifying intervention techniques being implemented incorrectly or improperly. Behavior Analyst will communicate concerns to the IDT via email within 24 hours of	

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			observation. · Staff will be retrained on completing/documenting 15 minute checks for Client G. · IDT will convene to revise Client G's BSP to include how staff are to monitor/supervise to prevent Client G's SIB. · Behavior Analyst will retrain staff on Client G's BSP including documentation of behavior events regarding Client G. · IDT will convene to discuss and implement plan involving Client G's skin picking/wound on top of head as well as outline/define high-risk monitoring as referenced in physical form from facility nurse on 2/18/15. · Nursing staff will include in risk plan for Client G description of high-risk monitoring as referenced in physical form from facility nurse on 2/18/15. · Program Director/QIDP will implement programming for Client G to promote activity engagement to discourage/help prevent SIB. · Obtain legal guardian consent for restrictive measures regarding hazardous materials for Client C and D as well as for bite protective sleeves for Client D. · Program Director/QIDP will be retrained regarding obtaining informed consent from guardians regarding restrictive measures. 2. **How will we identify other residents having the potential to be affected by the same**	

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			deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the same deficient practice. · The Program Director/QIDP will monitor the residents programming and behavior needs at a minimum, monthly basis. As needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plans, dining plans, etc. · Monthly, Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all 8 clients in the home. · Prior to working with the clients in the home, staff will complete client specific training. · Performance Audits, involving review of program data collection will be completed annually by Quality Assurance. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The Program Director/QIDP will monitor the residents programming and behavior needs at a minimum, monthly basis. As needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plans, dining plans, etc. · Monthly, Area Director will ensure the Program Director/QIDP is monitoring treatment programs	

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			for all 8 clients in the home. · Prior to working with the clients in the home, staff will complete client specific training. · Performance Audits, involving review of program data collection will be completed annually by Quality Assurance. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Director/QIDP will monitor the residents programming and behavior needs at a minimum, monthly basis. As needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plans, dining plans, etc. · Monthly, Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all 8 clients in the home. · Prior to working with the clients in the home, staff will complete client specific training. · Performance Audits, involving review of program data collection will be completed annually by Quality Assurance. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015	
W 0196 Bldg. 00	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a			

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	program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. Based on observation, interview and record review for 2 of 4 sampled clients (C and D), the facility to ensure each client received a continuous, aggressive and consistent active treatment program which addressed the training needs of each client. Findings include: 1. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, at the group home, client C did not receive a continuous, aggressive and consistent active treatment program. During the 4/20/15 observation period, client C independently walked from the dining room to the living room wearing a gait belt, sat in the dining room looking out the window while staff #10 custodially prepared dinner which consisted of broccoli, potatoes, porkchops in gravy and pineapple. Staff #10 also did not encourage client C to help prepare food (tuna fish, tomatoes and peaches) for the	W 0196	**W196 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: (i) The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. **1. What corrective action will be accomplished?** · **Programming will be implemented for Clients A, B, C, D, E, F and G to participate in dining skills and/or meal preparation** · Staff will be retrained on the importance of ensuring family style dining, active treatment during meal preparation and proper supervision of the client's needs during the meal. · Staff will be retrained on client's meal time objectives and	06/12/2015

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	lunches for the next day. At 5:40 PM, client C went back to the living room and sat on the couch without staff interaction, training and/or an activity to participate in. At 6:00 PM, staff #10 prompted staff to have the clients wash their hands for dinner. Client C was in the living room and was not encouraged to wash her hands. At 6:12 PM, client C went back to the dining room table to eat her dinner. Staff #4 sat next to client C at the dining room table. Staff #4 fixed client C's plate without involving the client. As staff #4 sat next to client C, client C ate with her hands before she was redirected to use her spoon with hand over hand assistance. Client C also placed large bites of food in her mouth without staff redirection. Staff #4 wiped client C's mouth without involving and/or encouraging client C to wipe her own mouth. At 6:18 PM, staff #4 started feeding client C versus allowing the client to finish eating with hand over hand assistance. While eating, client C stood up and sat down on 2 different occasions. Once client C was finished eating her dinner, client C independently stood and walked back to the living room area with her hands up at her neck. Client C sat in the living room looking around, sat on the couch with her eyes closed and/or sat with her knees and feet touching the back of the couch in a fetal		dining plans. · Staff will be trained on how to access client programming information and documentation needs in Therap (ISP, risk plans, goals, BSP, etc). · Staff will be retrained on the importance of ensuring active treatment at all times. · Training will be completed with the Program Coordinator and Program Director/QIDP regarding training of staff. · Prior to working with the clients in the home, staff will complete client specific training. · Clients C and D will be placed on programming to develop leisure skills. · Staff will be retrained on client's communication objectives. · Programming will be implemented for Client C regarding hand washing. · Programming will be implemented for Client C regarding dining skills including use of a utensil and wiping mouth. · Programming will be implemented for Client D addressing communication skills. · Programming will be implemented for Client C addressing personal hygiene, including toileting, dressing and oral hygiene. · Programming will be implemented for Client D addressing communication skill deficits as recommended by 5/30/14 Speech-Language evaluation. · Programming will be	

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	position until 7:32 PM when client C was prompted to get her bed time medications. Staff #10, who passed the medications, did not provide any medication training with the client. During the 4/20/15 observation period, staff #1, #4, #9 and #10 did not provide any training and/or activities with client C. During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the group home, Client C was up and dressed upon arrival to the group home. Client C was sitting in the living room in a fetal position with her eyes closed. At 7:00 AM, staff #1 custodially placed toast and pancakes on client C's high sided plate while client C remained in the living room in a fetal position and eyes closed. About 3 to 4 minutes later, staff #1 assisted client C to walk to the dining room holding client C's elbow and arm. Staff #1 did not use client C's gait belt. Client C's food was not cut into small pieces. Client C took 3 bites of her food and sat with her head bent down and hands up at the back of her neck. Client C refused to eat any more of her food. At 7:13 AM, client C stood and independently walked back to the living room and sat on the couch without redirection to participate in a more meaningful activity and/or training.		implemented for Client D addressing bathing and dressing. · Quality Assurance (QIDP) will complete competency based training with Program Director/QIDP regarding ensuring each client receives continuous, aggressive and consistent active treatment programs. · Quality Assurance will complete competency based training with staff on the importance of ensuring active treatment at all times. · At a minimum twice weekly for one month, Program Director/QIDP will document via electronic documentation system (Therap) t-log/note on site observations at the facility to ensure integration and coordination of active treatment programming. After twice weekly for one month observations, Program Director/QIDP will document via Therap t-log at a minimum once weekly for one month, observations to ensure integration and coordination of active treatment programming. After once weekly for one month observations, Program Director/QIDP will complete at a minimum once monthly observations at the facility to ensure integration and coordination of active treatment programming. · The Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all clients in the home via monthly completion of data collection reports, which includes electronic documentation system data review.	

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	Client C remained sitting in the living room area until the client received her morning medications and was assisted to load the van at 8:25 AM to go to the day program. During the 4/22/15 observation period between 6:25 AM and 7:38 AM, at the group home, client C did not receive a continuous aggressive active treatment program. Upon arrival to the group home, client C was sitting at the dining room table with a staff next to her, eating eggs. Client C was feeding herself with redirection to use her spoon. At 6:50 AM, client C stood up and independently walked to the living room wearing a gait belt. At 7:08 AM, client E returned to his bedroom to find client C attempting to get in his bed to lay down. Client E yelled for staff. Client C's bedroom was located on the other side of the group home. Staff #1 redirected client C out of client E's room and told the client her room was on the other hallway. Client C independently walked back to the living room and sat down on the couch without redirection to participate in a more meaningful activity and/or training. During the above mentioned 4/20, 4/21 and 4/22/15 observation periods, client C was non-verbal in communication in that the client could not speak. The facility staff did not provide any communication		Area Director will comment on electronic documentation system data review report as reviewed. · Area Director will review Program Director/QIDP's Therap t-log regarding site observation of integration and coordination of active treatment programming twice weekly for one month, once weekly for one month and monthly thereafter and will address any concerns with the Program Director/QIDP within 48 hours of review. · Area Director will make unannounced visit to facility weekly for one month and monthly thereafter, to ensure the Program Director/QIDP has effectively integrated and coordinated the active treatment programs. · The Program Director/QIDP will ensure at all times that programming is in place for all clients addressing their identified needs via monthly evaluation of program data collection, including revisions to programs as needed. 2. **How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The Program Director/QIDP will monitor the residents programming and behavior needs at a minimum, monthly basis. As needs change or new concerns are identified,	

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	training with client C. Client C's record was reviewed on 4/28/15 at 11:10 AM. Client C's 4/1/15 Individual Support Plan (ISP) indicated client C had the following formal training objectives: -To sit patiently in the same seat for minutes "appropriately." -To gather wash cloth to wash herself at bath time. -To regulate water temperatures with staff assistance. -To identify a group of coins from a group of objects. -To gather her cup for her water and prepare the water for her med pass. -"Point to the hazmat (hazardous material) when it's sitting next to other items." -To learn the sign for restroom so she can notify her staff when she needs to use the restroom or needs to be changed. Client C's objective to feed herself did not include any methodologies as the goal was listed on the same sheet with the client's bathing objective in the ISP. Client C's 3/4/15 Active Treatment Daily Schedule indicated the following (not all inclusive): -Monday PM		changes will be reflected in their programming, assessments, ISP, behavior plans, dining plans, etc. · Monthly, Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all 8 clients in the home. · Prior to working with the clients in the home, staff will complete client specific training. · Performance Audits, involving review of program data collection will be completed annually by Quality Assurance. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The Program Director/QIDP will monitor the residents programming and behavior needs at a minimum, monthly basis. As needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plans, dining plans, etc. · Monthly, Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all 8 clients in the home. · Prior to working with the clients in the home, staff will complete client specific training. · Performance Audits, involving review of program data collection will be completed annually by Quality Assurance. **1.How will the corrective action be monitored to ensure**	

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	4 PM-5 PM Medication 5 PM- 6 PM Chore and supper 6 PM -7 PM Leisure activities of choice such as doing puzzles, coloring, or doing "math sheets." 7 PM - 8 PM Bath/shower 8 PM - 9 PM Get medicine and get ready for bed. -Tuesday AM and Wednesday AM 6 AM - 7 AM "Wake up morning hygiene, get dressed, meds, straighten room, start breakfast." 7 AM -8 AM "Breakfast, Transport to Workshop." Client C's 4/1/15 Individual Plan of Protective Oversight-General Information indicated "[Client C] says a few words, but doesn't really communicate other than minimal gestures. She will guide you to what she wants, usually food or to go outside in the back." The assessment indicated client C could not communicate anything medically. The assessment indicated client C would not be able to communicate her wants and needs. Client C's 4/1/15 Individual Plan of Protective Oversight-Residential Information indicated "Needs total care with hygiene. She wears depends and doesn't use the toilet but will sit on it. She needs total assistance...." The		**the deficient practice will not recur?** · The Program Director/QIDP will monitor the residents programming and behavior needs at a minimum, monthly basis. As needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plans, dining plans, etc. · Monthly, Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all 8 clients in the home. · Prior to working with the clients in the home, staff will complete client specific training. · Performance Audits, involving review of program data collection will be completed annually by Quality Assurance. **1.What is the date by which the systemic changes will be completed?** a. June 12, 2015	

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	assessment indicated client C did not understand dangers, was not able to dress herself and required total assistance with household tasks. The assessment indicated client C required staff to brush her gums as the client was edentulous. Client C's June 2011 Speech Assessment did not have any recommendations to assist the client's IDT (interdisciplinary team) to develop an appropriate communication goal to communicate her wants and needs, and/or to communicate with others. Client C's record and/or 4/1/15 ISP indicated the facility failed to re-assess/assess client C's communication skills as needed. Client C's ISP also indicated client C needed basic skills training in regard to toileting, dressing, and oral hygiene that the client's interdisciplinary team had not addressed. Client C's 2/19/15 Quarterly Physical /Internal Medicine Progress Note indicated client C's diagnosis included, but was not limited to, Falls. Client C's quarterly physical indicated "Plan: -use gait belt as directed...." Client C's 4/1/15 Risk Plan indicated client C had a risk plan for falls. Client C's 4/1/15 risk plan indicated "...Staff are to assist clients as needed with ambulation and walking...She typically			

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	has a slow wide-based gait. She is very unsteady on uneven surfaces or steps...." Client C's 4/1/15 fall risk plan did not indicate when and/or how facility staff were to use a gait belt to assist client C. Client C's 2/16/15 Consultation Form indicated client C saw a speech therapist in regard to a swallow study. The 2/16/15 note indicated "Pt (patient) was able to tolerate small amounts of regular consistency foods if given small pieces. Staff is concerned (with) (decreased) intake and weight loss. Rec (recommend): Upgrade to regular consistency (with) staff controlled bites and sips of thin liquids. 1:1 (One staff to one client) supervision at all times for meals. Staff to cut food at table." Client C's 3/12/15 Behavior Support Plan (BSP) indicated facility staff needed to "Encourage the development of, and engagement in, a hobby, sport, exercise, volunteer work, appropriate leisure activity, and interactions with peers...." Interview with staff #9 on 4/20/15 at 7:55 PM stated client C wore a gait belt because she was "Running into walls. Depth Perception issues." Interview with staff #2 on 4/21/15 at 9:49 AM indicated when asked why client C			

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	wore a gait belt, staff #2 stated "We use a gait belt to get her up as she won't move. She's stubborn." Staff #2 indicated she was not aware of any falls. Interview with staff #1 on 4/22/15 at 8:55 AM stated client C wore a gait belt due to "depth perception." Staff #1 stated "She steps big and causes her to trip." Staff #1 indicated facility staff were to use the gait belt with client C when they were getting on and off the van. Staff #1 stated they would also use the gait belt "to help her stand up because it can be a struggle to get her up." Staff #1 indicated client C was not able to make her wants and needs known. Staff #1 indicated client C had an objective to sign toilet in the past. Staff #1 stated "She is not able to sign toilet." Staff #1 indicated client C did not have a formal communication training objective. Staff #1 indicated client C did not like to participate in any type of activity and/or training. Interview with Program Director (PD) #2 on 4/28/15 at 5:10 PM indicated the use of the gait belt should be in the client's Individual Support Plan/risk plan. PD #2 indicated client C was not not able to independently toilet and/or dress herself. PD #2 indicated client C's communication objective to sign toilet would probably need to be revised.			

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	When asked if client C could initiate her own leisure activities, PD #2 stated "Some." When asked when client C's objectives should be implemented, PD #2 stated "Formal and informal training should be occurring." PD #2 indicated facility staff should be implementing/following client C's active treatment schedule. 2. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, at the group home, client D did not receive an aggressive active, continuous and consistent active treatment program. During the 4/20/15 observation period, client D walked around the group home with a roller walker. Client D made loud vocalizations and/or used curse words when he became upset. Client D would periodically bite his wrist which had a bite sleeve on it when redirected out of the kitchen. Staff #1, #4, #9 and #10 did not redirect client D to an alternate activity and/or training. At 5:10 PM, client D walked into the kitchen and stood at the counter as staff #10 was cooking, staff #10 stated "No." Client D started biting his arm repeatedly and left the kitchen as staff #10 custodially prepared the dinner meal and the clients' lunches for the next day. At 5:40 PM, client D was in his bedroom sitting on the side of the bed in the dark without			

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	redirection and/or prompts to turn the light on. At 5:46 PM, client D left his bedroom and started walking down the hallway back and forth and then walked back to the kitchen area before getting redirected by client E as staff #10 was pureeing client D's food (porkchops, potatoes and broccoli). At 6:05 PM, staff #10 stated to staff he was going to walk with client D around the house to help the client "stay occupied" while the clients were washing their hands and waiting to eat. At 6:12 PM, client D came back to the dining room and reached for a cup of water on the table and accidentally knocked it over. Staff #10 sat next to client D and placed small portions of pureed food onto client D's plate. Once client D ate the amount placed on his plate, staff #10 would scoop more food onto his plate. Client D was able to pick up the spoon and feed himself. At 6:33 PM, staff #10 told client D he was done. Client D stood, got his walker and went back to his bedroom. Client D remained in his bedroom until it was time to get his bed time medication and then client D returned to his bedroom. Staff did not provide any meaningful activity and/or training with the client. During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the			

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	group home, client D was assisted to shower/bathe by staff #1. At 6:10 AM, client D came out of his room dressed and started walking around the house with his roller walker. At 6:19 AM, staff #1 prompted client D to sit down. Client D continued to walk around the group home with his roller walker as staff #1 was in the kitchen/dining room area and staff #2 continued to assist clients to get dressed. At 6:30 AM, client D walked into the laundry room at the back of the house which was also the medication room. Client D opened a pudding container and started to eat the pudding with his hands and got pudding on the counter in the medication room. Staff #1 was in the kitchen area preparing breakfast and staff #2 was in client B's bedroom assisting the client to get ready for the day. Client D then went to the front of the house while staff #1 went into client B's bedroom to assist staff #2 with client B. Client A was in the kitchen area watching the food as client D walked toward the stove/counter area in the kitchen. At 6:38 AM, Client D grabbed a slice of toast and took a bite out of it. Client A started yelling. Staff #1 returned to the kitchen and grabbed the toast out of client D's hand (client D is on a pureed diet). Client D swallowed what was in his mouth. At 6:49 AM, client D walked over to the kitchen			

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	counter and got into his pureed plate of food while staff #1 was cutting up client G's pancakes and staff #2 was wheeling client B to the dining room table. Client D ate some of the pureed food with his hands, before client A informed staff #1 client D was eating his food on the stove. Staff #1 brought client D's food to the table and staff #2 started feeding client D his pureed meal without encouraging the client to feed himself and/or use hand over hand assistance. Staff #2 poured the juice for client D, but client D was able to hold and drink his juice without staff assistance. At 7:16 AM, client D had finished eating and returned to the table. Client E started biting his arm and saying curse words. Client A reminded staff that client D did not get his morning coffee. Client D drank his coffee and returned to the back of the house to get his medicine. Client D was prompted to stand up to wash his hands. Client D refused and started biting his arm and hit staff #1 on the leg. Once client D took his medications, he returned to his bedroom until it was time to go to the day program. Client D did not receive any medication training at his 8 AM medication pass. During the 4/22/15 observation period between 6:25 AM and 7:38 AM, at the group home, client D not receive a			

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	continuous and aggressive active treatment program. Client D walked around the house with his roller walker, sat at the dining room table watching staff #1 prepare breakfast and/or sat in his bedroom without any interaction from staff and/or redirection to participate in a more meaningful activity. At 6:50 AM, client D became upset and started making loud vocalizations and biting his arm as client D attempted to get client G's coffee. Client A got client D a cup of coffee and the client calmed down. While client D was at the table, client D grabbed a piece of whole toast off the serving dish and took a bite before staff took the toast from him. Client D stood up biting his arm and went to his bedroom. During the above mentioned 4/20, 4/21, 4/22/15 observation periods, client D was basically non-verbal in communication in that the client did not speak except to curse. Facility staff did not provide any communication training with client D. Client D's record was reviewed on 4/28/15 at 3:56 PM. Client D's 3/29/15 ISP indicated client D had the following objectives: -To sit on the toilet. -To independently feed himself at meal times (HOH may be needed).			

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	-To regulate water temperature with staff assistance. -To choose an appropriate snack that follows his dining plan. -To participate in a group activity for 5 minutes. -To gather his pill crusher. -To identify a coin from a group of objects. -To point to the hazmat when it is sitting next to another item. Client D's 3/12/15 Behavior Plan (BP) indicated client D had a targeted behavior of "attempting to drink hazardous liquids, picking up all drinks and not paying attention as to whether they are hazardous to his health" and self-injurious behavior (SIB). Client D's BP defined the client's SIB as "continued chewing on wrist, arm, hand or finger." Client D's BP indicated when client D demonstrated SIB, staff was to "1. Approach calmly and ask [client D] to stop. 2. Pair request to stop behavior with a physical touch on arm. Don't pull arm away. 3. Repeat until task is complete...." Client D's BP indicated "[Client D] wears a bite protective sleeve to safeguard himself from injury due to biting his arm...." Client D's BP indicated client D should participate in a game, leisure activity, "community awareness, relaxation and effective ways			

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	of coping with anger...." Client D's 3/29/15 Active Treatment Daily Schedule indicated the following (not all inclusive): -Monday PM 4 PM-5 PM Medication 5 PM- 6 PM Chore and supper 6 PM -7 PM Bath/shower 7 PM - 8 PM Leisure activities of choice such as "...people watching, and dog watching." 8 PM - 9 PM Get medicine and get ready for bed. -Tuesday AM and Wednesday AM 6 AM - 7 AM "Wake up morning hygiene, get dressed, meds, straighten room, start breakfast." 7 AM -8 AM "Breakfast, Transport to Workshop." Client D's 3/29/15 Individual Plan of Protective Oversight-General Information indicated client D communicated his wants and needs by "gestures." The assessment indicated "[Client D] is typically non verbal. He will curse. He makes his needs/wants known by looking at what he wants, taking staff to what he wants, or just getting what he wants himself." The assessment indicated client D could			

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	not explain his health care needs, medication, "environmental allergies," the need for first aid and would yell or bite his arm if he was in pain. The assessment indicated client D required physical assistance to complete all oral hygiene tasks as the client had a "profound level of cognitive function." The assessment also indicated client D could not indicate his personal rights and/or give consent for medical care. The 3/29/15 assessment indicated client D would not be able to make his wants and needs known. Client D's 3/29/15 Individual Plan of Protective Oversight-Residential Information indicated client D was not able to "initiate hygiene tasks," was not able to dress himself, not able to complete any household task, and "required total physical assist with toileting needs." Client D's 5/30/14 Speech-Language Evaluation indicated client D was "...non-verbal and essentially non-vocal...." Client D's speech evaluation indicated client D had a current goal to "functionally use photo communication board remains an appropriate goal...." The assessment recommended the following (not all inclusive):			

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	-"...increasing his ability to functionally use 1-2 communication pictures to request a specific item/object...expand his choice making skills using eye gaze...Staff should encourage the client to participate in social activities which promote vocabulary and language skills. For example: listening to magazine/newspaper articles, pointing to pictures in books/magazines, simple object manipulation games (puzzles, shape sorters, pop-up objects, etc...)...." Client D's record and/or above mentioned 3/29/15 ISP indicated client D not have any training objectives which addressed the client's identified basic training needs in regard to bathing, dressing and communication. Interview with staff #9 on 4/20/15 at 7:55 PM stated client D had a "bite sleeve." Staff #9 indicated she did not know if client D had a behavior plan for his biting/SIB. Interview with staff #2 on 4/21/15 at 9:49 AM indicated client D did not have any communication training in place. Interview with staff #4 on 4/20/15 at 8:22 PM stated facility staff should "redirect him (client D) not an appropriate behavior when he bites."			

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	Interview with staff #1 on 4/22/15 at 8:55 AM indicated she was not aware of client D's training objectives. Staff #1 indicated she would have to look them up on the computer. Staff #1 stated facility staff "Normally make lunches in the evenings. [Client D] can scoop things." Staff #1 indicted client D was not able to make all his wants and needs known and was not independent in bathing, dressing and/or toileting. Staff #1 indicated client D did not have any formal training objectives in place to address the client's identified basic training needs. When asked why client D did not feed himself, staff #1 stated "[Client D] will grab spoon." Staff #1 also stated client D wants "to palm it" (eat with his hands). Interview with PD #2 on 4/28/15 at 5:10 PM indicated client D was not able to make all his wants and needs known and was not independent with bathing and dressing. PD #2 stated client D "should have training." PD #2 indicated client D did not have a training objective which addressed client D's communication training needs. PD #2 did not know how client D's 5/30/14 speech assessment recommendations had been addressed as client D did not have a communication training objective. PD #2 stated facility staff should prompt client D "to stop"			

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	when he started biting his arm. When asked when client D's objectives should be implemented, PD #2 stated "Formal and informal training should be occurring." When asked if client D could initiate his own leisure activity, PD #2 stated "some." PD #2 indicated facility staff should be implementing/following client D's active treatment schedule. 9-3-4(a)			
W 0218 Bldg. 00	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, record review and interview for 1 of 4 sampled clients (C), the facility failed to assess and/or re-assess the client's sensorimotor needs. Findings include: During the 4/20/15 observation period between 4:25 PM and 9:14 PM, the 4/21/15 observation period between 5:40 AM and 8:30 AM and on 4/22/15 between 6:25 AM and 7:38 AM, at the group home, client C wore a gait belt around her waist. During the above mentioned observation periods, client C ambulated independently without staff assistance, and/or staff held the client by her elbow/arm to assist the client to walk	W 0218	**W218 Individual Program Plan** The comprehensive functional assessment must include sensorimotor development. **1. What corrective action will be accomplished?** · Obtain physician order for Occupational Therapy/Physical Therapy evaluation to assess/reassess sensorimotor needs for Client C with regards to using the gait belt. · Client C's risk plan and IPOP will be updated to include when and/or how facility staff are to use a gait belt, should OT/PT evaluation recommend continued use of gait belt. · Staff will be retrained regarding the appropriate use of Client C's gait belt as well as Client	06/12/2015

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NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383	

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	to the living room. Facility staff did not utilize the client's gait belt. Client C's record was reviewed on 4/28/15 at 11:10 AM. Client C's 2/19/15 Quarterly Physical /Internal Medicine Progress Note indicated client C's diagnosis included, but was not limited to, Falls. Client C's quarterly physical indicated "Plan: -use gait belt as directed...." Client C's 4/1/15 Risk Plan indicated client C had a risk plan for falls. Client C's 4/1/15 risk plan indicated "...Staff are to assist clients as needed with ambulation and walking...She typically has a slow wide-based gait. She is very unsteady on uneven surfaces or steps...." Client C's 4/1/15 fall risk plan did not indicate when and/or how facility staff were to use a gait belt with the client. Client C's 4/1/15 risk plan and/or 4/1/15 Individual Support Plan did not indicate client C's sensorimotor needs had been assessed and/or re-assessed which determined the need/use for a gait belt. Interview with staff #9 on 4/20/15 at 7:55 PM stated client C wore a gait belt because she was "Running into walls. Depth Perception issues."		C's revised risk plan and IPOP, should OT/PT evaluation recommend continued use of gait belt. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Program Director/QIDP will ensure that clients' IPOPs and ISPs reflect information on client's skill deficits and identified training needs. · Review ISPs, behavior plans, assessments and programming for all clients and make appropriate revisions to plans. · Training will be completed with the Program Director/QIDP regarding appropriate programming for clients and expectation regarding maintaining evaluations involving sensorimotor development. · Program Director/QIDP will monitor the residents on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, and risk plans. · Program Director/QIDP and Program Coordinator will maintain OT/PT evaluations as recommended. **1.What measures will be put into place or what systemic changes will be made to ensure that the**	

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	Interview with staff #2 on 4/21/15 at 9:49 AM indicated when asked why client C wore a gait belt, staff #2 stated "We use a gait belt to get her up as she won't move. She's stubborn." Staff #2 indicated she was not aware of any falls. Interview with staff #1 on 4/22/15 at 8:55 AM stated client C wore a gait belt due to "depth perception." Staff #1 stated "She steps big and causes her to trip." Staff #1 indicated facility staff were to use the gait belt with client C when they were getting on and off the van. Staff #1 stated they would also use the gait belt "to help her stand up because it can be a struggle to get her up." Interview with Program Director #2 on 4/28/15 at 3:29 PM indicated PD #2 was not able to locate a Physical Therapy and/or an Occupational Therapy assessment to determine the client's sensorimotor training needs/use for a gait belt. 9-3-4(a)		**deficient practice does not recur:** · Program Director/QIDP will ensure that clients' IPOPs and ISPs reflect information on client's skill deficits and identified training needs. · Review ISPs, behavior plans, assessments and programming for all clients and make appropriate revisions to plans. · Training will be completed with the Program Director/QIDP regarding appropriate programming for clients and expectation regarding maintaining evaluations involving sensorimotor development. · Program Director/QIDP will monitor the residents on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, and risk plans. · Program Director/QIDP and Program Coordinator will maintain OT/PT evaluations as recommended. · Should OT/PT evaluation recommend continued use of gait belt, Program Coordinator will monitor use of Client C's gait belt daily when in the home. · Should OT/PT evaluation recommend continued use of gait belt, Program Coordinator will monitor documentation of use of Client C's gait belt daily. · Should OT/PT evaluation recommend continued use of gait belt, Nurse staff will verify appropriate use of Client C's gait belt when completing monthly nursing assessments.	

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			1.How will the corrective action be monitored to ensure the deficient practice will not recur? · Program Director/QIDP will ensure that clients' IPOPs and ISPs reflect information on client's skill deficits and identified training needs. · Review ISPs, behavior plans, assessments and programming for all clients and make appropriate revisions to plans. · Training will be completed with the Program Director/QIDP regarding appropriate programming for clients and expectation regarding maintaining evaluations involving sensorimotor development. · Program Director/QIDP will monitor the residents on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, and risk plans. · Program Director/QIDP and Program Coordinator will maintain OT/PT evaluations as recommended. · Should OT/PT evaluation recommend continued use of gait belt, Program Coordinator will monitor use of Client C's gait belt daily when in the home. · Should OT/PT evaluation recommend continued use of gait belt, Program Coordinator will monitor documentation of use of Client C's gait belt daily. · Should OT/PT evaluation recommend continued use of gait belt, Nurse staff will verify	

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			appropriate use of Client C's gait belt when completing monthly nursing assessments. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015	
W 0220 Bldg. 00	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development. Based on observation, interview and record review for 1 of 4 sampled clients (C), the facility failed to obtain a current speech assessment in regard to the client's communication needs. Findings include: During the 4/20/15 observation period between 4:25 PM and 9:14 PM, the 4/21/15 observation period between 5:40 AM and 8:30 AM and the 4/22/15 observation period between 6:25 AM and 7:38 AM, at the group home, client C was non-verbal in communication in that the client could not speak. The facility staff did not provide any communication training with client C. Client C's record was reviewed on 4/28/15 at 11:10 AM. Client C's 4/1/15 Individual Plan of Protective	W 0220	**W220 Individual Program Plan** The comprehensive functional assessment must include speech and language development. **1. What corrective action will be accomplished?** · Obtain physician order for Client C Speech assessment · Once speech assessment completed, Program Director/QIDP will implement formal programming to address speech assessment recommendations for communication skill development. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Program Director/QIDP will ensure that clients' IPOPs and ISPs	06/12/2015

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	Oversight-General Information indicated "[Client C] says a few words, but doesn't really communicate other than minimal gestures. She will guide you to what she wants, usually food or to go outside in the back." The assessment indicated client C could not communicate anything medically. The assessment indicated client C would not be able to communicate her wants and needs. Client C's June 2011 Speech Assessment did not have any recommendations to assist the client's IDT (interdisciplinary team) to develop an appropriate communication goal to communicate her wants and needs, and/or to communicate with others. Client C's 4/1/15 Individual Support Plan (ISP) indicated client C had an objective to learn the sign for restroom so she can notify her staff when she needs to use the restroom or needs to be changed. Interview with staff #1 on 4/22/15 at 8:55 AM indicated client C was not able to make her wants and needs known. Staff #1 indicated client C had an objective to sign toilet in the past. Staff #1 stated "She is not able to sign toilet." Interview with Program Director (PD) #2 on 4/28/15 at 5:10 PM indicated client		reflect information on client's skill deficits and identified training needs. · Review ISPs, behavior plans, assessments and programming for all clients and make appropriate revisions to plans. · Training will be completed with the Program Director/QIDP regarding appropriate programming and behavior interventions for clients. · Program Director/QIDP will monitor the residents on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, and risk plans. · Program Director/QIDP and Program Coordinator will maintain speech language evaluations as recommended. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Program Director/QIDP will ensure that clients' IPOPs and ISPs reflect information on client's skill deficits and identified training needs. · Review ISPs, behavior plans, assessments and programming for all clients and make appropriate revisions to plans. · Training will be completed with the Program Director/QIDP regarding appropriate programming and behavior interventions for clients. · Program Director/QIDP will	

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	C's communication objective to sign toilet would probably need to be revised. PD #2 indicated client C did not have a current speech assessment with recommendations for training. 9-3-4(a)		monitor the residents on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, and risk plans. · Program Director/QIDP and Program Coordinator will maintain speech language evaluations as recommended. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Program Director/QIDP will ensure that clients' IPOPs and ISPs reflect information on client's skill deficits and identified training needs. · Review ISPs, behavior plans, assessments and programming for all clients and make appropriate revisions to plans. · Training will be completed with the Program Director/QIDP regarding appropriate programming and behavior interventions for clients. · Program Director/QIDP will monitor the residents on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, and risk plans. · Program Director/QIDP and Program Coordinator will maintain speech language evaluations as recommended. **1.What is the date by which the systemic changes will be**	

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			completed? · June 12, 2015	
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 additional client (G), the client's Individual Support Plan (ISP) failed to address the client's identified training needs. Findings include: 1. During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the group home, staff #1 cut up 2 large pancakes for client G into bite size pieces. When client G came to the dining room table, client G sat down as 2 staff were at the table feeding/assisting clients A, C and D to eat. Client G ate all the pancakes within 2 to 3 minutes without redirection to slow down and to take smaller bites. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/21/15 at 1:45 PM. The facility's 4/16/15 reportable incident report indicated "On	W 0227	**W227 Individual Program Plan** The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive functional assessment required by paragraph (c)(3) of this section. **1. What corrective action will be accomplished?** · Client G's ISP will be updated to include formal training to address dining needs and privacy. · Programming will be implemented to address Client G's dining needs/slow pace when eating and encouraging fluid between bites. · Programming will be implemented to address Client G's training need with regard to privacy. · Staff will be trained on Client G's ISP revision. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same	06/12/2015

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	Thursday April 15, 2015 [client G] choked on a piece of pizza and was given the Heimlich maneuver to dislodge the food particle. According to staff, [client G] was eating dinner at the table with her housemates and staff. They were eating pizza for dinner. [Client G] began to choke so staff (staff #10) administered the Heimlich maneuver to dislodge the food particle. After 4 thrusts, the food was dislodged. It was a piece of pizza crust...." The reportable incident report indicated client G was taken to the hospital's emergency room to be checked. The 4/16/15 reportable incident report indicated client G did not have any problems as a result of her choking incident. The reportable incident report indicated client G was placed on a mechanical soft diet until she could have a swallow study completed. The reportable incident report indicated "...All staff are to keep a close watch on [client G] for future choking issues...." The 4/16/15 reportable incident report indicated client G had a risk plan in place for choking. Client G's record was reviewed on 4/22/15 at 5:05 PM and on 4/27/15 at 2:30 PM. Client G's 4/24/15 Dining Plan indicated client G was on a mechanical soft diet. The dining plan indicated "...3. Encourage slow paced eating/drinking.		deficient practice. · Program Director/QIDP will ensure that clients' IPOPs and ISPs reflect information on client's skill deficits and identified training needs. · Review ISPs, behavior plans, assessments and programming for all clients and make appropriate revisions to plans. · Training will be completed with the Program Director/QIDP regarding appropriate programming and behavior interventions for clients. · Program Director/QIDP will monitor the residents on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, and risk plans. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Program Director/QIDP will ensure that clients' IPOPs and ISPs reflect information on client's skill deficits and identified training needs. · Review ISPs, behavior plans, assessments and programming for all clients and make appropriate revisions to plans. · Training will be completed with the Program Director/QIDP regarding appropriate programming and behavior interventions for clients. · Program Director/QIDP will monitor the residents on a regular	

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	4. Encourage fluid between bites/bites no larger than 1 teaspoon. 5. Requires staff supervision to prevent choking...." Client G's 4/20/15 ISP indicated client G did not have a formal training objective to address the client's eating fast and/or taking large bites of food. Interview with Program Director (PD) #2 on 4/28/15 at 5:10 PM indicated client G did not have a formal training in place which addressed the client's identified mealtime training need. 2. During the 4/21/15 observation period between 5:40 AM and 8:30 AM and on 4/22/15 between 6:25 AM and 7:38 AM, at the group home, client G sat on the toilet and dressed with the door open while staff were busy with other clients. Specifically during the 4/21/15 observation period, client G utilized her seat walker and maneuvered herself to the bathroom. Client G sat on the toilet with the door open naked from the waist down. At 6:10 AM, client G continued to sit on the toilet and dress with the door open as client F walked down the back hallway looking for staff. Client G was naked from the waist up with exposed breasts. Client F walked past the open bathroom door. Also on 4/22/15, client G sat on the toilet naked from the waist		basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, and risk plans. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Program Director/QIDP will ensure that clients' IPOPs and ISPs reflect information on client's skill deficits and identified training needs. · Review ISPs, behavior plans, assessments and programming for all clients and make appropriate revisions to plans. · Training will be completed with the Program Director/QIDP regarding appropriate programming and behavior interventions for clients. · Program Director/QIDP will monitor the residents on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, and risk plans. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015	

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	down attempting to dress for the day. Client G's record was reviewed on 4/22/15 at 5:05 PM and on 4/27/15 at 2:30 PM. Client G's 4/20/15 ISP indicated client G's ISP did not address the client's identified training need in regard to privacy. Interview with staff #1 on 4/22/15 at 7:55 AM indicated client G did not have an ISP objective for privacy. Interview with PD #2 on 4/28/15 at 5:10 PM indicated client G's ISP did not address client G's identified training need. 9-3-4(a)			
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 2 of 4 sampled clients (B and C) and for 1 additional client (G), the clients' Individual Support Plans (ISPs) failed to indicate how facility staff were to restrain a client, how facility staff were to utilize a client's gait belt, and/or indicate how facility staff were to monitor/supervise a client to prevent the	W 0240	**W240 Individual Program Plan** The individual program plan must describe relevant interventions to support the individual toward independence. **1. What corrective action will be accomplished?** · Behavior Analyst has revised Client B's Behavior Support plan to include how the staff were to	06/12/2015

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	client from picking her head wound. Findings include: 1. Interview with client B's mother on 4/21/15 at 9:29 AM, by phone, indicated she had reported a bruise on client B's right forearm about two to two and a half weeks ago. Client B's mother indicated she saw the bruise when client B came to visit that weekend. Client B's mother stated the bruise on client B's arm "looked like a thumb print." Client B's mother indicated she found out staff were holding client B's arm down when he started to bite his arm. Client B's mother stated client B called her last Monday (4/13/15) stating "Mom help." Client B's mother indicated client B was upset. Client B's mother indicated client A got on the phone and tried to explain what client B was trying to tell her. Client B's mother indicated client A indicated they were having waffles for breakfast but client B wanted eggs and started biting his arm. Client B's mother stated client A stated staff #8 told the client he was having waffles and not eggs when "[staff #6] got involved and held [client B's] arms down and [staff #8] took him (client B) to his room." Interview with client A on 4/21/15 at 11:00 AM indicated staff #6 had held		restrain/hold Client B's arms/hands to assist with the applying protective mitts. · Behavior Analyst has re-trained staff regarding Client B's BSP revision, including how to restrain/hold Client B's arms/hands to assist with applying the protective mitts. · Behavior Analyst will continue to monitor monthly trends in behavior documentation for Client B regarding SIB and suggest to IDT revisions as needed. · Staff will be retrained on completing/documenting 15 minute checks for Client G. · IDT will convene to revise Client G's BSP to include how staff are to monitor/supervise to prevent Client G's SIB. · Behavior Analyst will retrain staff on Client G's BSP including documentation of behavior events regarding Client G. · IDT will convene to discuss and implement plan involving Client G's skin picking/wound on top of head as well as outline/define high-risk monitoring as referenced in physical form from facility nurse on 2/18/15. · Nursing staff will include in risk plan for Client G description of high-risk monitoring as referenced in physical form from facility nurse on 2/18/15. · Program Director/QIDP will implement programming for Client G to promote activity engagement to discourage/help prevent SIB.	

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	client B's arms down. Client A indicated she saw/witnessed staff #6 holding the client's arms. Interview with client B on 4/21/15 at 12:05 PM, with the day program manager (DPM) present, indicated client B could answer yes and no questions with some verbalization of words. Client B indicated he did not like the group home and/or staff. During the interview client B pointed to and looked at his arm. When asked if client B had any bruising on his arm, client stated "Yes." The day program supervisor checked client B's arm, shoulder and back and did not find a bruise at that time. When asked if client B had a bruise on his arm before, client B stated "Yes." When asked if a client caused the bruise, client B stated "No." When asked if staff caused the bruise, client B stated "Yeah." Interview with the DPM on 4/21/15 at 12:20 PM indicated the DPM was on call a couple of weeks ago when the weekend staff called on call and indicated client B did not get his 8 AM medications and to report a bruise on client B's arm. The DPM produced an "Program Coordinator On Call Book Summary of Calls." The On call book was reviewed on 4/21/15 at 12:20 PM which indicated client B did not receive his 8 AM medications on		· Client C's risk plan and IPOP will be updated to include when and/or how facility staff were to use a gait belt with the client. · Staff will be retrained regarding the appropriate use of Client C's gait belt as well as Client C's revised risk plan and IPOP. · Staff will be trained on how to access client programming information and documentation needs in Therap (ISP, risk plans, goals, assessments, BSP, etc). · Training will be completed with the Program Coordinator and Program Director/QIDP regarding training staff. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Program Director/QIDP will ensure that clients' IPOPs and ISPs reflect information on how the staff is to assist the client's with identified needs. · Review ISPs, behavior plans, assessments and programming for all clients and make appropriate revisions to plans. · Training will be completed with the Program Director/QIDP regarding appropriate programming and behavior interventions for clients. · Program Director/QIDP will	

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	4/5/15. The on-call book indicated "...Staff reported [client B] has bruising on right forearm that mom is concerned about. Reported to [PD] instructed staff to do GER on both." The DPM indicated the DPM spoke with facility staff from "5:40 to 5:55" on 4/21/15. Confidential interview A stated they had told staff #6 "to stop" as staff #6 had "grabbed" client B when restraining his arms. Confidential interview A stated they were to hold client B's arms down with "open hands." Confidential interview B stated when asked how client B got the bruise on his arm, confidential interview B stated "From [staff #6] restraining him in morning." Confidential interview B indicated they saw/witnessed staff #6 restraining client B. Confidential interview B stated "She (staff #6) holds too tight with a closed hand." Confidential interview E indicated client B had open areas on his right hand due to client B's biting his hands when upset. Confidential interview E indicated client B required physical redirection/restraints of arms when the client demonstrated SIB (self-injurious behavior) of biting his arm. Confidential interview E indicated facility staff would have to hold client B's		monitor the residents on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, and risk plans · Program Coordinator will monitor use and documentation of use of Client C's gait belt daily when in the home. · Nurse staff will verify appropriate use of Client C's gait belt when completing monthly nursing assessments. · IDT will continue to convene to revise as needed the plan involving Client G's skin picking/wound on top of head. · Nurse staff will monitor Client G's wound on top of head at a minimum monthly and will assist staff, Program Coordinator and Program Director/QIDP with following wound care clinic appointment recommendations. · Behavior Analyst will continue to monitor monthly trends in behavior documentation for Client B regarding SIB and suggest to IDT revisions as needed. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Program Director/QIDP will ensure that clients' IPOPs and ISPs reflect information on how the staff is to assist the client's with identified needs. · Review ISPs, behavior plans,	

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	arms down to put on the client's gloves/mitts when he attempted to bite himself. Confidential interview E stated "Staff to put hands flat to not leave marks." Confidential interview E stated "I seen bruises a couple of weekends ago. Looked like thumb print." The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/21/15 at 1:45 PM. The facility's 4/14/15 reportable incident report indicated "It was reported on April 14, 2015 that [client B] (consumer) may have been put into an inappropriate restraint. [Client B] has bite mitts that are to be put on when he is biting and hurting himself. It is suspected that staff [staff #6] held his arms down when applying the bite mitts during a behavior. [Staff #6] was suspended on April 14th and will remain suspended while an investigation is being conducted." Client B's record was reviewed on 4/23/15 at 10:25 AM and on 4/27/15 at 2:41 PM. Client B's May 2014 Behavior Plan (BP) indicated client B demonstrated "Self-injurious behavior: biting himself, typically on the arms/hands without breaking the skin. 1. Staff should verbally prompt [client		assessments and programming for all clients and make appropriate revisions to plans. · Training will be completed with the Program Director/QIDP regarding appropriate programming and behavior interventions for clients. · Program Director/QIDP will monitor the residents on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, and risk plans · Program Coordinator will monitor use and documentation of use of Client C's gait belt daily when in the home. · Nurse staff will verify appropriate use of Client C's gait belt when completing monthly nursing assessments. · IDT will continue to convene to revise as needed the plan involving Client G's skin picking/wound on top of head. · Nurse staff will monitor Client G's wound on top of head at a minimum monthly and will assist staff, Program Coordinator and Program Director/QIDP with following wound care clinic appointment recommendations. · Behavior Analyst will continue to monitor monthly trends in behavior documentation for Client B regarding SIB and suggest to IDT revisions as needed.	

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	B] to stop biting himself. 2. Staff should immediately redirect [client B] to his replacement behaviors. 3. If [client B] continues to self-harm, staff should explain to [client B] that they are putting his protective hand mitts on. Staff should put the mitts on so that his hands and fingers are covered. Staff should say, '[Client B] I did not want you to hurt yourself. You need to stop biting yourself. Adults do not behave this way'...5. Staff should document all incidents of self-injurious behaviors and provide any necessary medical care...." Client B's May 2014 BP indicated the client's BP did not indicate how facility staff were to restrain/hold client B's arms/hands to get the client's mitts on to prevent injury/harm to the client. Interview with PD #2 on 4/28/15 at 5:10 PM stated staff should prompt client B "to stop biting, redirect to replacement behavior, and if can't stop, put his mitts on." PD #2 indicated client B's BP did not indicate how facility staff was to hold/restrain the client's arm to get his mitts on. 2. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, at the group home, client G spent the majority of her time in her bedroom except to take a shower, to eat and to get her night time		**1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Program Director/QIDP will ensure that clients' IPOPs and ISPs reflect information on how the staff is to assist the client's with identified needs. · Review ISPs, behavior plans, assessments and programming for all clients and make appropriate revisions to plans. · Training will be completed with the Program Director/QIDP regarding appropriate programming and behavior interventions for clients. · Program Director/QIDP will monitor the residents on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, and risk plans · Program Coordinator will monitor use of Client C's gait belt daily when in the home. · Program Coordinator will monitor documentation of use of Client C's gait belt daily. · Nurse staff will verify appropriate use of Client C's gait belt when completing monthly nursing assessments. · IDT will continue to convene to revise as needed the plan involving Client G's skin picking/wound on top of head. · Nurse staff will monitor Client G's wound on top of head at a minimum monthly and will assist	

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	medications. At 4:55 PM, when client G came out of her bedroom to the dining room, client G sat on a seater walker wearing a gait belt and an ace wrap/bandage around her head. The ace wrap/bandage went around each side of the client's face and under her chin. Client G had a hat over top of the ace wrap. At 7:10 PM, when the client went to get her 8:00 PM medications, client G no longer had her head wrapped. Client G had a large open area at the top of her head. The open area was about the size of a quarter with an irregular shape. The open area had a red edge around it. Part of the edges had a red wet substance around the edges. The open area was surrounded by a larger area about the size of a half dollar. The larger area had hair missing. During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the group home, client G did not have the ace wrap while client G was asleep in her bed at 5:50 AM. At 6:05 AM, client G woke up and went to the bathroom. Client G did not have the ace wrap/bandage on. At 6:38 AM, when client G came into the dining room, the client's open area was dry looking and the edges around the open area was dark red in color. The facility's End of Shift (EOS) reports		staff, Program Coordinator and Program Director/QIDP with following wound care clinic appointment recommendations. · Behavior Analyst will continue to monitor monthly trends in behavior documentation for Client B regarding SIB and suggest to IDT revisions as needed. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015	

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	were reviewed on 4/23/15 at 10:45 AM. The EOS reports indicated the following (not all inclusive): -2/23/15 "[Client G] had been picking her scalp as there was blood all over her mattress...." -2/24/15 "[Client G] was picking at scalp today. I pulled her bed sheet so she will to make her bed when she gets home. Sheet had lots of blood on it...." -2/27/15 "[Client G] kept taking off bandage and picking...." -3/4/15 "[Client G] large head wound looks better but it looks like she has been picking at the smaller on (sic) now. Iced foot and redid wound on head...." -3/6/15 "[Client G] had head wound uncovered today and it looked like she had been picking at it. re (sic) did wound care...." -3/11/15 "[Client G] started picking at the smaller wound on her head again...." -3/13/15 "[Client G] took wound cover off during the night and I replaced it. When went to ice foot she had taken it off again. Replaced it and while getting dressed again took off cover."			

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	-3/16/15 "[Client G] keeps picking at head...." -3/18/15 "[Client G] took wrap off twice this am. She had been picking at it and it looks red and wet." -3/19/15 "[Client G] took off her headwrap least 5 times...." -3/19/15 at 10:34 PM, "[Client G] took off her head bandage several times. She has been rolling up the bandage neatly when she takes it off. She also started picking at the smaller wound on her head again." -3/24/15 "[Client G] took wound cover off several times last night...." -3/30/15 "[Client G] took off her head wrap a couple of times. Picked at her wound...." -4/9/15 "[Client G] had head wrap off this am. Didn't see her picking at head...." -4/11/15 "...Keeps taking head wrap off and trying to pick head wounds...." -4/13/15 "[Client G] has head wrap off and staff caught client picking at scalp			

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	while in bathroom getting dressed...." -4/22/15 "[Client G] keeps taking off head wrap...." Client G's 2/18/15 Physical Form completed by the facility's nurse indicated client G had an "Opened area on top of head-ulceration." The form indicated "Met with [client G] at her home for initial visit. [Client G] placed on high-risk monitoring due to current decline in health; health issues...." Client G's 4/17/15 Risk Plan indicated under the section entitled Health Status Change indicated "...[Client G] will also withdraw and increase her SIB. Staff should encourage [client G] to participate in activities. SIB is monitored with skin checks BID (two times a day) and staff sign off the MAR indicating that it was completed...." Client G's risk plan indicated "...She is encouraged to wear a hat to prevent her form picking at areas on top of her head. She is followed quarterly by a psychiatrist. Staff are to complete a skin check BID and record their findings in Therap." Client G's 4/14/15 Individual Plan of Protective Oversight-Residential Information indicated client G required 15 minute checks for seizures and			

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	"...behavior concerns of hitting others when she cannot communicate what she wants...." Client G's 4/20/15 ISP indicated client G was on 15 minute checks for "Safeguards." Client G's record indicated facility staff did not document 15 minute checks. Client G's 4/20/15 ISP indicated the client's IDT (interdisciplinary team) failed to specifically indicate how client G was to be monitored/supervised to prevent client G from injuring herself in regard to the client's SIB, and/or failed to clearly define what "high risk monitoring" client G had been placed on. Interview with staff #4 on 4/20/15 at 8:22 PM indicated client G would pick the wound at the top of her head. Staff #4 stated client G's "wound has been there since I've been here. Recently went to wound center to get treatment to area." When asked when client G picked, staff 4 stated "When alone and when in bedroom not doing anything." Staff #4 indicated client G was on 15 minute checks. Interview with staff #2 on 4/21/15 at 9:49 AM indicated client G would remove her head wrap during the night. Staff #2 stated client G would pick her wound in the "bathroom."			

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	Interview with staff #1 on 4/22/15 at 8:55 AM stated client G was to have her ace bandage on her head "All day, every day. Lately has not been tolerating it. Hates it." Staff #1 stated "She's been picking." When asked where/when does client G pick, staff #1 stated "Mostly at night. She takes it off at night or idle time by her self." Interview with PD #2 on 4/23/15 at 10:30 AM indicated when asked if she was able to locate the 15 minute check for client G, PD #2 stated "No we did not. Took some over there to start." Interview with PD #2 on 4/28/15 on 5:10 PM stated "Staff should document behavior more in behavior section of Therap." PD #2 stated "Not much (data) there." PD #2 indicated facility staff were putting the behavior information in the EOS reports. PD #2 stated "We do not have no policy for End of Shift reports. PD #2 indicated the PDs did not always look at the EOS in a timely manner. PD #1 stated facility "staff just stating in their own words what happened when worked." When asked if client G had an IDT to address the client's skin picking, PD #2 stated "No IDT note." PD #2 indicated client G's ISP and/or 6/5/14 Behavior Plan did not indicate how client G was to be			

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	monitored/supervised to prevent the client's SIB. When asked when the last time the facility's nurse assessed client G's wound, PD #2 stated "Can't find anything other than 3/1715 note. Looks like 3/17/15 was her last visit." PD #2 indicated client G had a risk plan for head wound. PD #2 indicated the wound care center gave staff permission to wrap the ace bandage around client G's head. 3. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, the 4/21/15 observation period between 5:40 AM and 8:30 AM and on 4/22/15 between 6:25 AM and 7:38 AM, at the group home, client C wore a gait belt around her waist. During the above mentioned observation periods, client C ambulated independently without staff assistance, and/or staff held the client by her elbow/arm to assist the client to walk to the living room. Facility staff did not utilize the client's gait belt. Client C's record was reviewed on 4/28/15 at 11:10 AM. Client C's 2/19/15 Quarterly Physical /Internal Medicine Progress Note indicated client C's diagnosis included, but was not limited to, Falls. Client C's quarterly physical indicated "Plan: -use gait belt as directed...."			

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	Client C's 4/1/15 Risk Plan indicated client C had a risk plan for falls. Client C's 4/1/15 risk plan indicated "...Staff are to assist clients as needed with ambulation and walking...She typically has a slow wide-based gait. She is very unsteady on uneven surfaces or steps...." Client C's 4/1/15 fall risk plan did not indicate when and/or how facility staff were to use a gait belt with the client. Interview with staff #9 on 4/20/15 at 7:55 PM stated client C wore a gait belt because she was "Running into walls. Depth Perception issues." Interview with staff #2 on 4/21/15 at 9:49 AM indicated when asked why client C wore a gait belt, staff #2 stated "We use a gait belt to get her up as she won't move. She's stubborn." Staff #2 indicated she was not aware of any falls. Interview with staff #1 on 4/22/15 at 8:55 AM stated client C wore a gait belt due to "depth perception." Staff #1 stated "She steps big and causes her to trip." Staff #1 indicated facility staff were to use the gait belt with client C when they were getting on and off the van. Staff #1 stated they would also use the gait belt "to help her stand up because it can be a struggle to get her up."			

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	Interview with Program Director #2 on 4/28/15 at 5:10 PM indicated the use of the gait belt should be in the client's Individual Support Plan/risk plan. This federal tag relates to complaint #IN00171811. 9-3-4(a)			
W 0242 Bldg. 00	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. Based on observation, interview and record review for 2 of 4 sampled clients (C and D), the clients' Individual Support Plans (ISPs) failed to address the clients' identified basic training needs in regard to bathing, dressing, toileting, oral hygiene and/or communication. Findings include: 1. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, the 4/21/15 observation period between 5:40 AM and 8:30 AM and the 4/22/15	W 0242	**W242 Individual Program Plan** The individual program plan must include, for those clients who lack the, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. **1. What corrective action will be accomplished?**	06/12/2015

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	observation period between 6:25 AM and 7:38 AM, at the group home, client C was non-verbal in communication in that the client could not speak. The facility staff did not provide any communication training with client C. Client C's record was reviewed on 4/28/15 at 11:10 AM. Client C's 4/1/15 Individual Plan of Protective Oversight-General Information indicated "[Client C] says a few words, but doesn't really communicate other than minimal gestures. She will guide you to what she wants, usually food or to go outside in the back." The assessment indicated client C could not communicate anything medically. The assessment indicated client C would not be able to communicate her wants and needs. Client C's 4/1/15 Individual Plan of Protective Oversight-Residential Information indicated "Needs total care with hygiene. She wears depends and doesn't use the toilet but will sit on it. She needs total assistance...." The assessment indicated client was not able to dress herself and required total assistance with household tasks. The assessment indicated client C required staff to brush her gums as the client was edentulous.		· Prior to working with the clients in the home, staff will complete client specific training · Programming addressing Client Cs communication skills will be reviewed and revised. · Programming will be implemented for Client C addressing personal hygiene, including toileting, dressing and oral hygiene. · Programming will be implemented for Client D addressing communication skill deficits as recommended by 5/30/14 Speech-Language evaluation. · Programming will be implemented for Client D addressing bathing and dressing. · The Program Director/QIDP will ensure at all times that programming is in place for all clients addressing their identified needs. · Staff will be trained on how to access client programming information and documentation needs in Therap (ISP, risk plans, goals, BSP, etc). **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The Program Director/QIDP will monitor the residents programming and behavior needs at a minimum, monthly basis. As needs	

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	Client C's June 2011 Speech Assessment did not have any recommendations to assist the client's IDT (interdisciplinary team) to develop an appropriate communication goal to communicate her wants and needs, and/or to communicate with others. Client C's 4/1/15 Individual Support Plan (ISP) indicated client C's had the following formal training objectives: -To sit patiently in the same seat for minutes "appropriately." -To gather wash cloth to wash herself at bath time. -To regulate water temperatures with staff assistance. -To identify a group of coins from a group of objects. -To gather her cup for her water and prepare the water for her med pass. -"Point to the hazmat (hazardous material) when it's sitting next to other items." -To learn the sign for restroom so she can notify her staff when she needs to use the restroom or needs to be changed. Client C's ISP indicated the client's IDT had not addressed client C's basic needs in regard to toileting, dressing, and oral hygiene. Interview with staff #1 on 4/22/15 at 8:55 AM indicated client C was not able to		change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plans, dining plans, etc. · Monthly, Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all 8 clients in the home. · Prior to working with the clients in the home, staff will complete client specific training. · Performance Audits, involving review of program data collection and review will be completed annually by Quality Assurance. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The Program Director/QIDP will monitor the residents programming and behavior needs at a minimum, monthly basis. As needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plans, dining plans, etc. · Monthly, Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all 8 clients in the home. · Prior to working with the clients in the home, staff will complete client specific training. · Performance Audits, involving review of program data collection and review will be	

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	make her wants and needs known. Staff #1 indicated client C had an objective to sign toilet in the past. Staff #1 stated "She is not able to sign toilet." Staff #1 indicated client C did not have a formal communication training objective. Interview with Program Director (PD) #2 on 4/28/15 at 5:10 PM indicated client C was not able to independently toilet and/or dress herself. PD #2 indicated client C's identified basic needs would need to be addressed. PD #2 indicated client C's communication objective to sign toilet would probably need to be revised. 2. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, the 4/21/15 observation period between 5:40 AM and 8:30 AM and the 4/22/15 observation period between 6:25 AM and 7:38 AM, at the group home, client D was non-verbal in communication in that the client could not speak (limited to curse words). The facility staff did not provide any communication training with client D. Client D's record was reviewed on 4/28/15 at 3:56 PM. Client D's 3/29/15 Individual Plan of Protective Oversight-General Information indicated client D communicated his wants and		completed annually by Quality Assurance. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Director/QIDP will monitor the residents programming and behavior needs at a minimum, monthly basis. As needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plans, dining plans, etc. · Monthly, Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all 8 clients in the home. · Prior to working with the clients in the home, staff will complete client specific training. · Performance Audits, involving review of program data collection and review will be completed annually by Quality Assurance. **1.What is the date by which the systemic changes will be completed?** ·June 12, 2015	

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	needs by "gestures." The assessment indicated "[Client D] is typically non verbal. He will curse. He makes his needs/wants known by looking at what he wants, taking staff to what he wants, or just getting what he wants himself." The assessment indicated client D could not explain his health care needs, medication, "environmental allergies," the need for first aid and would yell or bite his arm if he was in pain. The assessment indicated client D required physical assistance to complete all oral hygiene tasks as the client had a "profound level of cognitive function." The assessment also indicated client D could not indicate his personal rights and/or give consent for medical care. The 3/29/15 assessment indicated client D would not be able to make his wants and needs known. Client D's 3/29/15 Individual Plan of Protective Oversight-Residential Information indicated client D was not able to "initiate hygiene tasks," was not able to dress himself, not able to complete any household task, and "required total physical assist with toileting needs." Client D's 5/30/14 Speech-Language Evaluation indicated client D was "...non-verbal and essentially non-vocal...." Client D's speech			

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	evaluation indicated client D had a current goal to "functionally use photo communication board remains an appropriate goal...." The assessment recommended the following (not all inclusive): -"...increasing his ability to functionally use 1-2 communication pictures to request a specific item/object...expand his choice making skills using eye gaze...Staff should encourage the client to participate in social activities which promote vocabulary and language skills. For example: listening to magazine/newspaper articles, pointing to pictures in books/magazines, simple object manipulation games (puzzles, shape sorters, pop-up objects, etc...)...." Client D's 3/29/15 ISP indicated client D had the following objectives: -To sit on the toilet. -To independently feed himself at meal times (HOH may be needed). -To regulate water temperature with staff assistance. -To choose an appropriate snack that follows his dining plan. -To participate in a group activity for 5 minutes. -To gather his pill crusher. -To identify a coin from a group of			

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	objects. -To point to the hazmat when it is sitting next to another item. Client D's record and/or above mentioned 3/29/15 ISP indicated client D did not have training objectives which addressed the client's identified basic training needs in regard to bathing, dressing and communication. Interview with staff #2 on 4/21/15 at 9:49 AM indicated client D did not have any communication training in place. Interview with staff #1 on 4/22/15 at 8:55 AM indicated client D was not able to make his wants and needs known, was not independent in bathing, dressing and/or toileting. Staff #1 indicated client D did not have any formal communication training. Interview with PD #2 on 4/28/15 at 5:10 PM indicated client D was not able to make all his wants and needs known and was not independent with bathing and dressing. PD #2 stated client D "should have training." PD #2 indicated client D did not have training objectives for bathing and dressing. PD #2 did not know how client D's 5/30/14 speech assessment recommendations had been addressed as client D did not have a communication training objective.			

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	9-3-4(a)			
W 0249 Bldg. 00	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. Based on observation, interview and record review for 3 of 4 sampled clients (B, C and D), the facility failed to implement the clients' Individual Program Plan (ISP) objectives and/or behavior plans when formal and/or informal training opportunities existed. Findings include: 1. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, at the group home, client C independently walked from the dining room to the living room wearing a gait belt, sat in the dining room looking out the window while staff #10 custodially prepared dinner which consisted of broccoli, potatoes, porkchops in gravy and pineapple. Staff #10 also did not encourage client C to help prepare food (tuna fish, tomatoes and peaches) for the lunches for the next day. At 5:40 PM,	W 0249	**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 consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. **1. What corrective action will be accomplished?** · **Client C's Individual Plan will be updated to include when and/or how facility staff were to use a gait belt with the client.** · Staff will be retrained regarding the appropriate use of Client C's gait belt as well as Client C's revised risk plan. · As resident's needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, risk plans and physician orders.	06/12/2015

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	client C went back to the living room and sat on the couch without staff interaction, training and/or an activity to participate in. At 6:00 PM, staff #10 prompted staff to have the clients wash their hands for dinner. Client C was in the living room and was not encouraged to wash her hands. At 6:12 PM, client C went back to the dining room table to eat her dinner. Staff #4 sat next to client C at the dining room table. Staff #4 fixed client C's plate without involving the client. As staff #4 sat next to client C, client C ate with her hands before she was redirected to use her spoon with hand over hand assistance. Client C also placed large bites of food in her mouth without staff redirection. Staff #4 wiped client C's mouth without involving and/or encouraging client C to wipe her own mouth. At 6:18 PM, staff #4 started feeding client C versus allowing the client to finish eating with hand over hand assistance. While eating, client C stood up and sat down on 2 different occasions. Once client C was finished eating her dinner, client C independently stood and walked back to the living room area with her hands up at her neck. Client C sat in the living room looking around, sat on the couch with her eyes closed and/or sat with her knees and feet touching the back of the couch in a fetal position until 7:32 PM when client C was		· At a minimum twice weekly for one month, Program Director/QIDP will document via electronic documentation system (Therap) t-log/note on site observations at the facility to ensure integration (teaching, training, modeling) and coordination of active treatment programming. After twice weekly for one month observations, Program Director/QIDP will document via Therap t-log at a minimum once weekly for one month, observations to ensure integration and coordination of active treatment programming. After once weekly for one month observations, Program Director/QIDP will complete at a minimum once monthly observations at the facility to ensure integration and coordination of active treatment programming. · The Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all clients in the home via monthly completion of data collection reports, which includes electronic documentation system data review. Area Director will comment on electronic documentation system data review report as reviewed. · Area Director will review Program Director/QIDP's Therap t-log regarding site observation of integration and coordination of active treatment programming twice weekly for one month, once weekly for one month and monthly thereafter and will address any concerns with	

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	prompted to get her bed time medications. Staff #10, who passed the medications, did not provide any medication training with the client. During the 4/20/15 observation period, staff #1, #4, #9 and #10 did not provide any training and/or activities with client C. During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the group home, Client C was up and dressed upon arrival to the group home. Client C was sitting in the living room with in a fetal position with her eyes closed. At 7:00 AM, staff #1 custodially placed toast and pancakes on client C's high sided plate while client C remained in the living room in a fetal position and eyes closed. About 3 to 4 minutes later, staff #1 assisted client C to walk to the dining room holding client C's elbow and arm. Staff #1 did not use client C's gait belt. Client C's food was not cut into small pieces. Client C took 3 bites of her food and sat with her head bent down and hands up at the back of her neck. Client C refused to eat any more of her food. At 7:13 AM, client C stood and independently walked back to the living room and sat on the couch without redirection to participate in a more meaningful activity and/or training. Client C remained sitting in the living		the Program Director/QIDP within 48 hours of review. · Area Director will make unannounced visit to facility weekly for one month and monthly thereafter, to ensure the Program Director/QIDP has effectively integrated and coordinated the active treatment programs. · The Program Director/QIDP will ensure at all times that programming is in place for all clients addressing their identified needs via monthly evaluation of program data collection, including revisions to programs as needed. ·Program Coordinator will monitor use of Client C's gait belt daily when in the home. ·Nurse staff will verify appropriate use of Client C's gait belt when completing monthly nursing assessments. · Staff will be trained on how to access client programming information and documentation needs in Therap (ISP, risk plans, goals, BSP, etc). · Staff will be retrained on the importance of ensuring active treatment at all times. · Training will be completed with the Program Coordinator and Program Director/QIDP regarding training of staff. · Prior to working with the clients in the home, staff will complete client specific training. ·Programming will be implemented for Clients B, C and D to assist with meal preparation.	

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	room area until the client received her morning medications and was assisted to load the van at 8:25 AM to go to the day program. During the 4/22/15 observation period between 6:25 AM and 7:38 AM, at the group home, client C was sitting at the dining room table with a staff next to her eating eggs, upon arrival to the group home. Client C was feeding herself with redirection to use her spoon. At 6:50 AM, client C stood up and independently walked to the living room wearing a gait belt. At 7:08 AM, client E returned to his bedroom to find client C attempting to get in his bed to lay down. Client E yelled for staff. Client C's bedroom was on located on the other side of the group home. Staff #1 redirected client C out of client E's room and told the client her room was on the other hallway. Client C independently walked back to the living room and sat down on the couch without redirection to participate in a more meaningful activity and/or training. During the above mentioned 4/20, 4/21 and 4/22/15 observation periods, client C was non-verbal in communication in that the client could not speak. The facility staff did not provide any communication training with client C. Client C's record was reviewed on		·Programming will be implemented for Clients C and D to develop leisure skills. ·Programming will be implemented for Clients C and D to participate in family style dining. ·Staff will be retrained on the importance of ensuring family style dining, active treatment during meal preparation and proper supervision of the client's needs during the meal. ·Staff will be retrained on client's meal time objectives and communication objectives. ·Staff will be retrained on client's dining plans. · Programming will be implemented for Client C regarding hand washing. · Programming will be implemented for Client C regarding dining skills including use of a utensil and wiping mouth. ·Programming will be implemented for Client D addressing communication skills. ·Staff will be retrained on Client Ds BSP regarding interventions when Client D engages in self-injury/biting. · Staff will be retrained on Client B's BSP regarding redirection to visual schedule. · The Program Director/QIDP will ensure at all times that programming is in place for all clients addressing their identified needs via monthly evaluation of program data collection, including revisions to programs as needed.	

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	4/28/15 at 11:10 AM. Client C's 4/1/15 Individual Support Plan (ISP) indicated client C had the following formal training objectives: -To sit patiently in the same seat for minutes "appropriately." -To gather wash cloth to wash herself at bath time. -To regulate water temperatures with staff assistance. -To identify a group of coins from a group of objects. -To gather her cup for her water and prepare the water for her med pass. -"Point to the hazmat (hazardous material) when it's sitting next to other items." -To learn the sign for restroom so she can notify her staff when she needs to use the restroom or needs to be changed. Facility staff did not implement client C's 4/1/15 ISP objectives when formal and/or informal training opportunities existed. Client C's 3/4/15 Active Treatment Daily Schedule indicated the following (not all inclusive): -Monday PM 4 PM-5 PM Medication 5 PM- 6 PM Chore and supper 6 PM -7 PM Leisure activities of choice such as doing puzzles, coloring , or doing		**1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The Program Director/QIDP will monitor the residents programming and behavior needs at a minimum, monthly basis. As needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plans, dining plans, etc. · Monthly, Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all 8 clients in the home. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. · Staff will be trained on the active treatment schedules for Client's A – G at their next team meeting. · Prior to working with the clients in the home, staff will complete client specific training. · Performance Audits, involving review of program data collection and review will be completed annually by Quality Assurance. **1.How will the corrective action be monitored to ensure the deficient practice will not recur.** · The Program Director/QIDP will monitor the residents programming and behavior needs at a minimum, monthly basis. As needs change or new concerns are identified, changes will be	

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	"math sheets." 7 PM - 8 PM Bath/shower 8 PM - 9 PM Get medicine and get ready for bed. -Tuesday AM and Wednesday AM 6 AM - 7 AM "Wake up morning hygiene, get dressed, meds, straighten room, start breakfast." 7 AM -8 AM "Breakfast, Transport to Workshop." Client C's 2/16/15 Consultation Form indicated client C saw a speech therapist in regard to a swallow study. The 2/16/15 note indicated "Pt (patient) was able to tolerate small amounts of regular consistency foods if given small pieces...Staff to cut food at table." Client C's 3/12/15 Behavior Support Plan (BSP) indicated facility staff needed to "Encourage the development of, and engagement in, a hobby, sport, exercise, volunteer work, appropriate leisure activity, and interactions with peers...." Interview with staff #9 on 4/20/15 at 7:55 PM stated client C wore a gait belt because she was "Running into walls. Depth Perception issues." Interview with staff #2 on 4/21/15 at 9:49 AM indicated when asked why client C		reflected in their programming, assessments, ISP, behavior plans, dining plans, etc. · Monthly, Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all 8 clients in the home. · Prior to working with the clients in the home, staff will complete client specific training. · Performance Audits, involving review of program data collection and review will be completed annually by Quality Assurance. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015 **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The Program Director/QIDP will monitor the residents programming and behavior needs at a minimum, monthly basis. As needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plans, dining plans, etc. · Monthly, Area Director will ensure the Program Director/QIDP is monitoring treatment programs for all 8 clients in the home. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. · Staff will be	

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	wore a gait belt, staff #2 stated "We use a gait belt to get her up as she won't move. She's stubborn." Staff #2 indicated she was not aware of any falls. Interview with staff #1 on 4/22/15 at 8:55 AM stated client C wore a gait belt due to "depth perception." Staff #1 stated "She steps big and causes her to trip." Staff #1 indicated facility staff were to use the gait belt with client C when they were getting on and off the van. Staff #1 stated they would also use the gait belt "to help her stand up because it can be a struggle to get her up." Staff #1 indicated client C had an objective to sign toilet in the past. Staff #1 stated "She is not able to sign toilet." Staff #1 indicated client C did not like to participate in any type of activity and/or training. Interview with Program Director (PD) #2 on 4/28/15 at 5:10 PM indicated when asked if client C could initiate her own leisure activities, PD #2 stated "Some." When asked when client C's objectives should be implemented, PD #2 stated "Formal and informal training should be occurring." PD #2 indicated facility staff should be implementing/following client C's active treatment schedule. 2. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, at the		trained on the active treatment schedules for Client's A – G at their next team meeting. · Prior to working with the clients in the home, staff will complete client specific training. · Performance Audits, involving review of program data collection and review will be completed annually by Quality Assurance.	

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	group home, client D walked around the group home with a roller walker. Client D made loud vocalizations and/or used curse words when he became upset. Client D would periodically bite his wrist which had a bite sleeve on it when redirected out of the kitchen. Staff #1, #4, #9 and #10 did not redirect client D to an alternate activity and/or training. At 5:10 PM, client D walked into the kitchen and stood at the counter as staff #1 was cooking, staff #1 stated "No." Client D started biting his arm repeatedly and left the kitchen as staff #10 custodially prepared the dinner meal and the clients' lunches for the next day. At 5:40 PM, client D was in his bedroom sitting on the side of the bed in the dark without redirection and/or prompts to turn the light on. At 5:46 PM, client D left his bedroom and started walking down the hallway back and forth and then walked back to the kitchen area before getting redirected by client E as staff #10 was pureeing client D's food (porkchops, potatoes and broccoli). At 6:05 PM, staff #10 stated to staff he was going to walk with client D around the house to help the client "stay occupied" while the clients were washing their hands and waiting to eat. At 6:12 PM, client D came back to the dining room and reached for a cup of water on the table and accidentally knocked it over. Staff			

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	#10 sat next to client D and placed small portions of pureed food onto client D's plate. Once client D ate the amount placed on his plate, staff #10 would scoop more food onto his plate. Client D was able to pick up the spoon and feed himself. At 6:33 PM, staff #10 told client D he was done. Client D stood got his walker and went back to his bedroom. Client D remained in his bedroom until it was time to get his bed time medication and then client D returned to his bedroom. Staff did not provide any meaningful activity and/or training with the client. During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the group home, client D was assisted to shower/bathe by staff #1. At 6:10 AM, client D came out of his room dressed and started walking around the house with his roller walker. At 6:19 AM, staff #1 prompted client D to sit down. Client D continued to walk around the group home with his roller walker as staff #1 was in the kitchen/dining room area and staff #2 continued to assist clients to get dressed. At 6:30 AM, client D walked into the laundry room at the back of the house which was also the medication room. Client D opened a pudding container and started to eat the pudding with his hands and got pudding on the			

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	counter in the medication room. Staff #1 was in the kitchen area preparing breakfast and staff #2 was in client B's bedroom assisting the client to get ready for the day. Client D then went to the front of the house while staff #1 went into client B's bedroom to assist staff #2 with client B. Client A was in the kitchen area watching the food as client D walked toward the stove/counter area in the kitchen. At 6:38 AM, Client D grabbed a slice of toast and took a bite out of it. Client A started yelling. Staff #1 returned to the kitchen and grabbed the toast out of client D's hand (client D is on a pureed diet). Client D swallowed what was in his mouth. At 6:49 AM, client D walked over to the kitchen counter and got into his pureed plate of food while staff #1 was cutting up client G's pancakes and staff #2 was wheeling client B to the dining room table. Client D ate some of the pureed food with his hands, before client A informed staff #1 client D was eating his food on the stove. Staff #1 brought client D's food to the table and staff #2 started feeding client D his pureed meal without encouraging the client to feed himself and/or use hand over hand assistance. Staff #2 poured the juice for client D, but client D was able to hold and drink his juice without staff assistance. At 7:16 AM, client D had finished eating and returned to the table.			

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	Client E started biting his arm and saying curse words. Client A reminded staff that client D did not get his morning coffee. Client D drank his coffee and returned to the back of the house to get his medicine. Client D was prompted to stand up to wash his hands. Client D refused and started biting his arm and hit staff #1 on the leg. Once client D took his medications, he returned to his bedroom until it was time to go to the day program. Client D did not receive any medication training at his 8 AM medication pass. During the 4/22/15 observation period between 6:25 AM and 7:38 AM, at the group home, client D walked around the house with his roller walker, sat at the dining room table watching staff #1 prepare breakfast and/or sat in his bedroom without any interaction from staff and/or redirection to participate in a more meaningful activity. At 6:50 AM, client D became upset and started making loud vocalizations and biting his arm as client D attempted to get client G's coffee. Client A got client D a cup of coffee and the client calmed down. While client D was at the table, client D grabbed a piece of whole toast off the serving dish and took a bite before staff took the toast from him. Client D stood up biting his arm and went to his			

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	bedroom. During the above mentioned 4/20, 4/21, 4/22/15 observation periods, client D was basically non-verbal in communication in that the client did not speak except to curse. Facility staff did not provide any communication training with client D. Client D's record was reviewed on 4/28/15 at 3:56 PM. Client D's 3/29/15 ISP indicated client D had the following objectives: -To sit on the toilet. -To independently feed himself at meal times (HOH may be needed). -To regulate water temperature with staff assistance. -To choose an appropriate snack that follows his dining plan. -To participate in a group activity for 5 minutes. -To gather his pill crusher. -To identify a coin from a group of objects. -To point to the hazmat when it is sitting next to another item. Facility staff did not implement client D's ISP training objectives when formal and/or informal training opportunities existed. Client D's 3/12/15 Behavior Plan (BP) indicated client D had a targeted behavior of "attempting to drink hazardous liquids,			

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	picking up all drinks and not paying attention as to whether they are hazardous to his health" and self-injurious behavior (SIB). Client D's BP defined the client's SIB as "continued chewing on wrist, arm, hand or finger." Client D's BP indicated when client D demonstrated SIB, staff was to "1. Approach calmly and ask [client D] to stop. 2. Pair request to stop behavior with a physical touch on arm. Don't pull arm away. 3. Repeat until task is complete...." Client D's BP indicated "[Client D] wears a bite protective sleeve to safeguard himself from injury due to biting his arm...." Client D's BP indicated client D should participate in a game, leisure activity, "community awareness, relaxation and "effective ways of coping with anger...." Client D's 3/29/15 Active Treatment Daily Schedule indicated the following (not all inclusive): -Monday PM 4 PM-5 PM Medication 5 PM- 6 PM Chore and supper 6 PM -7 PM Bath/shower 7 PM - 8 PM Leisure activities of choice such as "...people watching, and dog watching." 8 PM - 9 PM Get medicine and get ready for bed.			

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	-Tuesday AM and Wednesday AM 6 AM - 7 AM "Wake up morning hygiene, get dressed, meds, straighten room, start breakfast." 7 AM -8 AM "Breakfast, Transport to Workshop." Interview with staff #9 on 4/20/15 at 7:55 PM stated client D had a "bite sleeve." Staff #9 indicated she did not know if client D had a behavior plan for his biting/SIB. Interview with staff #4 on 4/20/15 at 8:22 PM stated facility staff should "redirect him (client D) not an appropriate behavior when he bites." Interview with staff #1 on 4/22/15 at 8:55 AM indicated she was not aware of client D's training objectives. Staff #1 indicated she would have to look them up on the computer. Staff #1 stated facility staff "Normally make lunches in the evenings. [Client D] can scoop things." Staff #1 indicated client D was not able to make his wants and needs known, was not independent in bathing, dressing and/or toileting. Staff #1 indicated client D did not have any formal communication training. When asked why client D did not feed himself, staff #1 stated "[Client D] will grab spoon."			

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	Staff #1 also stated client D wants "to palm it" (eat with his hands). Interview with PD #2 on 4/28/15 at 5:10 PM stated facility staff should prompt client D "to stop" when he started biting his arm. When asked when client D's objectives should be implemented, PD #2 stated "Formal and informal training should be occurring." When asked if client D could initiate his own leisure activity, PD #2 stated "some." PD #2 indicated facility staff should be implementing/following client D's active treatment schedule. 3. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, at the group home, staff #10 custodially prepared client B's lunch, for 4/21/15, which consisted of Tuna salad sandwiches, tomatoes and peaches while client B sat in the dining room area at the dining room table. During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the group home, client B was fed by staff at the breakfast meal. Once client B finished eating, client B sat in the dining room, at the dining room table, without training and/or being offered an alternate activity to participate in. At 7:14 AM, client B became upset with staff #1.			

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	Client B attempted to knock off his glasses and bit his hand one time. Staff #1 tried to ask client B why he was upset and removed the client's glasses from his face. Staff #1 did not redirect client B to his visual schedule. Also, during the above mentioned observation period, client B did not receive any medication training at his morning medication pass. Client B's record was reviewed on 4/23/15 at 10:35 AM and on 4/27/15 at 2:41 PM. Client B's 4/20/15 ISP indicated client B had objectives to prepare his lunch with staff assistance, to state why he takes Lamotrigine ER (extended release) (seizures), to state ways he can cope when frustrated, to identify a quarter, and an objective to feed himself with physical assistance which facility staff did not implement when formal and/or informal training opportunities existed. Client B's May 2014 Behavior Plan (BP) indicated client B had a targeted behavior of SIB defined as "...biting himself, typically on the arms/hands without breaking the skin.			

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	1. Staff should verbally prompt [client B] to stop biting himself. 2. Staff should immediately redirect [client B] to his replacement behaviors. 3. If [client B] continues to self-harm, staff should explain to [client B] that they are putting his protective hand mitts on. Staff should put the mitts on so that his hands and fingers are covered. Staff should say, '[Client B] I did not want you to hurt yourself. You need to stop biting yourself. Adults do not behave this way'...5. Staff should document all incidents of self-injurious behaviors and provide any necessary medical care...." Client B's May 2014 BP indicated facility staff were to utilize a "visual daily schedule" with the client as his replacement behavior when he became upset. Interview with PD #2 on 4/28/15 at 5:10 PM stated facility staff should implement client B's behavior plan when the client became upset and/or started biting himself. When asked when client B's objectives should be implemented, PD #2 stated "Formal and informal training should be occurring." PD #2 indicated clients should be helping to prepare meals and/or help to prepare/pack their own lunches.			

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	9-3-4(a)			
W 0252 Bldg. 00	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on observation, interview and record review for 1 of 4 sampled clients (B) and for 1 additional client (G), the facility failed to collect/document data in regard to a client's behavior, repositioning, cleaning of a client's wheelchair and document 15 minute checks. Findings include: 1. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, at the group home, client G spent the majority of her time in her bedroom except to take a shower, to eat and to get her night time medications. At 4:55 PM, when client G came out of her bedroom to the dining room, client G sat on a seater walker wearing a gait belt and an ace wrap/bandage around her head. The ace wrap/bandage went around each side of the client's face and under her chin. Client G had a hat over top of the ace wrap. At 6:18 PM, client G carried her dishes to the kitchen and she scooted her	W 0252	**W252 Program Documentation** Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. **1. What corrective action will be accomplished?** · Staff will be retrained on completing/documenting 15 minute checks and behavior events for Client G. · Staff will be retrained on Client B's repositioning plan and schedule, including use of the wedge pillow. · Staff will be retrained on documenting Client B's repositioning plan and schedule, including how to document client refusals. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Staff will be retrained on completing/documenting 15 minute	06/12/2015

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	seat walker with her feet. Client G then went outside and smoked a cigarette on the back patio. Once client G returned inside the house, the client went to her bedroom. At 7:10 PM, when the client went to get her 8:00 PM medications, client G no longer had her head wrapped. Client G had a large open area at the top of her head. The open area was about the size of a quarter with an irregular shape. The open area had a red edge around it. Part of the edges had a red wet substance around the edges. The open area was surrounded by a larger area about the size of a half dollar. The larger area had hair missing. Interview with staff #10 on 4/20/15 at 7:14 PM indicated client G had removed her head wrap. Staff #10 indicated the area on top of client G's head had gotten smaller. Staff #10 indicated client G was going to the wound clinic for treatment. When asked how client G got the area, staff #10 stated client G "picked it." The facility's End of Shift (EOS) reports were reviewed on 4/23/15 at 10:45 AM. The EOS reports indicated the following (not all inclusive): -2/23/15 "[Client G] had been picking her scalp as there was blood all over her mattress...."		checks and behavior events for Client G. · Staff will be retrained on Client B's repositioning plan and schedule, including use of the wedge pillow. · Staff will be retrained on documenting Client B's repositioning plan and schedule, including how to document client refusals. · Program Coordinator will monitor completion of 15 minute checks and behavior event documentation daily when in the home. · Program Director/QIDP will monitor completion of 15 minute checks and behavior event documentation weekly for one month then monthly thereafter. · Behavior Analyst will review behavior event documentation monthly. · Program Coordinator will monitor use of the bed wedge daily when in the home. · Program Coordinator will review documentation of repositioning plan and schedule for Client B daily when in the home. · Program Director will monitor documentation of repositioning plan and schedule for Client B monthly. · Nursing staff will monitor documentation of repositioning plan and schedule for Client B weekly. · Nursing staff will verify use of bed wedge and repositioning plan and schedule when completing monthly nursing assessments with	

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	-2/24/15 "Client G] was picking at scalp today. I pulled her bed sheet so she will need to make her bed when she gets home. Sheet had lots of blood on it...." -2/27/15 "[Client G] kept taking off bandage and picking...." -3/4/15 "[Client G] large head wound looks better but it looks like she has been picking at the smaller on (sic) now. Iced foot and redid wound on head...." -3/6/15 "[Client G] had head wound uncovered today and it looked like she had been picking at it. re (sic) did wound care...." -3/11/15 "[Client G] started picking at the smaller wound on her head again...." -3/16/15 "[Client G] keeps picking at head...." -3/18/15 "[Client G] took wrap off twice this am. She had been picking at it and it looks red and wet." -3/19/15 at 10:34 PM, "[Client G] took off her head bandage several times. She has been rolling up the bandage neatly when she takes it off. She also started picking at the smaller wound on her head		Client B. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Staff will be retrained on completing/documenting 15 minute checks and behavior events for Client G. · Staff will be retrained on Client B's repositioning plan and schedule, including use of the wedge pillow. · Staff will be retrained on documenting Client B's repositioning plan and schedule, including how to document client refusals. · Program Coordinator will monitor completion of 15 minute checks and behavior event documentation daily when in the home. · Program Director/QIDP will monitor completion of 15 minute checks and behavior event documentation weekly for one month then monthly thereafter. · Behavior Analyst will review behavior event documentation monthly. · Program Coordinator will monitor use of the bed wedge daily when in the home. · Program Coordinator will review documentation of repositioning plan and schedule for Client B daily when in the home. · Program Director will monitor documentation of repositioning plan and schedule for	

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	again." -3/30/15 "[Client G] took off her head wrap a couple of times. Picked at her wound...." -4/11/15 "...Keeps taking head wrap off and trying to pick head wounds...." -4/13/15 "[Client G] has head wrap off and staff caught client picking at scalp while in bathroom getting dressed...." Client G's record was reviewed on 4/22/15 at 5:05 PM and on 4/27/15 at 2:30 PM. Client G's Skin/Wound Assessments documented by Direct Support Professionals (DSPs) indicated the following (not all inclusive): -2/4/15 "client (sic) picked head during the night as there was blood on the bed." -2/6/15 "scalp (sic) looks very red and irritated (sic) client (sic) was observed picking while getting dressed...." -2/9/15 "area (sic) looks larger and was red today. client (sic) seen picking at scalp in am." -2/10/15 "scalp (sic) wound looks bad, infection present and has been picking at it as it looks bigger today (sic)"		Client B monthly. · Nursing staff will monitor documentation of repositioning plan and schedule for Client B weekly. · Nursing staff will verify use of bed wedge and repositioning plan and schedule when completing monthly nursing assessments with Client B. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Staff will be retrained on completing/documenting 15 minute checks and behavior events for Client G. · Staff will be retrained on Client B's repositioning plan and schedule, including use of the wedge pillow. · Staff will be retrained on documenting Client B's repositioning plan and schedule, including how to document client refusals. · Program Coordinator will monitor completion of 15 minute checks and behavior event documentation daily when in the home. · Program Director/QIDP will monitor completion of 15 minute checks and behavior event documentation weekly for one month then monthly thereafter. · Behavior Analyst will review behavior event documentation monthly. · Program Coordinator will monitor use of the bed wedge daily	

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	-2/20/15 "client (sic) was picking at larger wound this am. Looks red and has a little infection in it." -2/24/15 "Scalp looks worse than yesterday. Client was picking at head in the am...." -2/27/15 "was caught a couple times taking off her wrap and picking at her head...." -3/4/15 "I (staff #6) think she may be picking at the wound that isn't covered. Looked larger and red." -3/6/15 "Client had pulled of (sic) wound cover and has been picking at area on scalp (sic) Staff replied (sic) dressing to wound. Looks like it is trying to heal." -3/11/15 "Wound on head continues to heal and looks better. Has started to pick at her smaller wound again." -3/13/15 "Large wound is looking much better. Client won't leave the wrap on and is picking at the smaller wound. It was larger this am and looked runny." -3/13/15 "Large area looks much improved. Client left dressing on through the night. Client has been		when in the home. · Program Coordinator will review documentation of repositioning plan and schedule for Client B daily when in the home. · Program Director will monitor documentation of repositioning plan and schedule for Client B monthly. · Nursing staff will monitor documentation of repositioning plan and schedule for Client B weekly. · Nursing staff will verify use of bed wedge and repositioning plan and schedule when completing monthly nursing assessments with Client B. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015	

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	picking the smaller on it and it has doubled in size (sic). Put medication on as directed." -3/17/15 "Client has been picking at her head today. area (sic) was open and had been bleeding. Staff covered the area again and also put bandage on front area wound." -3/18/15 at 9:55 AM, "Client continued to take off wound wrap and had been picking at the larger area...." -3/23/15 "Wound on head have been picked at during the night as client won't keep wrap on them...." -3/27/15 "larger (sic) wound has been picked at. smaller (sic) wound is larger and deep...." -3/30/15 "Larger wound on head had been picked at. Smaller wound remains the same...." -4/8/15 "Larger wound on head has been picked at. Smaller one continues to heal." -4/14/15 "...Won't leave spots on head alone. Keeps trying to scratch them." -4/14/15 (PM note) "client (sic) took			

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	wrap off during the night. Scalp looks like it has a little blood on it...." -4/22/15 "Wound on head is the same. Smaller wound on head has been picked at...." Client G's Medication History indicated the following (not all inclusive): -2/10/15 Client G was placed on Cephalexin 500 milligrams (mg) three times a day for 10 days "Antibiotic for lesions on head." -2/25/15 Client G was placed on Alprazolam 0.25 mg twice a day to "Decrease anxiety to decrease skin picking." -3/17/15 Client G's Prisma wound dressing was discontinued as a new wound order was obtained (returned to using Santyl dressing). -4/25/15 "Complete wound care, as instructed in scheduled medications section, as needed if [client G] is picking at her wound." Client G's Clinician Reports (behavior data) data from 1/1/15 to 4/22/15 indicated facility staff documented 5 incidents of client G picking her head as			

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	indicated by the following: -2/3/15 "Lately whenever staff catches her picking her head, she will tell them to go away or start yelling. -3/21/15 "[Client G] continues to pick at her head." -3/22/15 "[Client G] continues to pick at her head." -3/28/15 "[Client G] continues to pick her head and also keeps taking the wrap off." -3/29/15 "[Client G] continues to pick at herself." Client G's behavior data from 2/1/15 to 4/27/15 indicated only 1 more documented incident of SIB which occurred on 4/25/15. The report indicated "[Client G] continue to pick at head on a rare occasion." Client G's 4/14/15 Individual Plan of Protective Oversight-Residential Information indicated client G required 15 minute checks for seizures and "...behavior concerns of hitting others when she cannot communicate what she wants...." Client G's 4/20/15 ISP indicated client G was on 15 minute checks for "Safeguards." Client G's record indicated facility staff did not document 15 minute checks. The facility failed to ensure			

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	facility staff completed and/or documented 15 minute checks. Client G's 6/5/14 Behavior Plan (BP) indicated client G demonstrated SIB defined as "(slapping himself (sic) in his (sic) face leaving welts, red marks, bruising)." Client G's BP indicated facility staff were to document when the behavior occurred. Interview with staff #4 on 4/20/15 8:22 PM indicated client G would pick the wound at the top of her head. When asked when client G picked, staff #4 stated "When alone and when in bedroom not doing anything." Staff #4 indicated client G was on 15 minute checks. Interview with staff #1 on 4/22/15 at 8:55 AM stated client G was to have her ace bandage on her head "All day, every day. Lately has not been tolerating it. Hates it." Staff #1 stated "She's been picking." When asked where/when does client G pick, staff #1 stated "Mostly at night. She takes it off at night or idle time by her self." When asked how facility staff were monitoring the client to prevent her from picking, staff #1 stated "She is on 15 minutes checks and she stay out (of room) with us." Interview with PD #2 on 4/23/15 at 10:30			

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	AM indicated when asked who reads the End of Shift reports stated the "PC/HM& PD and who ever is on the recipient list." When asked if she was able to locate the 15 minute checks for client G, PD #2 at stated "No we did not. Took some over there to start." Interview with PD #2 on 4/28/15 on 5:10 PM stated "Staff should document behavior more in behavior section of Therap." PD #2 stated "Not much (data) there." PD #2 facility staff were putting the behavior information in the EOS reports. PD #2 stated "We do not have no policy for End of Shift reports." 2. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, the 4/21/15 observation period between 5:40 AM and 8:30 AM and on 4/22/15 between 6:25 AM and 7:38 AM, at the group home, client B utilized a custom made wheelchair which was pushed by staff. Client B sat on a Roho cushion. Client B's wheelchair smelled/had an odor. Client B's record was reviewed on 4/23/15 at 10:35 AM and on 4/27/15 at 2:41 PM. Client B's April 2015 Medication Administration Record (MAR)indicated client B's wheelchair was to be cleaned daily. Client B's 4/15			

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	MAR indicated client B's wheelchair was cleaned on 4/4, 4/6, 4/11,4/12, 4/18 and 4/19/15. The MAR indicated "Staff will deep clean [client B's] wheelchair from top to bottom daily. This includes all wheelchair accessories (ie (example): harness, foot rests) to ensure wheelchair cleanliness." Interview with staff #2 on 4/21/15 at 9:49 AM stated she thought the evening shift cleaned client B's wheelchair "every other day." Staff #2 stated client B's wheelchair had a "mildew smell." Interview with staff #1 on 4/22/15 at 8:55 AM stated client B's wheelchair was to be cleaned "nightly by PM (evening) staff." Staff #1 stated "That is a struggle between PM and night staff." Staff #1 indicated the evening shift staff indicate they do not have time to clean his wheelchair and the night staff indicates it should be done by evening staff. 3. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, the 4/21/15 observation period between 5:40 AM and 8:30 AM and on 4/22/15 between 6:25 AM and 7:38 AM, at the group home, client sat upright in his wheelchair for all observation periods. Client B had a blue pillow behind his legs on the leg rests. Facility staff did not			

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	change/adjust client B's wheelchair to a different position, move the client to an alternate surface and/or use a wedge pillow under the client's hips. Client B's record was reviewed on 4/27/15 at 2:41 PM. Client B's risk plans dated 1/22/15 included a plan for impaired skin integrity, "...The key to keeping the skin intact is keeping it dry and pressure free...Pressure can be relieved by repositioning the client and encouraging functional alignment when sitting upright...Staff assist him with changing (every two hours while awake and every 4 hours while sleeping) and any time he is wet and initial off on the MAR (medication administration record). How to re-position [client B] while in wheelchair (every two hours). Staff will use wedge pillow and place under hip and rotate sides, ensuring proper body alignment. Staff will place [client B's] chair in reclining position to relieve pressure. Staff will ensure buttocks are placed far back in chair and footrests adjusted so knees are at or slightly below hips. [Client B] uses a pressure relief cushion in his wheelchair to prevent skin issues. [Client B] uses a hoyer lift for transfers. [Client B] is taken out of his chair and placed in bed or recliner when he gets home from workshop for one hour, to relieve pressure. How to			

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	re-position [client B] while he is in bed (every two hours). Staff will use bed pad to turn [client B] from side to side or supine position. Staff will use pillow to place under bed pad to prop [client B] on side to relieve pressure. Staff will readjust shoulders to avoid poor circulation and use a pillow to place between knees and ankles to keep them from touching. Avoid lying directly on hip bones. When lying on back, keep lower legs up by placing a pillow under the lower part of the legs (mid calf to ankle). [Client B] has a new seat cushion for his wheelchair and a new mattress to help alleviate pressure while sitting and sleeping. [Client B] also wears heel protector boots daily to prevent skin issues. Staff transfers [client B] using a hoyer lift which prevents friction to the skin." Client B's Repositioning records on the MAR for April 2015 indicated client B was to be provided incontinence care and repositioned every two hours. The MAR indicated client B was not repositioned every two hours as indicated by the following: -4/11/15 At 10 PM -4/16/15 At 12 AM, 2 AM and 4 AM and from 10 AM, 12 PM and 2 PM. -4/17/15 At 8 AM.			

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	-4/22/15 At 6 AM, 8 AM, 10 AM, 12 PM and 2 PM. -4/26/15 At 12 AM, 2 AM, 4 AM and 10 PM. -4/27/15 At 12 AM and 4 AM. The April 2015 MAR indicated there was no documentation indicating what position client B had been placed in every two hours to ensure alternative positioning was occurring. Client B's April 2015 MAR for incontinent care indicated the following (not all inclusive): -4/10/15 At 12 PM and 2 PM. -4/11/15 At 10 PM. -4/25/15 At 6 AM. -4/26/15 At 2 AM, 6 AM and 10 AM. An interview was conducted with Program Director (PD) #2 on 4/28/15 at 4:55 P.M. When asked about client B's repositioning schedule being documented, PD #2 stated, "The only place it is documented is on the MAR and it is not that specific. I could see where it would be beneficial to document what side he is positioned in so it is alternated." An interview was conducted with nurse staff #1 on 4/29/15 at 10:47 AM, by phone. Nurse staff #1 indicated client B			

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	had a history of skin break downs. Nurse staff #1 indicated client B should be repositioned and toileted every 2 hours. Nurse staff #1 indicated facility staff were to use a wedge pillow under the hip of the client, transfer the client to a recliner and/or mat. Nurse staff #1 indicated recently staff told her they do not use a wedge pillow. Nurse staff #1 stated facility staff indicated "They do not know where it is." Nurse staff #1 also indicated facility staff told nurse staff #1 client B would refuse to be placed on a mat and/or sit in the recliner. Nurse staff #1 indicated she was not aware of this, as the facility staff were not documenting the refusals. Nurse staff #1 indicated the facility staff were initialing client B was being repositioned, but nurse staff #1 did not know how the client was being repositioned. This federal tag relates to complaint #IN00171811. 9-3-4(a)			
W 0262 Bldg. 00	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection			

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	and rights. Based on interview and record review for 2 of 4 sampled clients (C and D) with restrictive programs, the facility failed to have its Human Rights Committee (HRC) review and/or approve the clients' restrictive behavior programs. Findings include: 1. Client C's record was reviewed on 4/28/15 at 11:10 AM. Client C's 3/12/15 Behavior Plan (BP) indicated client C had a targeted behavior of "...attempting to drink hazards/all liquids regardless of whether they are hazardous for her to drink." Client C's BP indicated the group home's hazardous materials and cleaning supplies were locked due to the client's identified behavior. Client C's 3/29/15 Individual Support Plan (ISP) and/or 3/12/15 BP indicated the facility did not have its HRC review and/or approve the client's restrictive program. Interview with Program Director (PD) #2 on 4/28/15 at 5:10 PM indicated she was not able to locate when the facility's HRC reviewed the client's restrictive program plan. 2. Client D's record was reviewed on 4/28/15 at 3:56 PM. Client D's 3/12/15 BP indicated client D had a targeted	W 0262	**W262 Program Monitoring & Change** The committee should review, approve and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. **1. What corrective action will be accomplished?** · Human Rights Committee will review and/or approve restrictive measures regarding hazardous materials for Client C and D as well as bite protective sleeves for Client D. · The IDT will meet to discuss any needed restrictions when necessary and will seek HRC review and approval after IDT discussion. · Program Director/QIDP will be retrained regarding obtaining Human Rights Committee review and/or approval with any restrictive measures. · Area Director will monitor Human Rights Committee reviews and/or approvals as annual ISPs arise and as BSPs are updated. · Performance Audits, involving review of Human Rights Committee review and/or approval will be completed annually by Quality Assurance. **2. How will we identify other residents having the potential to be affected by the same deficient**	06/12/2015

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	behavior of "...attempting to drink hazards/all liquids regardless of whether they are hazardous for him to drink." Client D's BP indicated the group home's hazardous materials and cleaning supplies were locked due to the client's identified behavior. Client D's BP also indicated the client had a targeted behavior of demonstrating self-injurious behavior (SIB) defined as "Continued chewing on wrist, arm, hand or fingers)." Client D's BP indicated "... [Client D] wears a bite protective sleeve to safeguard himself from injury due to biting his arm...." Client D's 3/29/15 ISP and/or 3/12/15 BP indicated the facility did not have its HRC review and/or approve the client's restrictive program. Interview with Program Director (PD) #2 on 4/28/15 at 5:10 PM indicated she was not able to locate when the facility's HRC reviewed client D's restrictive program. 9-3-4(a)		**practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Human Rights Committee will review and/or approve restrictive measures regarding hazardous materials for Client C and D as well as bite protective sleeves for Client D. · The IDT will meet to discuss any needed restrictions when necessary and will seek HRC review and approval after IDT discussion. · Program Director/QIDP will be retrained regarding obtaining Human Rights Committee review and/or approval with any restrictive measures. · Area Director will monitor Human Rights Committee reviews and/or approvals as annual ISPs arise and as BSPs are updated. · Performance Audits, involving review of Human Rights Committee review and/or approval will be completed annually by Quality Assurance. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Human Rights Committee will review and/or approve restrictive measures regarding hazardous materials for Client C and D as well as bite protective sleeves for Client D. · The IDT will meet to discuss	

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			any needed restrictions when necessary and will seek HRC review and approval after IDT discussion. · Program Director/QIDP will be retrained regarding obtaining Human Rights Committee review and/or approval with any restrictive measures. · Area Director will monitor Human Rights Committee reviews and/or approvals as annual ISPs arise and as BSPs are updated. · Performance Audits, involving review of Human Rights Committee review and/or approval will be completed annually by Quality Assurance. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Human Rights Committee will review and/or approve restrictive measures regarding hazardous materials for Client C and D as well as bite protective sleeves for Client D. · The IDT will meet to discuss any needed restrictions when necessary and will seek HRC review and approval after IDT discussion. · Program Director/QIDP will be retrained regarding obtaining Human Rights Committee review and/or approval with any restrictive measures. · Area Director will monitor Human Rights Committee reviews and/or approvals as annual ISPs arise and as BSPs are updated. · Performance Audits,	

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	15G364		05/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	10311 E JACKSON SELMA, IN 47383

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			involving review of Human Rights Committee review and/or approval will be completed annually by Quality Assurance. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015	
W 0263 Bldg. 00	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE 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. Based on interview and record review for 2 of 4 sampled clients (C and D), the facility failed to obtain written informed consent for the clients' restrictive programs. Findings include: 1. Client C's record was reviewed on 4/28/15 at 11:10 AM. Client C's 3/12/15 Behavior Plan (BP) indicated client C had a targeted behavior of "...attempting to drink hazards/all liquids regardless of whether they are hazardous for her to drink." Client C's BP indicated the group home's hazardous materials and cleaning supplies were locked due to the client's identified behavior.	W 0263	**W263 Program Monitoring & Change** 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. **What corrective action will be accomplished?** · Obtain legal guardian consent for restrictive measures for Client C and Client D hazardous materials and Client D's use of bite protective sleeves. · Program Director/QIDP will be retrained regarding obtaining informed consent from guardians regarding restrictive measures. · Area Director will monitor informed consent from guardians as annual ISPs arise and as BSPs are updated.	06/12/2015

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	Client C's 4/1/15 Individual Support Plan (ISP) indicated client C's sister was the client's guardian. Client C's 3/29/15 ISP and/or 3/12/15 BP indicated the facility did not obtain written informed consent for the client's restrictive program. Interview with Program Director (PD) #2 on 4/28/15 at 5:10 PM indicated she was not able to locate when client C's guardian gave written informed consent for the client's restrictive program plan. 2. Client D's record was reviewed on 4/28/15 at 3:56 PM. Client D's 3/12/15 BP indicated client D had a targeted behavior of "...attempting to drink hazards/all liquids regardless of whether they are hazardous for him to drink." Client D's BP indicated the group home's hazardous materials and cleaning supplies were locked due to the client's identified behavior. Client D's BP also indicated the client had a targeted behavior of demonstrating self-injurious behavior (SIB) defined as "Continued chewing on wrist, arm, hand or fingers)." Client D's BP indicated "...[Client D] wears a bite protective sleeve to safeguard himself from injury due to biting his arm...." Client D's 3/29/15 ISP indicated client D's sister was the client's guardian.		· Performance Audits, involving review of guardian informed consents will be completed annually by Quality Assurance. **1. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Program Director/QIDP will be retrained regarding obtaining informed consent from guardians regarding restrictive measures. · Area Director will monitor informed consent from guardians as annual ISPs arise and as BSPs are updated. · Performance Audits, involving review of guardian informed consents will be completed annually by Quality Assurance. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Program Director/QIDP will be retrained regarding obtaining informed consent from guardians regarding restrictive measures. · Area Director will monitor informed consent from guardians as annual ISPs arise and as BSPs are updated. · Performance Audits, involving review of guardian informed consents will be completed	

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	Client D's 3/29/15 ISP and/or 3/12/15 BP indicated the facility did not obtain written informed consent in regard to the client's restrictive program. Interview with Program Director (PD) #2 on 4/28/15 at 5:10 PM indicated she was not able to locate when client D's guardian gave written informed consent for the client's restrictive program plan. 9-3-4(a)		annually by Quality Assurance. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Program Director/QIDP will be retrained regarding obtaining informed consent from guardians regarding restrictive measures. · Area Director will monitor informed consent from guardians as annual ISPs arise and as BSPs are updated. · Performance Audits, involving review of guardian informed consents will be completed annually by Quality Assurance. **1.What is the date by which the systemic changes will be completed?** · **June 12, 2015**	
W 0268 Bldg. 00	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, interview and record review for 1 of 4 sampled clients (B), the facility failed to ensure the client's dignity in regard to cleaning the client's wheelchair daily to prevent smells/odor. Findings include: During the 4/20/15 observation period	W 0268	**W268 Conduct toward Client** These policies and procedures must promote the growth, development and independence of the client. **1. What corrective action will be accomplished?** · Staff will be retrained regarding procedure and documentation for cleaning Client B's wheelchair daily.	06/12/2015

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	between 4:25 PM and 9:14 PM, the 4/21/15 observation period between 5:40 AM and 8:30 AM and on 4/22/15 between 6:25 AM and 7:38 AM, at the group home, client B utilized a custom made wheelchair which was pushed by staff. Client B sat on a Roho cushion. Client B's wheelchair smelled/had an odor. Client B's record was reviewed on 4/23/15 at 10:35 AM and on 4/27/15 at 2:41 PM. Client B's April 2015 Medication Administration Record (MAR) indicated client B's wheelchair was to be cleaned daily. Client B's 4/15 MAR indicated client B's wheelchair was cleaned on 4/4, 4/6, 4/11,4/12, 4/18 and 4/19/15. The MAR indicated "Staff will deep clean [client B's] wheelchair from top to bottom daily. This includes all wheelchair accessories (ie (example): harness, foot rests) to ensure wheelchair cleanliness." Interview with staff #2 on 4/21/15 at 9:49 AM stated she thought the evening shift cleaned client B's wheelchair "every other day." Staff #2 stated client B's wheelchair had a "mildew smell." Interview with staff #1 on 4/22/15 at 8:55 AM stated client B's wheelchair was to be cleaned "nightly by PM (evening)		**2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Program Coordinator will monitor Client B's wheelchair for cleanliness and review documentation of wheelchair cleaning daily when in the home. · Program Director/QIDP will monitor documentation of Client B's wheelchair cleaning weekly for one month then monthly thereafter. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Program Coordinator will monitor Client B's wheelchair for cleanliness and review documentation of wheelchair cleaning daily when in the home. · Program Director/QIDP will monitor documentation of Client B's wheelchair cleaning weekly for one month then monthly thereafter. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Program Coordinator will monitor Client B's wheelchair for cleanliness and review documentation of wheelchair cleaning daily when in the home. · Program Director/QIDP will	

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	staff." Staff #1 stated "That is a struggle between PM and night staff." Staff #1 indicated the evening shift staff indicate they do not have time to clean his wheelchair and the night staff indicates it should be done by evening staff. 9-3-5(a)		monitor documentation of Client B's wheelchair cleaning weekly for one month then monthly thereafter. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015	
W 0286 Bldg. 00	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used for disciplinary purposes. Based on observation, interview and record review for 1 of 4 sampled clients (B) and for 1 additional client (F), the facility failed to ensure staff did not discipline clients as a result of a behavior. Findings include: The facility's End of Shift Reports (EOS) were reviewed on 4/23/15 at 10:45 AM. The facility's EOS indicated the following (not all inclusive): -2/24/15 Client F "...did his laundry, but didn't fold it. Refused a shower because HM (home manager) said he couldn't have money to go shopping tonight due to not holding up his end of their agreement. Said he wasn't going to do	W 0286	**W286 Mgmt. of Inappropriate Client Behavior** Techniques to manage inappropriate client behavior must never be used for disciplinary action. **What corrective action will be accomplished?** · Home Manager's (Program Coordinator) employment relationship with facility has been severed. · Client F's Behavior Support Plan will be revised to include descriptions of restrictions/consequences to ensure facility staff do not restrict Client F unfairly and/or appear as disciplinary/punitive for client's actions. · Staff will be retrained on client right restrictions, on Client B's Behavior Support Plan and on Client F's Behavior Support Plan.	06/12/2015

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	anything for HM anymore...." -3/5/15 "[Client B] refused to eat breakfast I (staff #6) guess because it wasn't eggs. Started to show out when taking meds (medicine) but staff reminded him that he couldn't go to work shop (sic) unless he took meds and acted appropriately." -4/8/15 "[Client B] started biting self during breakfast for no reason. Client was cussing staff when I (staff #6) was getting him up. Client was placed in his room...." Interview with client B's mother on 4/21/15 at 9:29 AM, by phone, stated client B called her last Monday (4/13/15) stating "Mom help." Client B's mother indicated client B was upset. Client B's mother indicated client A got on the phone and tried to explain what client B was trying to tell her. Client B's mother indicated client A indicated they were having waffles for breakfast but client B wanted eggs and started biting his arm. Client B's mother stated client A stated staff #8 told the client he was having waffles and not eggs when "[staff #6] got involved and held [client B's] arms down and [staff #8] took him (client B) to his room." Client B's mother indicated staff #8 did not know he (staff #8) was not		· Program Coordinator and Program Director will be retrained on client right restrictions. 1. **How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Program Director/QIDP will monitor the residents on an ongoing basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, risk plans and physician orders. · Behavior Analyst will continue at least monthly observations to assist in identifying techniques being used for disciplinary action. · Program Coordinator and Program Director will be retrained on client right restrictions. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Program Director/QIDP will monitor the residents on an ongoing basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, risk plans and physician orders. · Behavior Analyst will continue at least monthly observations to assist in identifying techniques	

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	allowed to put client B in his room when he was having a behavior of biting his arm. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/21/15 at 1:45 PM. The facility's 4/16/15 reportable incident report indicated "[Name of BDDS Coordinator] received call from consumer's mother wanting to report issues with treatment and care of consumer by staff in the group home. Mother (name of client B's mother) reported several issues that consumer has been having with staff at the group home for several months. -Consumer being held down during behaviors causing bruising to his person. -Consumer being put in his room for 'not behaving like an adult'...." Client B's record was reviewed on 4/23/15 at 10:25 AM and on 4/27/15 at 2:41 PM. Client B's May 2014 Behavior Plan (BP) indicated client B demonstrated "Self-injurious behavior (SIB): biting himself, typically on the arms/hands without breaking the skin. 1. Staff should verbally prompt [client B] to stop biting himself. 2. Staff should immediately redirect		being used for disciplinary action. · Program Coordinator and Program Director will be retrained on client right restrictions. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Program Director/QIDP will monitor the residents on a n ongoing basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, risk plans and physician orders. · Behavior Analyst will continue at least monthly observations to assist in identifying techniques being used for disciplinary action. · Program Coordinator and Program Director will be retrained on client right restrictions. **1.What is the date by which the systemic changes will be completed?** 1.June 12, 2015	

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	[client B] to his replacement behaviors. 3. If [client B] continues to self-harm, staff should explain to [client B] that they are putting his protective hand mitts on. Staff should put the mitts on so that his hands and fingers are covered. Staff should say, '[Client B] I did not want you to hurt yourself. You need to stop biting yourself. Adults do not behave this way'...5. Staff should document all incidents of self-injurious behaviors and provide any necessary medical care...." Client B's May 2014 BP indicated facility staff were to utilize a "visual daily schedule" with the client as his replacement behavior. Client B's BP did not indicate facility staff were to take the client to his bedroom when he became upset and/or demonstrated SIB. Client F's record was reviewed on 4/30/15 at 11:06 AM. Client F's 4/20/15 Individual Support Plan (ISP) indicated client F had an objective to recognize when there is inappropriate staffing (home alone, staff leaves in middle of shift, one staff on duty and/or if a staff is sleeping). Client F's 3/19/15 Behavior Support Plan (BSP) indicated "...Teaching Method 12 Please explain to [client F] the natural consequences of non compliant behavior. ie (example), he will miss out on			

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	opportunities to go to the convenience store with staff. Give him real life examples. (If staff does not do what they are asked to do then they have consequences but if they do what they are required to do then they get a paycheck)." Client F's 3/15 BSP did not specifically indicate what restrictions/consequences were to be used with client F to ensure facility staff did not restrict client F unfairly and/or appear as disciplinary/punitive for the client's actions. Client F's 3/19/15 BSP did not indicate the client had any right restrictions in regard to going out into community, in regard to his money/finances and/or in regard to getting seconds by doing chores. Client F's BSP and/or 4/20/15 Individual Support Plan did not indicate the facility's Human Rights Committee (HRC) reviewed the client's BSP and/or reviewed any right's restriction for client F as the HRC representative signature section was blank. Interview with client F on 4/20/15 at 5:46 PM stated he did not like "some" staff at the group home. Interview with client B on 4/21/15 at 12:05 PM, with the day program manager (DPM) present, indicated client B could answer yes and no questions with some			

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	verbalization of words. Client B indicated he did not like the group home and/or staff. Interview with PD (Program Director) #2 on 4/23/15 at 10:30 AM indicated facility staff should not tell a client if he does not take his meds, he will not be able to go to the workshop/day program. PD #2 indicated client B demonstrated SIB. PD #2 indicated client B's BSP did not indicate client B was to be taken to his room when he became upset and/or started biting his arm. This federal tag relates to complaint #IN000171811. 9-3-5(a)			
W 0287 Bldg. 00	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used for the convenience of staff. Based on observation, interview and record review for 1 of 4 sampled clients (C), the facility failed to ensure the use of a gait belt was not being used for staff's convenience. Findings include:	W 0287	**W287 Mgmt. of Inappropriate Client Behavior** Techniques to manage inappropriate client behavior must never be used for the convenience of staff. **1. What corrective action will be accomplished?** · Client C's individual plan will be updated to include when and/or	06/12/2015

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	During the 4/20/15 observation period between 4:25 PM and 9:14 PM, the 4/21/15 observation period between 5:40 AM and 8:30 AM and on 4/22/15 between 6:25 AM and 7:38 AM, at the group home, client C wore a gait belt around her waist. During the above mentioned observation periods, client C ambulated independently without staff assistance, and/or staff held the client by her elbow/arm to assist the client to walk to the living room. Facility staff did not utilize the client's gait belt. Client C's record was reviewed on 4/28/15 at 11:10 AM. Client C's 2/19/15 Quarterly Physical /Internal Medicine Progress Note indicated client C's diagnosis included, but was not limited to, Falls. Client C's quarterly physical indicated "Plan: -use gait belt as directed...." Client C's 4/1/15 Risk Plan indicated client C had a risk plan for falls. Client C's 4/1/15 risk plan indicated "...Staff are to assist clients as needed with ambulation and walking...She typically has a slow wide-based gait. She is very unsteady on uneven surfaces or steps...." Client C's 4/1/15 fall risk plan did not indicate when and/or how facility staff were to use a gait belt with the client.		how facility staff are to use the gait belt. · Staff will be retrained regarding the appropriate use of Client C's gait belt as well as Client C's revised individual plan. · Program Director/QIDP will monitor the residents on an ongoing basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, risk plans and physician orders ·Program Coordinator will monitor use of Client C's gait belt daily when in the home. ·Program Coordinator will monitor documentation of use of Client C's gait belt daily. ·Nurse staff will verify appropriate use of Client C's gait belt when completing monthly nursing assessments. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** a. All residents have the potential to be affected by the same deficient practice. b. Program Director/QIDP will monitor the residents on an ongoing basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, risk plans and physician orders. **1.What measures will be put into**	

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	Interview with staff #9 on 4/20/15 at 7:55 PM stated client C wore a gait belt because she was "Running into walls. Depth Perception issues." Interview with staff #2 on 4/21/15 at 9:49 AM indicated when asked why client C wore a gait belt, staff #2 stated "We use a gait belt to get her up as she won't move. She's stubborn." Staff #2 indicated she was not aware of any falls. Interview with staff #1 on 4/22/15 at 8:55 AM stated client C wore a gait belt due to "depth perception." Staff #1 stated "She steps big and causes her to trip." Staff #1 indicated facility staff were to use the gait belt with client C when they were getting on and off the van. Staff #1 stated they would also use the gait belt "to help her stand up because it can be a struggle to get her up." Interview with Program Director #2 on 4/28/15 at 5:10 PM indicated the use of the gait belt should be in the client's Individual Support Plan/risk plan. 9-3-5(a)		**place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Client C's individual plan will be updated to include when and/or how facility staff are to use the gait belt. · Staff will be retrained regarding the appropriate use of Client C's gait belt as well as Client C's revised individual plan. ·Program Coordinator will monitor use of Client C's gait belt daily when in the home. ·Program Coordinator will monitor documentation of use of Client C's gait belt daily. ·Nurse staff will verify appropriate use of Client C's gait belt when completing monthly nursing assessments. · Program Director/QIDP will monitor the residents on an ongoing basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, risk plans and physician orders. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** ·Program Coordinator will monitor use of Client C's gait belt daily when in the home. ·Program Coordinator will review documentation of use of Client C's gait belt daily when in the home. ·Nurse staff will verify appropriate use of Client C's gait	

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	15G364		05/13/2015

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REM OCCAZIO LLC	10311 E JACKSON SELMA, IN 47383

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			belt when completing monthly nursing assessments. ·Program Director/QIDP will monitor the residents on an ongoing basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, behavior plan, risk plans and physician orders. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015	
W 0318 Bldg. 00	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 3 of 4 sampled clients (B, C and D) and for 2 additional clients (F and G). The facility's Health Care Services failed to ensure its nursing services met the healthcare and nursing needs of each client who resided at the facility. Findings include: 1. The facility's health care services failed to ensure its nursing services met the health care needs of clients. The facility's health care services failed to monitor and supervise staff in regard to	W 0318	**W318 Health Care Services** The facility must ensure that specific health care services requirements are met. **1. What corrective action will be accomplished?** · Health Services Supervisor will retrain nurse on notifying physician of all medication errors and instructions moving forward. · Update risk plans or develop plans for identified risk – Nurse staff will send next three plans to Health Services supervisor for review. · Health Services Supervisor will retrain nurse staff on providing competency based trainings and ensure nurse staff gets copies of those trainings to the Program Director/QIDP for client specific training record. · Health Services Supervisor	06/12/2015

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	medication errors/medication administration, to ensure clients' physicians were contacted in regard to clients' medication errors, updated and/or developed needed risk plans. The facility's health care services failed to ensure facility staff were trained in regard to wound care and documentation. The facility's health care services failed to ensure staff repositioned clients, monitored/assessed a client's health care need and addressed a client's dietary recommendations, addressed a client's weight loss and/or ensured facility staff weighed the client weekly as ordered for clients B, C and G. Please see W331. 2. The facility's health care services failed to ensure staff were initially trained and demonstrated competency in wound care and using a Hoyer Lift for clients B and G. Please see W342. 3. The facility's health care services failed to ensure the facility failed to ensure staff followed doctor's orders in regard to medication administration for clients B, C, D, F and G. Please see W368. 4. The facility's health care services failed to ensure client G's medication was administered without error. Please see W369.		will retrain nurse staff on items reportable to physician and follow up on medical issues in a timely manner (within 24-48 hours). · Nurse staff will train staff on changes in client's orders and plan of care. · Update risk plans/protocols as necessary and ensure staff training to include understanding and competency based training as indicated. · Develop competency based training for wound care and documentation of wound including descriptive terms and any prior pain management to include parameters of time dose, pain scale, when to notify the nurse, documentation and follow up and train staff and verify competency. · Develop competency based training for Hoyer lift and train staff and verify competency · Nurse staff will retrain staff on weekly weights and reportable parameters to the nurse staff. · Nurse staff will review the weights weekly and report changes or patterns to the physician. · Nurse staff will address all orders timely and ensure changes are made to plan of care/ risk plans as needed; update physician's orders or verify the changes to MAR. · Train staff as indicated on plan of care. · Nurse to contact pharmacy for a disposition record or return to pharmacy form and implement in the home and train all staff to use.	

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	This federal tag relates to complaint #IN00171811. 9-3-6(a)		· The disposition record or return to pharmacy form can be kept in the home for verification of what was returned. Two signatures required. · Health Services Supervisor will train Nurse staff on Medication Administration review that is to be done quarterly for three quarters and then at least yearly thereafter. · Staff will be retrained on Client B's repositioning plan and schedule, including use of the wedge pillow. · Staff will be retrained on documenting Client B's repositioning plan and schedule, including how to document client refusals. · Program Coordinator will monitor use of the bed wedge daily when in the home. · Program Coordinator will review documentation of repositioning plan and schedule for Client B daily when in the home. · Program Director will monitor documentation of repositioning plan and schedule for Client B monthly. · Nursing staff will monitor documentation of repositioning plan and schedule for Client B weekly. · Nursing staff will verify use of bed wedge and repositioning plan and schedule when completing monthly nursing assessments with Client B. · Staff training has been completed by facility nurse regarding medication administration procedures.	

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			· All new staff will have 3 medication practicums before passing medications independently. · Nurse staff will monitor the medication administration plan monthly via review of electronic MAR documentation and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. The IDT will then convene to discuss identified needs as necessary and follow up on any needs identified from prior meetings. · Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. **2. How will we identify other**	

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			residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the same deficient practice. · Retrain nurse on notifying physician of all medication errors and instructions moving forward. · Update risk plans or develop plans for identified risk – Nurse staff will send next three plans to supervisor for review. · Retrain nurse staff on providing competency based trainings and ensure nurse staff gets copies of those trainings to the Program Director/QIDP for client specific training record. · Retrain nurse staff on items reportable to physician and follow up on medical issues in a timely manner (within 24-48 hours). · Nurse staff will train staff on changes in client's orders and plan of care. · Update risk plans/protocols as necessary and ensure staff training to include understanding and competency based training as indicated. · Develop competency based training for wound care and documentation of wound including descriptive terms and any prior pain management to include parameters of time dose, pain scale, when to notify the nurse, documentation and follow up and train staff and verify competency. · Develop competency based training for Hoyer lift and train staff and verify	

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			competency · Retrain staff on weekly weights and reportable parameters to the nurse staff. · Nurse staff will review the weights weekly and report changes or patterns to the physician. · Nurse staff will address all orders timely and ensure changes are made to plan of care/ risk plans as needed; update physician's orders or verify the changes to MAR. · Train staff as indicated on plan of care. · Nurse to contact pharmacy for a disposition record or return to pharmacy form and implement in the home and train all staff to use. · The disposition record or return to pharmacy form can be kept in the home for verification of what was returned. Two signatures required. · Medication Administration review to be done quarterly for three quarters and then at least yearly · Staff will be retrained on Client B's repositioning plan and schedule, including use of the wedge pillow. · Staff will be retrained on documenting Client B's repositioning plan and schedule, including how to document client refusals. · Program Coordinator will monitor use of the bed wedge daily when in the home. · Program Coordinator will review documentation of repositioning plan and schedule for Client B daily when in the home. · Program Director will monitor documentation of repositioning plan and schedule for Client B	

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			monthly. · Nursing staff will monitor documentation of repositioning plan and schedule for Client B weekly. · Nursing staff will verify use of bed wedge and repositioning plan and schedule when completing monthly nursing assessments with Client B. · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and	

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			thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Retrain nurse on notifying physician of all medication errors and instructions moving forward. · Update risk plans or develop plans for identified risk – Nurse staff will send next three plans to supervisor for review. · Retrain nurse staff on providing competency based trainings and ensure nurse staff gets copies of those trainings to the Program Director/QIDP for client specific training record. · Retrain nurse staff on items reportable to physician and follow up on medical issues in a timely manner (within 24-48 hours). · Nurse staff will train staff on changes in client's orders and plan of care. · Update risk plans/protocols as necessary and ensure staff training to include understanding and competency based training as indicated. · Develop competency based training for wound care and documentation of wound including descriptive terms and any prior pain management to include parameters of time dose, pain scale, when to notify the nurse, documentation and	

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			follow up and train staff and verify competency. · Develop competency based training for Hoyer lift and train staff and verify competency · Retrain staff on weekly weights and reportable parameters to the nurse staff. · Nurse staff will review the weights weekly and report changes or patterns to the physician. · Nurse staff will address all orders timely and ensure changes are made to plan of care/ risk plans as needed; update physician's orders or verify the changes to MAR. · Train staff as indicated on plan of care. · Nurse to contact pharmacy for a disposition record or return to pharmacy form and implement in the home and train all staff to use. · The disposition record or return to pharmacy form can be kept in the home for verification of what was returned. Two signatures required. · Medication Administration review to be done quarterly for three quarters and then at least yearly · Staff will be retrained on Client B's repositioning plan and schedule, including use of the wedge pillow. · Staff will be retrained on documenting Client B's repositioning plan and schedule, including how to document client refusals. · Program Coordinator will monitor use of the bed wedge daily when in the home. · Program Coordinator will review documentation of repositioning plan and schedule for Client B	

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			daily when in the home. · Program Director will monitor documentation of repositioning plan and schedule for Client B monthly. · Nursing staff will monitor documentation of repositioning plan and schedule for Client B weekly. · Nursing staff will verify use of bed wedge and repositioning plan and schedule when completing monthly nursing assessments with Client B. · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication	

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			practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Retrain nurse on notifying physician of all medication errors and instructions moving forward. · Update risk plans or develop plans for identified risk – Nurse staff will send next three plans to supervisor for review. · Retrain nurse staff on providing competency based trainings and ensure nurse staff gets copies of those trainings to the Program Director/QIDP for client specific training record. · Retrain nurse staff on items reportable to physician and follow up on medical issues in a timely manner (within 24-48 hours). · Nurse staff will train staff on changes in client's orders and plan of care. · Update risk plans/protocols as necessary and ensure staff training to include understanding and competency based training as indicated. · Develop competency based training for wound care and documentation of wound including descriptive terms and any prior pain management	

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			to include parameters of time dose, pain scale, when to notify the nurse, documentation and follow up and train staff and verify competency. · Develop competency based training for Hoyer lift and train staff and verify competency · Retrain staff on weekly weights and reportable parameters to the nurse staff. · Nurse staff will review the weights weekly and report changes or patterns to the physician. · Nurse staff will address all orders timely and ensure changes are made to plan of care/ risk plans as needed; update physician's orders or verify the changes to MAR. · Train staff as indicated on plan of care. · Nurse to contact pharmacy for a disposition record or return to pharmacy form and implement in the home and train all staff to use. · The disposition record or return to pharmacy form can be kept in the home for verification of what was returned. Two signatures required. · Medication Administration review to be done quarterly for three quarters and then at least yearly · Staff will be retrained on Client B's repositioning plan and schedule, including use of the wedge pillow. · Staff will be retrained on documenting Client B's repositioning plan and schedule, including how to document client refusals. · Program Coordinator will monitor use of the bed wedge daily when in the home. ·	

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			Program Coordinator will review documentation of repositioning plan and schedule for Client B daily when in the home. · Program Director will monitor documentation of repositioning plan and schedule for Client B monthly. · Nursing staff will monitor documentation of repositioning plan and schedule for Client B weekly. · Nursing staff will verify use of bed wedge and repositioning plan and schedule when completing monthly nursing assessments with Client B. · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter	

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			monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015	
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 2 of 4 sampled clients (B and C) and for 1 additional client (G), the facility's nursing services failed to meet health care needs of clients. The facility's nursing services failed to monitor and supervise staff in regard to medication errors/medication administration, to ensure clients' physicians were contacted in regard to clients' medication errors, updated and/or developed needed risk plans. The facility's nursing services failed to ensure facility staff were trained in regard to wound care and documentation. The facility's nursing services failed to ensure	W 0331	**W331 Nursing Services** The facility must provide clients with nursing services in accordance with their needs. **1. What corrective action will be accomplished?** · Health Services Supervisor will retrain nurse on notifying physician of all medication errors and instructions moving forward. · Update risk plans or develop plans for identified risk – Nurse staff will send next three plans to supervisor for review. · Health Services Supervisor will retrain nurse staff on providing competency based trainings and ensure nurse staff gets copies of those trainings to the Program	06/12/2015

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	staff repositioned clients, monitored/assessed a client's health care need, addressed a client's dietary recommendations, addressed a client's weight loss, and/or ensured facility staff weighed the client weekly as ordered. Findings include: 1. During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the group home, client G ate her breakfast at 6:49 AM. Staff #1 indicated she was going to pass medications on 4/21/15 and give staff #2 a "break." Client G came to the medication room to get her morning medications at 7:25 AM. Client G assisted staff in administering her own medications as staff #1 would hold a pill bottle (one at a time) and hand it to client G to get a pill out of the bottle. Client G received Omeprazole 40 milligrams 1 tablet at the morning medication pass. Client G's Omeprazole DR (non erosive gastritis) bottle indicated the client was to receive the medication 20 minutes prior to meals. Interview with staff #1 on 4/21/15 at 7:50 AM indicated when asked why client G's Omeprazole was administered after breakfast, staff #1 stated "If she does not take with other meds she will not take it. Our nurse gave us permission to give it after meals versus before meals."		Director/QIDP for client specific training record. · Health Services Supervisor will retrain nurse staff on items reportable to physician and follow up on medical issues in a timely manner (within 24-48 hours). · Nurse staff will train staff on changes in client's orders and plan of care. · Update risk plans/protocols as necessary and ensure staff training to include understanding and competency based training as indicated. · Develop competency based training for wound care and documentation of wound including descriptive terms and any prior pain management to include parameters of time dose, pain scale, when to notify the nurse, documentation and follow up and train staff and verify competency. · Develop competency based training for Hoyer lift and train staff and verify competency · Nurse staff will retrain staff on weekly weights and reportable parameters to the nurse staff. · Nurse staff will review the weights weekly and report changes or patterns to the physician. · Nurse staff will address all orders timely and ensure changes are made to plan of care/ risk plans as needed; update physician's orders or verify the changes to MAR. · Train staff as indicated on plan of care. · Nurse to contact pharmacy for	

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	During the 4/22/15 observation period between 6:25 AM and 7:38 AM, at the group home, client B was sitting at the dining room table having breakfast upon arrival to the group home. Client B sat in his wheelchair until the client left for the day program. The client did not get any medications (8 AM medications). Staff #2 passed clients' medications in the group home on 4/22/15. Interview with staff #1 on 4/22/15 at 7:40 AM by phone indicated client B received his 8 AM morning medications Oxcarbazepine 600mg tablet (for seizures) and Reno Caps Softgel 1 mg (for ulcer healing) after client B got up on 4/22/15 around 6 AM. Staff #1 indicated client B would have behaviors if they gave him the medications before he left for work. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/21/15 at 1:45 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following medication errors: 1. On 2/14/15, "It was reported on Sunday February 15, 2015 at 8pm (sic) that the 8am medications at Selma on February 14, 2015 were not passed. This med (medication) error occurred due to		a disposition record or return to pharmacy form and implement in the home and train all staff to use. · The disposition record or return to pharmacy form can be kept in the home for verification of what was returned. Two signatures required. · Medication Administration review to be done quarterly for three quarters and then at least yearly · Staff will be retrained on Client B's repositioning plan and schedule, including use of the wedge pillow. · Staff will be retrained on documenting Client B's repositioning plan and schedule, including how to document client refusals. · Program Coordinator will monitor use of the bed wedge daily when in the home. · Program Coordinator will review documentation of repositioning plan and schedule for Client B daily when in the home · Program Director will monitor documentation of repositioning plan and schedule for Client B monthly. · Nursing staff will monitor documentation of repositioning plan and schedule for Client B weekly. · Nursing staff will verify use of bed wedge and repositioning plan and schedule when completing monthly nursing assessments with Client B. · Staff training has been completed by facility nurse regarding medication administration	

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	new staff and that this med pass was to occur during a shift change. All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR (medication administration record) at the beginning of their shift. No side effects were seen after this med error. The prescribing doctor was not contacted. Nurse and Program Director (PD) were contacted about this med error. As of 3pm on Monday February 16, 2015, there were still no side effects from this med error." The facility's 2/14/15 reportable incident reports indicated clients B, C, D, F and G did not receive their medications. The facility's 2/18/15 Investigation Summaries for clients B, C, D, F and G indicated staff #2 made the 2/14/15 medication errors. The facility's 2/18/15 investigations indicated in the Factual Findings section "Interview with [staff #2] (DSP) (Direct Support Professional) on February 17, 2015 -Stated that this consumer (clients C, D, F and G on 4 separate summaries) didn't have a med error. -Stated that she (staff #2) doesn't have Therap (facility computerized record system) access and couldn't record on the M.A.R...." The facility's 2/18/15 investigations indicated staff #3 and #4 indicated the clients did not receive their		procedures. · All new staff will have 3 medication practicums before passing medications independently. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. The IDT will convene to discuss identified needs as necessary. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. The IDT will convene to discuss identified needs as necessary. · Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Nurse staff to obtain order for albumin level for Client C as	

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	medications, and were not present when staff #2 administered the medications. Client B's 2/18/15 Investigation Summary under the section entitled Factual Findings, indicated "Interview with [staff #2] (DSP) on February 17, 2015 -Stated this consumer didn't get his medications because she (staff #2) was waiting to do it when the next staff came in to assist her. -Stated that she forgot to do it when the next staff came in. -Stated that she doesn't have Therap access and couldn't record on the MAR...." The facility's investigation and/or reportable incident report failed to indicate what medications did not get administered at the 8 AM medication pass. 2. On 2/18/15, "It was reported to the HM (home manager) on Wednesday February 18, 2015 at 8:15pm that [client C] was accidentally given her 8am medications (due on 2-19-15) at the 4pm med pass on 2-18-15. This med error occurred due staff not have her full concentration and focus on this med error at the time (sic). All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR at the beginning of their shift. No side		recommended by dietary recommendation 1/15. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Retrain nurse on notifying physician of all medication errors and instructions moving forward. · Update risk plans or develop plans for identified risk – Nurse staff will send next three plans to supervisor for review. · Retrain nurse staff on providing competency based trainings and ensure nurse staff gets copies of those trainings to the Program Director/QIDP for client specific training record. · Retrain nurse staff on items reportable to physician and follow up on medical issues in a timely manner (within 24-48 hours). · Nurse staff will train staff on changes in client's orders and plan of care. · Update risk plans/protocols as necessary and ensure staff training to include understanding and competency based training as indicated. · Develop competency based training for wound care and documentation of wound including descriptive terms and any prior pain management to include parameters of time dose, pain scale, when to notify the nurse, documentation and	

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	effects were seen after this med error. The prescribing doctor was not contacted. Nurse and Program Director were contacted about this med error on 2-18-15 right (sic) the HM learned of this error...This certain staff will be retrained over how to properly pass medications." The facility's 2/24/15 Investigation Summary indicated staff #5 made the medication error. The facility's 2/18/15 investigation indicated staff #5 "...Stated that she would be willing to go thru (sic) additional training for med passes...." 3. On 2/26/15, "It was reported that on Thursday February 26, 2015 at 8pm that staff (staff #5) completed a med error with [client G] (client G). Staff forgot to give [client G] one of her medications. This med error occurred due to staff not realizing that [client G] had this medication. This medication is new to [client G]. All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR and their messages at the beginning of their shift. The home manager was reminded to inform all staff about any changes in the consumers' medications. No side effects were seen after this med error. The prescribing doctor was not contacted. Nurse and Program Director were contacted about this med error. As of 4:30pm on Friday		follow up and train staff and verify competency. · Develop competency based training for Hoyer lift and train staff and verify competency · Retrain staff on weekly weights and reportable parameters to the nurse staff. · Nurse staff will review the weights weekly and report changes or patterns to the physician. · Nurse staff will address all orders timely and ensure changes are made to plan of care/ risk plans as needed; update physician's orders or verify the changes to MAR. · Train staff as indicated on plan of care. · Nurse to contact pharmacy for a disposition record or return to pharmacy form and implement in the home and train all staff to use. · The disposition record or return to pharmacy form can be kept in the home for verification of what was returned. Two signatures required. · Medication Administration review to be done quarterly for three quarters and then at least yearly · Staff will be retrained on Client B's repositioning plan and schedule, including use of the wedge pillow. · Staff will be retrained on documenting Client B's repositioning plan and schedule, including how to document client refusals. · Program Coordinator will monitor use of the bed wedge daily when in the home. · Program Coordinator will review documentation of repositioning plan and schedule for Client B	

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	February 27, 2015, there were still no side effects from this med error." The facility's 3/3/15 follow-up to the 2/26/15 reportable incident report indicated client G did not receive her ordered Xanax .25 milligrams (controlled substance-skin picking). 4. On 3/1/15, "It was reported that on Sunday March 1, 2015 at 8pm that staff (staff #4) completed a med error with [client G]. Staff forgot to give [client G] her Xanax (Alprazolam) .25mg tablet. [Client G] is to receive this medication 2 times a day. All staff are reminded to follow the 6 rights of medication administration. All staff are reminded to check the MAR and their messages at the beginning of their shift. The home manager was reminded to inform all staff about any changes in the consumer's medications. No side effects were seen after this med error. The prescribing doctor was not contacted. Nurse and Program Director were contacted about this med error...At house meeting on Wednesday all staff (including the staff who made the error) will be retrained by the HM and PD (Program Director)." The facility's 3/3/15 Incident Management Quality Review indicated "Nurse Recommendations (if		daily when in the home · Program Director will monitor documentation of repositioning plan and schedule for Client B monthly. · Nursing staff will monitor documentation of repositioning plan and schedule for Client B weekly. · Nursing staff will verify use of bed wedge and repositioning plan and schedule when completing monthly nursing assessments with Client B. · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication	

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	applicable):" was blank. 5. On 3/14/15, "It was discovered that at 11am on Saturday March 14, 2015 that [client B] had a med error. [Client B's] Oxcarbazepine 600mg tablet (for seizures) and Reno Caps Softgel 1 mg (for ulcer healing) were not passed. The weekend day staff discovered this med error. Normally the 3rd (third) shift staff (staff #2) passes the morning 8am medications. [Client B] was the only consumer in this house that 3rd shift staff forgot to pass the medications for...The staff was reminded to follow the 6 rights of medication administration. This staff was reminded to check the MAR at the beginning of the med pass, during the med pass, and after the med pass. No side effects were seen after this med error. The prescribing doctor was not contacted. Home Manager and Program Director was (sic) contacted about this med error. As of 8pm that day, there still were no side effects from this med error...." The facility's 3/20/15 Incident Management Quality Assurance Review indicated the facility's nurse did not review and/or make any recommendations in regard to 3/14/15 medication error as the nurse's section was blank.		practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Nurse staff to obtain order for albumin level for Client C as recommended by dietary recommendation 1/15. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Retrain nurse on notifying physician of all medication errors and instructions moving forward. · Update risk plans or develop plans for identified risk – Nurse staff will send next three plans to supervisor for review. · Retrain nurse staff on providing competency based trainings and ensure nurse staff gets copies of those trainings to the Program Director/QIDP for client specific training record. · Retrain nurse staff on items reportable to physician and follow up on medical issues in a timely manner (within 24-48 hours). · Nurse staff will train staff on changes in client's orders and plan of care. · Update risk plans/protocols as necessary and ensure staff training to include understanding and competency based training as indicated. · Develop	

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	6. On 3/23/15, "It was reported on Monday March 23, 2015 at 8pm that [client F] didn't receive his 8am medications that morning. Those missed medications include (Chlorhexidine 0.12% Rinse-15ml (milliliters) (Gingivitis); Invega ER 9 MB tablet (psychosis); Lisinopril 10 mg-(Hypertension); and Topiramate 50 MG tablet (Mood stabilizer). Staff was reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR at the beginning of their shift. No side effects were seen after this med error. The prescribing doctor was not contacted. Home Manager and Program Director was (sic) contacted about this med error. As of 3-25-15, there were still no side effects from this med error...." The facility's 3/27/15 Investigation Summary indicated staff #6 had made the error on 3/23/15. The facility's 3/27/15 Incident Management Quality Assurance Review indicated the facility's nurse did not make any recommendations as the Nurse's area was blank. 7. On 4/5/15, "It was reported on Sunday April 5, 2015 at 4pm that the 8am		competency based training for wound care and documentation of wound including descriptive terms and any prior pain management to include parameters of time dose, pain scale, when to notify the nurse, documentation and follow up and train staff and verify competency. · Develop competency based training for Hoyer lift and train staff and verify competency · Retrain staff on weekly weights and reportable parameters to the nurse staff. · Nurse staff will review the weights weekly and report changes or patterns to the physician. · Nurse staff will address all orders timely and ensure changes are made to plan of care/ risk plans as needed; update physician's orders or verify the changes to MAR. · Train staff as indicated on plan of care. · Nurse to contact pharmacy for a disposition record or return to pharmacy form and implement in the home and train all staff to use. · The disposition record or return to pharmacy form can be kept in the home for verification of what was returned. Two signatures required. · Medication Administration review to be done quarterly for three quarters and then at least yearly · Staff will be retrained on Client B's repositioning plan and schedule, including use of the wedge pillow. · Staff will be retrained on documenting Client B's repositioning plan and schedule,	

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	medications for [client B] were not passed earlier that day...This med error occurred due to confusion of who was going to pass his medications. All staff were reminded to communicate with each other during shift changes. All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR at the beginning of their shift. No side effects were seen after this med error. The prescribing doctor was not contacted. Nurse and Program Director were contacted about this med error." The facility's 4/14/15 follow-up report to the 4/5/15 reportable incident report indicated client B did not receive his 8 AM Oxcarbazepine and Reno Softgel medications. The facility's 4/14/15 Investigation Summary indicated staff #2 had left client B's medications to be administered by the day shift staff "...per the day shift's request...." The facility's 4/14/15 Incident Management Quality Assurance Review indicated recommendation by the facility's Area Director (AD) of "Follow MAR & (and) med pass protocol. Med Practicum with staff." The facility's nursing services failed to address/monitor		including how to document client refusals. · Program Coordinator will monitor use of the bed wedge daily when in the home. · Program Coordinator will review documentation of repositioning plan and schedule for Client B daily when in the home · Program Director will monitor documentation of repositioning plan and schedule for Client B monthly. · Nursing staff will monitor documentation of repositioning plan and schedule for Client B weekly. · Nursing staff will verify use of bed wedge and repositioning plan and schedule when completing monthly nursing assessments with Client B. · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and	

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	staff #2 in regard to her pattern of medication errors. 8. On 4/12/15, "It was reported that [client B] was not given his 8am on Sunday April 12th. [Client B] did not receive the following medications. OXCARBAZEPINE 600 MG TABLET for seizures & RENO CAPS SOFTGEL 1mg for Ulcer Healing. The med error occurred due (sic) confusion between the 3rd shift staff and the day shift staff who was going to pass [client B's] medications. All staff were reminded to communicate with each other during shift changes. All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR at the beginning of their shift. Record of discussion was completed with the staff. No side effects were seen after this med error. The prescribing doctor was not contacted. This med error was reported late to the Nurse and the Program Director." The facility's 4/14/15 Investigation Summary indicated staff #2 was the staff who made the medication error. The facility's investigation indicated staff #2 "...Stated that she left [client B's] medications to be done by the following staff per the day shift's request. - Stated that she completed everyone else's med		thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Nurse staff to obtain order for albumin level for Client C as recommended by dietary recommendation 1/15. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Retrain nurse on notifying physician of all medication errors and instructions moving forward. · Update risk plans or develop plans for identified risk – Nurse staff will send next three plans to supervisor for review. · Retrain nurse staff on providing competency based trainings and ensure nurse staff gets copies of those trainings to the Program Director/QIDP for client specific training record. · Retrain nurse staff on items reportable to physician and follow up on medical issues in a timely manner (within 24-48 hours). · Nurse staff will train staff on changes in	

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	passes...." The facility's 4/14/15 investigation indicated staff #7 stated that when she came in for her shift she forgot that she wanted to pass [client B's] medications...." The facility's 4/14/15 investigation failed to indicate why the day shift passed client B's medication versus the third shift. The facility's 4/14/15 Incident Management Review indicated the AD recommended on 4/15/15 to complete a medication practicum with staff (#2). The 4/14/15 incident form indicated the facility's nurse did not review the incidents and/or make any recommendations. The facility's incident review form and/or 4/14/15 investigation indicated the facility nursing services failed to address staff #2's pattern of medication errors (4) with client B. The facility's above mentioned reportable incident reports/medication errors indicated the facility's nursing services failed to notify clients B, C, D, F and G's physicians in regard to the medication errors. The facility's nursing services failed to monitor and/or provide oversight of the staff when passing medications to ensure staff were competent to pass medications without error. The facility failed to ensure its nursing services recommended needed		client's orders and plan of care. · Update risk plans/protocols as necessary and ensure staff training to include understanding and competency based training as indicated. · Develop competency based training for wound care and documentation of wound including descriptive terms and any prior pain management to include parameters of time dose, pain scale, when to notify the nurse, documentation and follow up and train staff and verify competency. · Develop competency based training for Hoyer lift and train staff and verify competency · Retrain staff on weekly weights and reportable parameters to the nurse staff. · Nurse staff will review the weights weekly and report changes or patterns to the physician. · Nurse staff will address all orders timely and ensure changes are made to plan of care/ risk plans as needed; update physician's orders or verify the changes to MAR. · Train staff as indicated on plan of care. · Nurse to contact pharmacy for a disposition record or return to pharmacy form and implement in the home and train all staff to use. · The disposition record or return to pharmacy form can be kept in the home for verification of what was returned. Two signatures required. · Medication Administration review to be done quarterly for three quarters and then at least yearly · Staff will be	

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	corrective actions/measures to prevent medication errors. The facility's nursing services failed to address the pattern of medication errors with staff #2 which involved client B. Client G's record was reviewed on 4/22/15 at 5:05 PM. Client G's 3/31/15 physician's orders indicated client G received Omeprazole 40 milligrams 20 minutes before breakfast daily for 3 months. Client G's April's 2015 MAR indicated client G received Alprazolam (skin picking) 0.25 milligrams, Artificial tears (dry eyes) daily at 8:00 Baclofen (Cerebral Palsy) 10 milligrams, Calcium 500+D (Menopause) two times a day, Citalopram HBR(hydrobromide) 40 milligrams (Depressive Disorder), Cranberry Juice three times a day, Divalproex Sod DR (delayed release) 500 milligrams (Seizure Control), Ocala (stool softener)100 milligrams daily, Loratadine (allergy) 10 milligrams, Oxybutynin CL (chloride-incontinence) ER (extended release) 5 milligrams and Santyl (wound care dressing) dressing. Client G's April, 2015 MAR indicated client G did not receive her morning medications at the 8 AM medication pass on 4/22/15 as there was no documentation/initials for the medication		retrained on Client B's repositioning plan and schedule, including use of the wedge pillow. · Staff will be retrained on documenting Client B's repositioning plan and schedule, including how to document client refusals. · Program Coordinator will monitor use of the bed wedge daily when in the home. · Program Coordinator will review documentation of repositioning plan and schedule for Client B daily when in the home · Program Director will monitor documentation of repositioning plan and schedule for Client B monthly. · Nursing staff will monitor documentation of repositioning plan and schedule for Client B weekly. · Nursing staff will verify use of bed wedge and repositioning plan and schedule when completing monthly nursing assessments with Client B. · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. ·	

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	pass. Client B's record was reviewed on 4/23/15 at 10:35 AM. Client B's 2/13/15 Quarterly physical (physician's order) indicated client B received Oxcarbazepine 600 milligrams in the morning and 1 Reno Caps daily. Client B's April 2015 MAR indicated client B received the Reno Capsule in the morning at 8 AM. Client B's 2/13/15 Quarterly Physical indicated client B's diagnosis included, but was not limited to, Epilepsy Unspecified. Client C's April 2015 MAR was reviewed on 4/23/15 at 7:15 AM. Client C's April 2015 MAR indicated client C received the following medications at the 8:00 AM medication pass: Calcium Carb/D 500-400 (supplement) chew three times a day, Polyethylene Glycol (constipation) daily at 8 AM, Primidone (Seizures) 250 and milligrams two times a day. Client D's April 2015 MAR was reviewed on 4/23/15 at 7:15 AM. Client D's April 2015 MAR indicated client D received the following medications at 8:00 AM: Calcium Carb (nutritional supplement) 500 milligrams, Carnation Instant Breakfast (supplement) and Chlorhexidine Rinse 0.12% for		Program Coordinator will monitor the MAR daily for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Nurse staff to obtain order for albumin level for Client C as recommended by dietary recommendation 1/15. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015	

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	periodontal disease. Client F's April 2015 MAR was reviewed on 4/23/15 7:15 AM. Client F's April 2015 MAR indicated client F received the following 7:00 AM and 8:00 AM medications: Chlorhexidine Rinse (gingivitis), Invega (Psychosis) ER 9 milligrams, Lisinopril (Hypertension) once daily and Topiramate (mood) 50 milligrams two times a day. The facility's End of Shift (EOS) reports were reviewed on 4/23/15 at 10:45 AM. The facility's 3/1/15 report indicated "...I (staff #7) came across [client E's] medication that is on hold was passed this morning. there (sic) is (sic) only supposed to be 56 left and there is (sic) 50 left. The hole for this morning was also marked on the MAR. I called the HM (home manager) and informed her of what I had found. She said she would handle it...." Review of the facility's reportable incident reports from February 2015 to the present indicated the HM did not report client E's medication error. The facility's Inservice records were reviewed on 4/22/15 at 10:55 AM. The facility's inservice records indicated facility staff were retrained in regard to Medication Pass/administration on 3/4/15 and on 4/1/15. The facility's 4/1/15			

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	Inservice Meeting record indicated staff #2 was retrained in medication administration on 4/1/15. Staff #2 did not attend the 3/4/15 training. Staff #2's personnel record was reviewed on 4/22/15 at 4:05 PM. Staff #2's personnel record indicated staff #2 Core A and B (state training to pass medications) was A-88% and B-88%. Staff #2's personnel record indicated Staff #2 received a Record of Discussion Form on 4/1/15. The form indicated "90 Day check up; Discuss Med Pass, MARs, Documentation...[Staff #2] is having difficulties w/ (with) passing meds, documenting, following orders, etc. DSP (staff #2) will contact HM/PD if needs additional training. DSP to correct these issues/concerns." Review of the facility's reportable incident reports indicated staff #2 continued to have medication errors after her 4/1/15 record of discussion. Confidential interview A indicated facility staff documented medications were given when clients' medications had not been administered. Confidential interview A indicated there had been more medication errors at the group home than had been reported. Confidential interview A indicated when meds were not given, they would be returned to the pharmacy.			

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	Confidential interview E indicated the third shift staff would make medication errors on the weekend. Interview with the Area Director (AD) and the Program Director (PD) on 4/21/15 at 3:00 PM indicated the facility's nurse would conduct the core A and B training. The PD and the AD indicated the group home manager would do the medication Practicum which would initially be done before staff could actually pass medications. The PD and the AD indicated they were aware the home was having problems with medication errors. The PD indicated they had discussed and retrained staff in regard to the medication administration policy at staff meetings and by doing medication practicums. The PD and the AD stated the group home manager was doing one "random" medication practicum a week. The PD stated if there was a medication error, the staff would receive a "Record of Discussion before you get a written warning." The PD and AD indicated the facility's nurse did not participate in staff meetings and did not conduct any medication practicums. The PD and the AD indicated the staff continued to have medication errors. The AD indicated their corrective action had not been working in regard to retraining			

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	staff. The PD indicated they were aware of the issues with staff #2. The PD stated they were working with HR (Human Resources) "to do a final warning. We tried retraining and that's why we are going to HR." The PD indicated staff #2 was still allowed to pass medication. The PD stated "She is unsure how to help him (client B)." The PD and AD indicated staff #2 was not sure how to administer client B's medication to the client as he would get upset at times. The PD and the AD indicated they had not provided any additional training with staff #2 to assist the staff to be able to handle and/or pass medications to client B. The PD indicated the facility had retrained staff in regard to the 6 rights of medication and medication administration. The PD and the AD indicated they were not aware of any false documentation in the group home. The PD indicated no clients and/or additional staff were interviewed in regard to the medication errors. Interview with staff #1 on 4/22/15 at 8:55 AM stated she completed med practicums "1 time a month and as needed as they tell me to do so." Staff #1 stated "Every med error gets a practicum up to 3 and then a verbal write up." Interview with the PD on 4/22/15 at 11:01 AM stated the facility just started			

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	doing the "random" Medication Practicums one to one and a half weeks ago. The PD indicated the manager had only done 1 random practicum and that was on 3/4/15. The other medication practicums were done last week with different staff. When asked if client G received her AM medications on 4/22/15, the PD indicated she had asked the manager and the manager indicated staff #2 did administer client G's medications but did not sign the MAR. When asked how they knew she administered the medications, the PD indicated the medication sticker/label was in the book which came off the medication packet. The PD indicated the manager stated staff #2 passed the medications. The PD indicated it did not appear the manager was with staff #2 when staff #2 passed the medications. Interview with the State Director on 4/22/15 at 11:55 AM indicated she was told the facility was monitoring staff #2 and she was not to pass medications unless the manager was present with her. The State Director indicated this was to have started a week ago. Interview with nurse staff #1 on 4/22/15 at 4:26 PM, by phone, stated if there is a medication error, "They should contact the the doctor immediately." Nurse staff			

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	#1 indicated the client's doctor should still be contacted even if it the error was discovered at a later date. Nurse staff #1 indicated she was not always informed when a medication error occurred. Nurse staff #1 stated "Only if informed of med errors." Nurse staff #1 stated she was aware of a medication error with client B in April, but "it was after the fact." Nurse staff #1 indicated client B did not get his medications on a Saturday and a Sunday. Nurse staff #1 indicated she would check the MARs when she was in the group home. Nurse staff #1 indicated there may have been some medication errors in the group home in March 2015. Nurse staff #1 indicated the group home's medication errors were due to staff signing/initialing the MAR as if the medications were given, but they had not been given. Nurse staff #1 indicated she did not monitor the group home in regard to medication errors. Nurse staff #1 indicated the HM and the PD trained and/or retrained staff. Nurse staff #1 stated "I do not monitor med passes unless I am asked to do so." Nurse staff #1 indicated if medications are not given, the pills would be returned to the pharmacy. Nurse staff #1 indicated there was no tracking/documentation to show how much medication was being returned to the pharmacy. When asked when client G should take her Omeprazole,			

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	Nurse staff #1 indicated it would probably be before she ate breakfast, but it would depend how it was written on the physician's orders. When asked if she gave staff permission to give client G the Omeprazole after breakfast when she had an order to be administered 20 minutes before her meal, nurse staff #1 stated "No." Nurse staff #1 indicated there would have to be an order to do that. Nurse staff #1 indicated she may have given permission one time for them to do that, but it would have been for that one time. Nurse staff #1 indicated she could not remember doing that. The facility's Medication Practicums (Medication Administration Skills Checklist) were reviewed on 4/22/15 at 10:55 AM. The checklists indicated the Home Manager completed the checklists. The checklists indicated the manager did a medication practicum with staff #2 on 4/14/15. The 4/14/15 practicum/checklist indicated staff #2 had check marks in the "Satisfactory" column. Review of the Medication skills checklist from 10/14 to 4/15 indicated the facility's nursing services did not conduct any medication practicum's with staff. Review of the facility's Medication Practicums indicated the Home Manager conducted one random checklist prior to			

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	April 2015 on 3/4/15 with staff #8. 2. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, at the group home, client G spent the majority of her time in her bedroom except to take a shower, to eat and to get her night time medications. At 4:55 PM, when client G came out of her bedroom to the dining room, client G sat on a seater walker wearing a gait belt and an ace wrap/bandage around her head. The ace wrap/bandage went around each side of the client's face and under her chin. Client G had a hat over top of the ace wrap. At 6:18 PM, client G carried her dishes to the kitchen and she scooted her seat walker with her feet. Client G then went outside and smoked a cigarette on the back patio. Once client G returned inside the house, the client went to her bedroom. At 7:10 PM, when the client went to get her 8:00 PM medications, client G no longer had her head wrapped. Client G had a large open area at the top of her head. The open area was about the size of a quarter with an irregular shape. The open area had a red edge around it. Part of the edges had a red wet substance around the edges. The open area was surrounded by a larger area about the size of a half dollar. The larger area had hair missing. Staff #10, who was administering the medication, sprayed a			

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	numbing spray (American 20 percent) on the area, placed a Saline Solution on a gauze pad and sat it on top of the open area and then placed another dry gauze pad on top of the wet gauze and then applied a clean ace bandage around the gauze and the client's head. Staff #10 then took some tape strips and taped the ace wrap underneath client G's chin. Interview with staff #10 on 4/20/15 at 7:14 PM indicated client G had removed her head wrap. Staff #10 indicated the area on top of client G's head had gotten smaller. Staff #10 indicated client G was going to the wound clinic for treatment. When asked how client G got the area, staff #10 stated client G "picked it." During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the group home, client G did not have the ace wrap on while client G was asleep in her bed at 5:50 AM. At 6:05 AM, client G woke up and went to the bathroom. Client G did not have the ace wrap/bandage on. At 6:38 AM, when client G came into the dining room, the client's open area was dry looking and the edges around the open area were dark red in color. When client G got her morning medications, staff #1 treated client G's head by putting Santyl (debriding ointment which cleans wounds) on a			

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	gauze bandage and then placed Saline solution on a bandage and placed the bandage on top of client G's head. Staff #1 then took a clean ace wrap and wrapped it around the client's head and placed 2 tape strips on the ace wrap under client G's chin. Staff #1 and #10 did not clean client G's wound during both observation periods. The facility's End of Shift (EOS) reports were reviewed on 4/23/15 at 10:45 AM. The EOS reports indicated the following (not all inclusive): -2/23/15 "[Client G] had been picking her scalp as there was blood all over her mattress...." -2/24/15 "Client G] was picking at scalp today. I pulled her bed sheet so she will need to make her bed when she gets home. Sheet had lots of blood on it...." -2/27/15 "[Client G] kept taking off bandage and picking...." -3/4/15 "[Client G] large head wound looks better but it looks like she has been picking at the smaller on (sic) now. Iced foot and redid wound on head...." -3/6/15 "[Client G] had head wound uncovered today and it looked like she			

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	had been picking at it. re (sic) did wound care...." -3/11/15 "[Client G] started picking at the smaller wound on her head again...." -3/13/15 "[Client G] took wound cover off during the night and I replaced it. When went to ice foot she had taken it off again. Replaced it and while getting dressed again took off cover." -3/15/15 "...Keeps taking head wrap off...." -3/16/15 "[Client G] keeps picking at head...." -3/17/15 "...[Client G] went to the wound clinic to have her head checked out. Her wound went from 2.8 inches in width to 1.8 which is greatly improving...." -3/18/15 "[Client G] took wrap off twice this am. She had been picking at it and it looks red and wet." -3/19/15 "[Client G] took off her headwrap least 5 times...." -3/19/15 at 10:34 PM, "[Client G] took off her head bandage several times. She has been rolling up the bandage neatly when she takes it off. She also started			

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	picking at the smaller wound on her head again." -3/24/15 "[Client G] took wound cover off several times last night...." -3/30/15 "[Client G] took off her head wrap a couple of times. Picked at her wound...." -4/1/15 "...Only took the bandage off of head once,...." -4/2/15 "[Client G] keeps taking off wrap...." -4/9/15 "[Client G] had head wrap off this am. Didn't see her picking at head...." -4/10/15 "[Client G] only took her dressing off a couple of times...." -4/11/15 "...Keeps taking head wrap off and trying to pick head wounds...." -4/13/15 "[Client G] has head wrap off and staff caught client picking at scalp while in bathroom getting dressed...." -4/22/15 "[Client G] keeps taking off head wrap...." Client G's record was reviewed on			

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	4/22/15 at 5:05 PM and on 4/27/15 at 2:30 PM. Client G's Skin/Wound Assessments documented by Direct Support Professionals (DSPs) indicated the following (not all inclusive): -2/4/15 "client (sic) picked head during the night as there was blood on the bed." -2/6/15 "scalp (sic) looks very red and irritated (sic) client (sic) was observed picking while getting dressed...." -2/9/15 "area (sic) looks larger and was red today. client (sic) seen picking at scalp in am." -2/10/15 "scalp (sic) wound looks bad, infection present and has been picking at it as it looks bigger today (sic)" -2/11/15 "Wounds on head looking slightly better than they were...." -2/19/15 "Wound on head has some infection sitting on top. Doesn't really look red...." -2/20/15 "client (sic) was picking at larger wound this am. Looks red and has a little infection in it." -2/22/15 "wound (sic) on head all other skin in tact (sic)"			

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	-2/23/15 "Wound on head looked dark and red on the outside...." -2/24/15 "Scalp looks worse than yesterday. Client was picking at head in the am...." -2/24/15 "Went to wound center today. Has a bandage on head to cover wound. Was instructed not to remove it...." -2/26/15 "Changed head dressing, looks better than it did yesterday...." -2/27/15 "was caught a couple times taking off her wrap and picking at her head...." -3/4/15 "I (staff #6) think she may be picking at the wound that isn't covered. Looked larger and red." -3/6/15 "Client had pulled of (sic) wound cover and has been picking at area on scalp (sic) Staff replied (sic) dressing to wound. Looks like it is trying to heal." -3/8/15 "Head ulcer is healing nicely." -3/11/15 "Wound on head continues to heal and looks better. Has started to pick at her smaller wound again."			

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	-3/13/15 "Large wound is looking much better. Client won't leave the wrap on and is picking at the smaller wound. It was larger this am and looked runny." -3/13/15 "Large area looks much improved. Client left dressing on through the night. Client has been picking the smaller on it and it has doubled in size (sic). Put medication on as directed." -3/16/15 "Client had bandage off this am and area looked red...." -3/17/15 "Client has been picking at her head today. area (sic) was open and had been bleeding. Staff covered the area again and also put bandage on front area wound." -3/18/15 at 9:55 AM, "Client continued to take off wound wrap and had been picking at the larger area...." -3/18/15 at 9:50 PM, "Wound on head continues to heal. Is now nearly half the size...." -3/20/15 "Client continues to take wound wrap off. The area in the front looks like it is deeper than it was yesterday. Back area look red and runny today."			

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	-3/23/15 "Wound on head have (sic) been picked at during the night as client won't keep wrap on them...." -3/26/15 "smaller (sic) wound look (sic) better and is drying up. The wound is red and looks infected. wound (sic) has several areas that are deep." -3/27/15 "larger (sic) wound has been picked at. smaller (sic) wound is larger and deep...." -3/30/15 "Larger wound on head had been picked at. Smaller wound remains the same...." -4/1/15 "Wounds on the head remain the same. No no new wounds or lesions...." -4/7/15 "The wound on her head is healing and looking a lot better even stated by the doctor that it is looking better and healing." -4/8/15 "Larger wound on head has been picked at. Smaller one continues to heal." -4/14/15 "...Won't leave spots on head alone. Keeps trying to scratch them." -4/14/15 (PM note) "client (sic) took wrap off during the night. Scalp looks			

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	like it has a little blood on it...." -4/16/15 "...Wounds on head continue to heal." -4/18/15 "No new skin wounds. Wounds on head continue to heal." -4/22/15 "Wound on head is the same. Smaller wound on head has been picked at...." -4/23/15 "...Wounds on head continue to heal." -4/24/15 "Large wound on head remains the same. Smaller wound is healing. No new wound or lesions...." Client G's 2/16/15 Internal Medicine Progress Notes (Final Report) indicated client G was "...seen at local Urgent care where patient was apparently felt to have skin cancer of the scalp...." The doctor's report indicated at the time of the 2/16/15 visit, they were not able to obtain the urgent care report. The note indicated "...DDx (diagnoses) include, chronic infection, ongoing trauma (scratching), vasculitis (inflamed blood vessels), impaired healing due to poor nutrition, or malignancy., Scalp ulceration...-Wound Clinic referral, POWER ORDERS (weight gain supplement)...Outside			

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	Dermatology Consult (order)...For: non healing scalp ulcer,...." Client G's 2/19/15 Appointment form indicated client went to see a dermatologist for the area on top of her head. The form indicated "dermatologist (sic) is unable to care for wound. prescribed (sic) vinegar soaks until seen by wound care (sic)." Client G's Consultation Forms indicated the following wound clinic notes (not all inclusive): -2/24/15 Client G went to the wound center due to an "Open wound on head." The form indicated "Twice daily scalp ulcer needs to be washed thoroughly. Apply Santyl 1/16" (inch) thick and moist gauze. Retain in place with ace wrap. May use Benzocaine 20% (percent) spray to anesthetic before each cleaning. All remnants of the Santyl ointment need to be removed before new Santyl is applied." An attached Physician Orders/Patient Instructions sheet indicated client G's wound was to be cleaned with "saline." The form indicated "Diagnosis: Trauma." -3/17/15 Client G returned to the wound center. The form indicated "scalp ulcer. See copy of Dr's orders." The physician's			

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	orders indicated "Wound care instructions...Steps to complete for wound care BID (two times a day). 1. Clean area with soap and water & (and) pat dry. 2. Use Benzocaine spray as directed on MAR (Medication Administration Record). Apply Santyl cream as directed on MAR. 4. Apply wet gauze pad using saline. 5. Cover with dry dry (sic) gauze pad. Wrap/secure dressing with Ace bandage." Client G's physician's orders indicated Altabax 1% ointment (topical for skin infections) was still on the client's 3/17/15 physician's order. The medication was started on 1/5/15. -4/7/15 Client G went to the wound center for "Wound Care." "Visit at wound center for ulcer assessment/re-evaluation. Changes in treatment plan made. Wound care instructions (Prisma dressing)...Wound care instructions for wound on head: 1. Clean area with saline. 2. Apply slightly moistened Prisma dressing. 3. Apply gauze pad. 4. Apply Ace wrap. Change dressing every other day." An attached 4/7/15 Physician Orders/Patient Instructions indicated "(1) Head parietal (front area of head) area -Stop Santyl. Apply slightly moistened Prisma, gauze, Ace wrap. (Clean with saline)." The form indicated "Diagnosis: Factitial			

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	(self-inflicted lesions of the skin)." Client G's Medication History indicated the following (not all inclusive): -2/10/15 Client G was placed on Cephalexin 500 milligrams (mg) three times a day for 10 days "Antibiotic for lesions on head." -2/25/15 Client G was placed on Alprazolam 0.25 mg twice a day to "Decrease anxiety to decrease skin picking." -3/17/15 Client G's Prisma wound dressing was discontinued as a new wound order was obtained (returned to using Santyl dressing). -4/25/15 "Complete wound care, as instructed in scheduled medications section, as needed if [client G] is picking at her wound." Client G's 2/18/15 Physical Form completed by the facility's nurse indicated client G had an "Opened area on top of head-ulceration." The form indicated "Met with [client G] at her home for initial visit. [Client G] placed on high-risk monitoring due to current decline in health; health issues. [Client G] has ulceration on her head that is 4			

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	1/2" in diameter & 2 1/2" in long. Area is red, moist, opened. 0 (zero) bleeding, 0 drainage, 0 foul odor. [Client G] is currently on an antibiotic and will see wound care tomorrow...Writer (nurse staff #1) added a risk plan for pain assessment to be completed to address pain issues (due to) [client G's] unable to verbalize her pain effectively. All orders are on MAR for staff to follow." Client G's 3/17/15 Physical Form indicated client G had 2 ulcerations on top of head. "Bigger ulceration is showing improvement but [client G] has started to pick at it. Sees wound center today." The form also indicated "Met (with) [client G] & assessed wound on head. Wound was dressed appropriately-head wrap was on. Wound measured 3" diameter & 1" long-this is an improvement. Wound was moist, red, opened. [Client G] has started to pick at it recently. Removing her head wrap @ (at) noc (night). There was a smaller area on top front of her head that is new, bigger due to picking at it. It is 1" long, 0 drainage but is red...continue to skin checks & encourage her not to pick at skin." Client G's Health Notes on Therap indicated the following (not all inclusive):			

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	-2/26/15 Nurse staff #1 was at the group home "to check the status of the wound." The note indicated "...Wound care supplies were available and staff voiced understanding of wound care instructions." -2/25/15 "[Client G] was seen by wound center on 2-24-15 for the wound on her head. [Client G] has followed up with dermatology for years for her skin issues. [Client G's] lesion on her head continued to get worse despite the treatment by her dermatologist. [Client G] went to urgent care and they recommended that she go to another dermatologist for consult. [Client G] did that and was referred to wound care. Orders obtained from wound care for dressing changes BID., HM present for appointment and will train staff on dressing changes. Instructions on MAR and a print out will be available to staff in med room as well. Writer contacted wound center to clarify orders on previous creams/treatments as we do not currently have a D/C (discontinue) order for them. The doctor is not in the office today, but will be tomorrow. Will place previous creams/treatments on hold until further clarification and continue with current wound care orders."			

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	-2/25/15 Nurse staff #1 heard back from the doctor's office. The note indicated "The previous ointments/solution are NOT to be applied to the open wound on her head, but are able to use on any other areas where she was being treated. [Client G] may still use her prescription shampoo as directed . Vinegar spray will be placed on hold until further notice; awaiting results from culture. Staff are to ensure the wound is cleaned thoroughly prior to the dressing changes. Staff are to follow wound care instructions as directed on MAR and risk plan. Assess the need to medicate with PRN Tylenol at least 30 minutes prior to dressing changes as this can be painful for [client G]. The doctor stated they do not believe that the area is skin cancer. They believe the wound is due to [client G's] skin picking...." Client G's record, physical forms and/or health notes indicated the facility's nursing services failed to monitor, assess and/or document their assessments of client G's open area on the client's head on a more frequent basis due to the client's picking the area and/or removing her head wrap to ensure the client's wound was not infected. The facility's nursing services failed to ensure facility staff were trained/competent in providing wound care.			

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	Client G's 4/17/15 Risk Plan indicated under the section entitled Health Status Change indicated "...[Client G] will also withdraw and increase her SIB. Staff should encourage [client G] to participate in activities. SIB is monitored with skin checks BID (two times a day) and staff sign off the MAR indicating that it was completed...." Client G's risk plan indicated "...She is encouraged to wear a hat to prevent her from picking at areas on top of her head. She is followed quarterly by a psychiatrist. Staff are to complete a skin check BID and record their findings in Therap." The 4/17/15 risk plan indicated facility staff were to assess the client's pain level. The note indicated "...They will assess [client G's] vitals with each med pass at (least BID) and record them in Therap. The client's 3/17/15 Risk Plan indicated the following 2/25/15 wound care instructions: "Wound care is to be completed twice a day. (7:00am and 8:00pm) 1. Gently clean the area with soap & water and pat dry. 2. Use Benzocaine spray to the area. This is a topical anesthetic to numb the area. Apply a thin film to the area. 3. Apply Santyl ointment. This is a debriding ointment. This can be applied with a gauze pad. 4. Apply a wet gauze using saline. 5. Cover with a dry gauze pad. 6. Wrap/secure the dressing with an			

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	Ace bandage. Document the appearance of the wound in the skin/wound in therap with each dressing change. Report any concerns, skin changes, s/s (signs/symptoms) infection to the HM who will consult with MD (medical doctor)/nurse. Assess prior to her dressing changes as these may cause her discomfort. Document the effectiveness of the pain medication as we want to ensure we are treating her pain effectively." Client G's April 2015 MAR indicated facility staff documented they assessed client G for pain at each medication pass. The 4/15 MAR indicated "Pain assessment to be completed at least 3 times a daily with med pass and PRN (as needed) if [client G] indicates or shows signs of pain. Pain assessment tool will be posted in the med room. Pain will be scored per med passer's observations. The score will be documented in detailed mode on MAR and addressed as necessary. If a PRN medication for pain is needed, document effectiveness 1 hour after administration." Client G's 4/15 MAR indicated the client received Acetaminophen 325 mg on 4/1/15 and on 4/14/15. Client G's MAR indicated the facility's nursing services failed to ensure facility staff filled out the pain assessment detail on the Therap MAR on			

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	4/1 and 4/14/15. Client G's 4/14/15 Individual Plan of Protective Oversight-Residential Information indicated client G required 15 minute checks for seizures and "...behavior concerns of hitting others when she cannot communicate what she wants...." Client G's 4/20/15 ISP indicated client G was on 15 minute checks for "Safeguards." Client G's record indicated facility staff did not document 15 minute checks. Client G's 4/20/15 ISP indicated the client's IDT (interdisciplinary team) failed to specifically indicate how client G was to be monitored/supervised to prevent client G from injuring herself in regard to the client's SIB. The facility's nursing services failed to clearly define what "high risk monitoring" client G had been placed on. Client G's 6/5/14 Behavior Plan (BP) indicated client G demonstrated SIB defined as "(slapping himself (sic) in his (sic) face leaving welts, red marks, bruising)." Client G's BP indicated when client G demonstrated SIB, staff was to "Ask [client G] to stop skin picking. 2. Counsel that she could cause herself harm. 3. Redirect [client G] to another activity." The BP indicated client G was			

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	to be redirected to "...an alternate activity using her hands (chore, writing, looking at a book or magazine, get a snack or a drink)...." Client G's BP and/or ISP indicated the facility failed to address client G's identified need of removing her head wrap/ace bandage. Client G's record indicated client G's risk plan for wound care failed to specifically indicate how client G was to be monitored/supervised to prevent the client's SIB and/or injury to her head. The facility's nursing services failed to ensure the client's risk plans were updated as needed in regard to the client's wound care. The facility's Inservice Meeting records were reviewed on 4/22/15 at 10:55 AM. Client G's client specific training did not include wound care. The facility's nursing services failed to ensure its nursing staff trained staff in regard to wound care, cleaning open wounds, and to ensure staff competency in wound care. The facility's nursing services failed to ensure facility staff were trained in regard to documenting appearances/information in regard to wounds, and to ensure facility staff notified nursing services with concerns in regard to client G's head wound.			

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	Interview with staff #4 on 4/20/15 at 8:22 PM indicated client G would pick the wound at the top of her head. Staff #4 stated client G's "wound has been there since I've been here. Recently went to wound center to get treatment to area." When asked when client G picked, staff #4 stated "When alone and when in bedroom not doing anything." Staff #4 indicated client G was on 15 minute checks. Staff #4 stated she had seen client G pick at the area and redirected the client to wash her hands and would "redress the wound." Staff #4 indicated the area on top of client G's head was getting smaller. Interview with staff #2 on 4/21/15 at 9:49 AM indicated client G would remove her head wrap during the night. Staff #2 stated client G would pick her wound in the "bathroom." Interview with staff #1 on 4/22/15 at 8:55 AM stated client G was to have her ace bandage on her head "All day, every day. Lately has not been tolerating it. Hates it." Staff #1 stated "She's been picking." When asked where/when does client G pick, staff #1 stated "Mostly at night. She takes it off at night or idle time by her self." Staff #1 indicated client G was going to the wound center. Staff #1 indicated client G started going to the			

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	wound center on 2/15/15. Staff #1 indicated client G was going to the wound center every three weeks. Staff #1 indicated the ace bandage and Santyl ointment had helped the client's wound. When asked how facility staff were monitoring the client to prevent her from picking, staff #1 stated "She is on 15 minutes checks and she stay out (of room) with us." Interview with PD #2 on 4/23/15 at 10:30 AM indicated when asked who reads the End of Shift reports stated the "PC/HM& PD and who ever is on the recipient list." When asked if she was able to locate the 15 minute checks for client G, PD #2 stated "No we did not. Took some over there to start." Interview with nurse staff #1 on 4/29/15 at 10:47 AM, by phone, indicated client G had an open area at the top of her head and the client was going to the wound center for treatment. When asked who trained staff in regard to wound care, nurse staff #1 stated the home manager "originally did the training." Nurse staff #1 stated "I came by one day and manager showed me. I asked her if she felt comfortable training staff. She said she did." Nurse staff #1 indicated she had not trained staff in regards to wounds/open wounds, care of wounds			

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	(how to document and what they were to look for in regard to potential problems with wounds). Nurse staff #1 indicated facility staff had not demonstrated competency training in regard to wound care. Nurse staff #1 indicated facility staff were to clean client G's wound prior to applying any new medication. Nurse staff #1 indicated facility staff were to use soap and water when cleaning the client's wound. Nurse staff #1 stated "Staff were afraid of hurting her." Nurse staff #1 indicated facility staff should give the client Tylenol 30 minutes prior to doing the wound care treatment. Nurse staff #1 indicated she had removed some of the topicals and past treatment from the house as the group home staff were still using the Benzocaine numbing spray. Nurse staff #1 stated "We do not have an order to use the Benzocaine spray." Nurse staff #1 indicated the skin wound assessments were completed by the staff at the group home. Nurse staff #1 stated "Skin wound documentation not up to date." Nurse staff #1 indicated facility staff was not always documenting how the wound looked. Nurse staff #1 indicated client G just returned to the wound clinic. Nurse staff #1 stated "She is back to Prisma dressing." When asked how often she assessed or monitored client G's wound, nurse staff #1 stated "I just saw her on 4/23/15. and she got a			

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	change at wound care." When asked why there was no additional documentation of her assessment since 3/17/15 in Therap, nurse staff #1 stated "It was scanned on 4/26/15." Nurse staff #1 stated she was still trying to get a hold of the doctor "to see if dressing change is to be PRN." Nurse staff #1 indicated facility staff had been putting the medication back on the wound. Nurse staff #1 indicated client G's MAR indicated how facility staff were to clean client G's wound. Nurse staff #1 indicated client G's risk plan needed to specifically indicate how client G's wound should be cleaned. Interview with PD #2 on 4/28/15 on 5:10 PM when asked when the last time the facility's nurse assessed client G's wound, PD #2 stated "Can't find anything other than 3/17/15 note. Looks like 3/17/15 was her last visit." PD #2 indicated client G had a risk plan for her head wound. PD #2 indicated the wound care center gave staff permission to wrap the ace bandage around client G's head. 3. During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the group home, client C refused to eat her breakfast except for a few bites of food. Client C's record was reviewed on 4/28/15 at 11:10 AM. Client C's 2/16/15			

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	Consultation Form indicated client C saw a speech therapist in regard to a swallow study. The 2/16/15 note indicated "Pt (patient) was able to tolerate small amounts of regular consistency foods if given small pieces. Staff is concerned (with) (decreased) intake and weight loss. Rec (recommend): "Upgrade to regular consistency (with) staff controlled bites and sips of thin liquids. 1:1 (One staff to one client) supervision at all times for meals. Staff to cut food at table." Client C's Health Tracking Monthly Report indicated the following weights: -October 2014 121 pounds -November 2014 115 pounds -December 2014 No weights documented -January 2015 No weights documented -February 2015 No weights documented -March 7, 2015 111.6 pounds -March 21, 2015 109 pounds -March 29, 2015 109 pounds -April 5, 2015 106.8 pounds Client C's 2/19/15 Quarterly Physical indicated client C was to be weighed weekly and to document in Therap (facility's computer record system). Client C's 1/13/15 Quarterly Nutrition Review indicated client C saw her doctor on 1/15/15 and the doctor office weighed			

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	the client at 106.7 pounds. Client C's nutrition review indicated weekly weights were started on 1/15/15 and Ensure (dietary supplement) three times a day was started on 12/14/14 at and emergency room visit to improve intake. The nutrition review indicated client C also seen her doctor on 1/28/15 for "eating issues, wt (weight) loss and CBC (blood lab work) abnormalities." The note indicated client C's doctor increased client C's Ensure up to 5 cans a day on 1/28/15 and ordered a swallow study. The nutrition assessment indicated "...Weight decreased 8.3# (pounds) this quarter-wt down 14# x (times) 90 days-wt change down 12% (percent) which is significant. Wt is at lower end of AWR (average weight range) = 105-135#-would not further wt loss...would rec (recommend) an albumin to assess nutrition status...." Client C's nutritional review indicated recommendations to obtain weekly weights. The assessment also indicated "Request for Physician's Order (s) and Justification for Request 1. Clarify supplement order with MD (medical doctor) of giving Ensure Plus-MD order was for Ensure. 2. Request MD order for Albumin level to assess visceral protein stores (detects malnutrition)." Client C's 2/18/15 Physical Form (nurse			

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	assessment) indicated "...Intake remains poor). 0 (zero) weight available even though she is scheduled for weekly weights-Staff are not following protocol-PD/AD (Program Director/Area Director) are aware...." The note indicated client C's (4/1/15) risk plan for choking was updated to a regular diet. Client C's labs and/or records from 4/14 to 4/15 did not indicate the nurse addressed client C's 1/15 dietary recommendations as no albumin labs were present in the client's record/Therap. Client C's consultation forms and/or record indicated the facility's nursing services did not clarify client C's Ensure order. Client C's 4/1/15 ISP (Individual Support Plan) indicated client C's 4/1/15 risk plans did not specifically address client C's weight loss. Interview with PD #2 on 4/28/15 at 5:10 PM indicated client C had been taken to the doctor in regard to her weight loss. PD #2 indicated she could not locate any documentation where client C's IDT met to review and/or address the client's weight loss. Interview with nurse staff #1 on 4/29/15 at 10:47 AM, by phone, indicated client			

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	C had lost weight. Nurse staff #1 stated the group home had "Ensure and Ensure Complete" in the house as of 4/29/15. Nurse staff #1 indicated client C's recommendation to clarify the client's Ensure had not been done. Nurse staff #1 indicated she called client C's doctor office yesterday to see if the Albumin level had been done as client C had some labs done on 3/11/15. Nurse staff #1 indicated she did not know what labs had been completed on 3/11/15. 4. During the 4/20/15 observation period between 4:25 PM and 9:15 PM, the 4/21/15 observation period between 5:40 AM and 8:30 AM, and the 4/22/15 observation period between 6:25 AM and 6:43 AM, at the group home, client B wore AFO's (leg braces) on both of his legs which went down into the client's shoes. The facility's End Of Shift (EOS) Reports were reviewed on 4/23/15 at 10:45 AM. The facility's 4/12/15 EOS report indicated "...I've (staff #9) also been noticing that his AFO's are getting put on to (sic) tightly and are leaving bruises...." Client B's record was reviewed on 4/23/15 at 10:35 AM and on 4/27/15 at 2:41 PM. Client B's record and/or Health Notes indicated the facility's nursing			

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	services did not assess the area on client B's ankle. Client B's 2/13/15 Quarterly Physical indicated client B had a history of pressure ulcers and skin breakdown. Interview with nurse staff #1 on 4/29/15 at 10:47 AM, by phone, indicated she was aware of the area on client B's ankle. Nurse staff #1 stated "He has a past wound on his ankle. They are checked thoroughly." Nurse staff #1 stated she spoke with staff #1 and staff #1 told her client B's braces/AFOs were being "put on too tight." Nurse staff #1 stated she gave staff #1 recommendations over the phone to make sure staff were "putting 2 fingers between the AFO and foot." Nurse staff #1 indicated they did not see/assess client B's bruise/area on foot. 5. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, the 4/21/15 observation period between 5:40 AM and 8:30 AM and on 4/22/15 between 6:25 AM and 7:38 AM, at the group home, client C wore a gait belt around her waist. During the above mentioned observation periods, client C ambulated independently without staff assistance, and/or staff held the client by her elbow/arm to assist the client to walk to the living room. Facility staff did not			

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	utilize the client's gait belt. Client C's record was reviewed on 4/28/15 at 11:10 AM. Client C's 2/19/15 Quarterly Physical /Internal Medicine Progress Note indicated client C's diagnosis included, but was not limited to, Falls. Client C's quarterly physical indicated "Plan: -use gait belt as directed...." Client C's 4/1/15 Risk Plan indicated client C had a risk plan for falls. Client C's 4/1/15 risk plan indicated "...Staff are to assist clients as needed with ambulation and walking...She typically has a slow wide-based gait. She is very unsteady on uneven surfaces or steps...." Client C's 4/1/15 fall risk plan did not indicate when and/or how facility staff were to use a gait belt with the client. Interview with staff #9 on 4/20/15 at 7:55 PM stated client C wore a gait belt because she was "Running into walls. Depth Perception issues." Interview with staff #2 on 4/21/15 at 9:49 AM indicated when asked why client C wore a gait belt, staff #2 stated "We use a gait belt to get her up as she won't move. She's stubborn." Staff #2 indicated she was not aware of any falls.			

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	Interview with staff #1 on 4/22/15 at 8:55 AM stated client C wore a gait belt due to "depth perception." Staff #1 stated "She steps big and causes her to trip." Staff #1 indicated facility staff were to use the gait belt with client C when they were getting on and off the van. Staff #1 stated they would also use the gait belt "to help her stand up because it can be a struggle to get her up." Interview with Program Director #2 on 4/28/15 at 5:10 PM indicated the use of the gait belt should be in the client's Individual Support Plan/risk plan. 5. Observations at the group home were conducted on 4/23/15 from 6:40 A.M. through 8:37 A.M. Client B was seated upright in his wheelchair throughout the observation period. Observations at the group home were conducted on 4/27/15 from 5:59 P.M. through 7:23 P.M. A.M. Client B was seated upright in his wheelchair throughout the observation period. Client B's record was reviewed on 4/27/15 at 2:41 P.M. Client B's record indicated he had the following, but not limited to diagnoses; quadriplegia, abnormal involuntary movements, cerebral palsy, neuralgia, tonic flexion of			

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	bi-lateral wrists, hands and knees, scoliosis, with a history of traumatic skin changes, sacral decubitus ulcer, chronic ulcers from biting himself and incontinence of bowel and bladder. T logs for client B indicated the following: 3/16/15 written by facility health services coordinator (HSC) "...skin breakdown on gluteal area. This is the same area that has been an issue before and healed with wound care. Writer recommends that HM (house manager) get [client B] an appointment with the wound care center ASAP (as soon as possible)." 1/23/15 written by HSC "...The area of concern is his sacral area. The area is showing redness. It is not an opened area, no s/s (signs or symptoms) of infection, no drainage, no warmth. redness is likely due to moisture from incontinence. Writer stressed importance of following [client B's] protocols/risk plans. Ensure staff are following the toileting schedule (every two hours while awake and every 4 hours during sleep and (PRN) as needed). Up on toilet BID (twice daily) and keeping [client B] clean and dry...reposition at least every two hours, use cushions to relieve pressure...."			

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	10/24/14 written by HSC "...The area of concern is his sacral area. [client B] had a small wound previously in that area and it appears that it is showing some redness. The area is not an opened area, no s/s of infection, no drainage, no warmth. redness is likely due to moisture from incontinence. Writer stressed importance of following [client B's] protocols/risk plans. Ensure staff are following the toileting schedule (every two hours while awake and every 4 hours during sleep and (PRN) as needed). Up on toilet BID (twice daily) and keeping [client B] clean and dry...reposition at least every two hours, use protective heel boots, cushions to relieve pressure...." 8/8/14 written by direct support professional (DSP) #15 "[Client B] has the start of a small pressure sore on his right buttocks. He needs to be on the roho cushion until further notice. It is very important that he is kept dry, repositioned often and out of his chair for awhile over the weekend." Client B's risk plans dated 1/22/15 included a plan for impaired skin integrity, "...The key to keeping the skin intact is keeping it dry and pressure free...Pressure can be relieved by repositioning the client and encouraging functional alignment when sitting			

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	upright...Staff assist him with changing (every two hours while awake and every 4 hours while sleeping) and any time he is wet and initial off on the MAR (medication administration record). How to re-position [client B] while in wheelchair (every two hours). Staff will use wedge pillow and place under hip and rotate sides, ensuring proper body alignment. Staff will place [client B's] chair in reclining position to relieve pressure. Staff will ensure buttocks are placed far back in chair and footrests adjusted so knees are at or slightly below hips. [Client B] uses a pressure relief cushion in his wheelchair to prevent skin issues. [Client B] uses a hoyer lift for transfers. [Client B] is taken out of his chair and placed in bed or recliner when he gets home from workshop for one hour, to relieve pressure. How to re-position [client B] while he is in bed (every two hours). Staff will use bed pad to turn [client B] from side to side or supine position. Staff will use pillow to place under bed pad to prop [client B] on side to relieve pressure. Staff will readjust shoulders to avoid poor circulation and use a pillow to place between knees and ankles to keep them from touching. Avoid lying directly on hip bones. When lying on back, keep lower legs up by placing a pillow under the lower part of the legs (mid calf to			

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	ankle). [Client B] has a new seat cushion for his wheelchair and a new mattress to help alleviate pressure while sitting and sleeping. [Client B] also wears heel protector boots daily to prevent skin issues. Staff transfers [client B] using a hoyer lift which prevents friction to the skin." Client B's Repositioning records on the MAR for April 2015 indicated client B was to be provided incontinence care and repositioned every two hours. The MAR indicated client B was not repositioned every two hours and provided incontinence care as indicated on the MAR with inconsi			
W 0342 Bldg. 00	483.460(c)(5)(iii) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. Based on observation, interview and record review for 1 of 4 sampled clients (B) and for 1 additional client (G), the facility's nursing services failed to ensure staff were initially trained and demonstrated competency in wound care, and on using a Hoyer Lift.	W 0342	**W342 Nursing Services** Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness and basic skills	06/12/2015

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	Findings include: 1. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, at the group home, client G spent the majority of her time in her bedroom except to take a shower, to eat and to get her night time medications. At 4:55 PM, when client G came out of her bedroom to the dining room, client G sat on a seater walker wearing a gait belt and an ace wrap/bandage around her head. The ace wrap/bandage went around each side of the client's face and under her chin. Client G had a hat over top of the ace wrap. At 6:18 PM, client G carried her dishes to the kitchen and she scooted her seat walker with her feet. Client G then went outside and smoked a cigarette on the back patio. Once client G returned inside the house, the client went to her bedroom. At 7:10 PM, when the client went to get her 8:00 PM medications, client G no longer had her head wrapped. Client G had a large open area at the top of her head. The open area was about the size of a quarter with an irregular shape. The open area had a red edge around it. Part of the edges had a red wet substance around the edges. The open area was surrounded by a larger area about the size of a half dollar. The larger area had hair missing. Staff #10, who was administering the medication, sprayed a		required to meet the health needs of the clients. **What corrective action will be accomplished?** · Update risk plans or develop plans for identified risk – Nurse staff will send next three plans to supervisor for review. · Retrain nurse staff on providing competency based trainings and ensure nurse staff gets copies of those trainings to the Program Director/QIDP for client specific training record. · Retrain nurse staff on items reportable to physician and follow up on medical issues in a timely manner (within 24-48 hours). · Nurse staff will train staff on changes in client's orders and plan of care. · Update risk plans/protocols as necessary and ensure staff training to include understanding and competency based training as indicated. · Develop competency based training for wound care and documentation of wound including descriptive terms and any prior pain management to include parameters of time dose, pain scale, when to notify the nurse, documentation and follow up and train staff and verify competency. · Develop competency based training for Hoyer lift and train staff and verify competency · Retrain staff on weekly weights and reportable parameters to	

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	numbing spray (American 20 percent) on the area, placed a Saline Solution on a gauze pad and sat it on top of the open area and then placed another dry gauze pad on top of the wet gauze and then applied a clean ace bandage around the gauze and the client's head. Staff #10 then took some tape strips and taped the ace wrap underneath client G's chin. Interview with staff #10 on 4/20/15 at 7:14 PM indicated client G had removed her head wrap. Staff #10 indicated the area on top of client G's head had got smaller. Staff #10 indicated client G was going to the wound clinic for treatment. When asked how client G got the area, staff #10 stated client G "picked it." During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the group home, client G did not have the ace wrap while client G was asleep in her bed at 5:50 AM. At 6:05 AM, client G woke up and went to the bathroom. Client G did not have the ace wrap/bandage on. At 6:38 AM, when client G came into the dining room, the client's open area was dry looking and the edges around the open area was dark red in color. When client G got her morning medications, staff #1 treated client G's head by putting Santyl (debriding ointment which cleans wounds) on a gauze bandage and then		the nurse staff. **1. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Update risk plans or develop plans for identified risk – Nurse staff will send next three plans to supervisor for review. · Retrain nurse staff on providing competency based trainings and ensure nurse staff gets copies of those trainings to the Program Director/QIDP for client specific training record. · Retrain nurse staff on items reportable to physician and follow up on medical issues in a timely manner (within 24-48 hours). · Nurse staff will train staff on changes in client's orders and plan of care. · Update risk plans/protocols as necessary and ensure staff training to include understanding and competency based training as indicated. · Develop competency based training for wound care and documentation of wound including descriptive terms and any prior pain management to include parameters of time dose, pain scale, when to notify the nurse, documentation and follow up and train staff and verify competency.	

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	placed Saline solution on a bandage and placed the bandage on top of client G's head. Staff #1 then took a clean ace wrap and wrapped it around the client's head and placed 2 tape strips on the ace wrap under client G's chin. Staff #1 and #10 did not clean client G's wound during both observation periods. Client G's record was reviewed on 4/22/15 at 5:05 PM and on 4/27/15 at 2:30 PM. Client G's Skin/Wound Assessments documented by Direct Support Professionals (DSPs) indicated the following (not all inclusive): -2/4/15 "client (sic) picked head during the night as there was blood on the bed." -2/6/15 "scalp (sic) looks very red and irritated (sic) client (sic) was observed picking while getting dressed...." -2/9/15 "area (sic) looks larger and was red today. client (sic) seen picking at scalp in am." -2/10/15 "scalp (sic) wound looks bad, infection present and has been picking at it as it looks bigger today (sic)" -2/11/15 "Wounds on head looking slightly better than they were...."		· Develop competency based training for Hoyer lift and train staff and verify competency · Retrain staff on weekly weights and reportable parameters to the nurse staff. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Update risk plans or develop plans for identified risk – Nurse staff will send next three plans to supervisor for review. · Retrain nurse staff on providing competency based trainings and ensure nurse staff gets copies of those trainings to the Program Director/QIDP for client specific training record. · Retrain nurse staff on items reportable to physician and follow up on medical issues in a timely manner (within 24-48 hours). · Nurse staff will train staff on changes in client's orders and plan of care. · Update risk plans/protocols as necessary and ensure staff training to include understanding and competency based training as indicated. · Develop competency based training for wound care and documentation of wound including descriptive terms and any prior pain management to include parameters of time dose, pain scale, when to notify the nurse, documentation and follow up and train staff and verify	

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	-2/19/15 "Wound on head has some infection sitting on top. Doesn't really look red...." -2/20/15 "client (sic) was picking at larger wound this am. Looks red and has a little infection in it." -2/22/15 "wound (sic) on head all other skin in tact (sic)" -2/23/15 "Wound on head looked dark and red on the outside...." -2/24/15 "Scalp looks worse than yesterday. Client was picking at head in the am...." -2/24/15 "Went to wound center today. Has a bandage on head to cover wound. Was instructed not to remove it...." -2/26/15 "Changed head dressing, looks better than it did yesterday...." -2/27/15 "was caught a couple times taking off her wrap and picking at her head...." -3/4/15 "I (staff #6) think she may be picking at the wound that isn't covered. Looked larger and red." -3/6/15 "Client had pulled of (sic) wound		competency. · Develop competency based training for Hoyer lift and train staff and verify competency · Retrain staff on weekly weights and reportable parameters to the nurse staff. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Update risk plans or develop plans for identified risk – Nurse staff will send next three plans to supervisor for review. · Retrain nurse staff on providing competency based trainings and ensure nurse staff gets copies of those trainings to the Program Director/QIDP for client specific training record. · Retrain nurse staff on items reportable to physician and follow up on medical issues in a timely manner (within 24-48 hours). · Nurse staff will train staff on changes in client's orders and plan of care. · Update risk plans/protocols as necessary and ensure staff training to include understanding and competency based training as indicated. · Develop competency based training for wound care and documentation of wound including descriptive terms and any prior pain management to include parameters of time dose, pain scale, when to notify the nurse, documentation and follow up and train staff and verify	

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	cover and has been picking at area on scalp (sic) Staff replied (sic) dressing to wound. Looks like it is trying to heal." -3/8/15 "Head ulcer is healing nicely." -3/11/15 "Wound on head continues to heal and looks better. Has started to pick at her smaller wound again." -3/13/15 "Large wound is looking much better. Client won't leave the wrap on and is picking at the smaller wound. It was larger this am and looked runny." -3/13/15 "Large area looks much improved. Client left dressing on through the night. Client has been picking the smaller on it and it has doubled in size (sic). Put medication on as directed." -3/16/15 "Client had bandage off this am and area looked red...." -3/17/15 "Client has been picking at her head today. area (sic) was open and had been bleeding. Staff covered the area again and also put bandage on front area wound." -3/18/15 at 9:50 PM, "Wound on head continues to heal. Is now nearly half the size...."		competency. · Develop competency based training for Hoyer lift and train staff and verify competency · Retrain staff on weekly weights and reportable parameters to the nurse staff. **1.What is the date by which the systemic changes will be completed?** ·June 12, 2015	

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	-3/20/15 "Client continues to take wound wrap off. The area in the front looks like it is deeper than it was yesterday. Back area look red and runny today." -3/26/15 "smaller (sic) wound look better and is drying up. The wound is red and looks infected. wound (sic) has several areas that are deep." -3/27/15 "larger (sic) wound has been picked at. smaller (sic) wound is larger and deep...." -3/30/15 "Larger wound on head had been picked at. Smaller wound remains the same...." -4/1/15 "Wounds on the head remain the same. No no new wounds are lesions...." -4/7/15 "The wound on her head is healing and looking a lot better even stated by the doctor that it is looking better and healing." -4/14/15 (PM note) "client (sic) took wrap off during the night. Scalp looks like it has a little blood on it...." -4/16/15 "...Wounds on head continues to heal."			

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	-4/18/15 "No new skin wounds. Wounds on head continue to heal." -4/22/15 "Wound on head is the same. Smaller wound on head has been picked at...." -4/23/15 "...Wounds on head continue to heal." -4/24/15 "Large wound on head remains the same. Smaller wound is healing. No new wound or lesions...." Client G's Consultation Forms indicated the following wound clinic notes (not all inclusive): -2/24/15 Client G went to the wound center due to an "Open wound on head." The form indicated "Twice daily scalp ulcer needs to be washed thoroughly. Apply Santyl 1/16" (inch) thick and moist gauze. Retain in place with ace wrap. May use Benzocaine 20% (percent) spray to anesthetic before each cleaning. All remnants of the Santyl ointment need to be removed before new Santyl is applied." An attached Physician Orders/Patient Instructions sheet indicated client G's wound was to be cleaned with "saline." The form indicated "Diagnosis: Trauma."			

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	-3/17/15 Client G returned to the wound center. The form indicated "scalp ulcer. See copy of Dr's orders." The physician's orders indicated "Wound care instructions...Steps to complete for wound care BID (two times a day). 1. Clean area with soap and water & (and) pat dry. 2. Use Benzocaine spray as directed on MAR (Medication Administration Record). Apply Santyl cream as directed on MAR. 4. Apply wet gauze pad using saline. 5. Cover with dry dry (sic) gauze pad. Wrap/secure dressing with Ace bandage." -4/7/15 Client G went to the wound center for "Wound Care." "Visit at wound center for ulcer assessment/re-evaluation. Changes in treatment plan made. Wound care instructions (Prisma dressing)...Wound care instructions for wound on head: 1. Clean area with saline. 2. Apply slightly moistened Prisma dressing. 3. Apply gauze pad. 4. Apply Ace wrap. Change dressing every other day." An attached 4/7/15 Physician Orders/Patient Instructions indicated "(1) Head parietal (front area of head) area -Stop Santyl. Apply slightly moistened Prisma, gauze, Ace wrap. (Clean with saline)." The form indicated "Diagnosis: Factitial (self-inflicted lesions of the skin)."			

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	Client G's 2/18/15 Physical Form completed by the facility's nurse indicated client G had an "Opened area on top of head-ulceration." The form indicated "Met with [client G] at her home for initial visit. [Client G] placed on high-risk monitoring due to current decline in health; health issues. [Client G] has ulceration on her head that is 4 1/2" in diameter & 2 1/2" in long. Area is red, moist, opened. 0 (zero) bleeding, 0 drainage, 0 foul odor. [Client G] is currently on an antibiotic and will see wound care tomorrow...Writer (nurse staff #1) added a risk plan for pain assessment to be completed to address pain issues (due to) [client G's] unable to verbalize her pain effectively. All orders are on MAR for staff to follow." Client G's Health Notes on Therap indicated the following (not all inclusive): -2/26/15 Nurse staff #1 was at the group home "to check the status of the wound." The note indicated "...Wound care supplies were available and staff voiced understanding of wound care instructions." -2/25/15 "[Client G] was seen by wound center on 2-24-15 for the wound on her head. [Client G] has followed up with			

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	dermatology for years for her skin issues. [Client G's] lesion on her head continued to get worse despite the treatment by her dermatologist. [Client G] went to urgent care and they recommended that she go to another dermatologist for consult. [Client G] did that and was referred to wound care. Orders obtained from wound care for dressing changes BID., HM present for appointment and will train staff on dressing changes. Instructions on MAR and a print out will be available to staff in med room as well. Writer contacted wound center to clarify orders on previous creams/treatments as we do not currently have a D/C (discontinue) order for them. The doctor is not in the office today, but will be tomorrow. Will place previous creams/treatments on hold until further clarification and continue with current wound care orders." -2/25/15 Nurse staff #1 heard back from the doctor's office. The note indicated "The previous ointments/solution are NOT to be applied to the open wound on her head, but are able to use on any other areas where she was being treated. [Client G] may still use her prescription shampoo as directed . Vinegar spray will be placed on hold until further notice; awaiting results from culture. Staff are to ensure the wound is cleaned thoroughly			

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	prior to the dressing changes. Staff are to follow wound care instructions as directed on MAR and risk plan...." Client G's 4/17/15 Risk Plan indicated under the section entitled Health Status Change indicated "...[Client G] will also withdraw and increase her SIB. Staff should encourage [client G] to participate in activities. SIB is monitored with skin checks BID (two times a day) and staff sign off the MAR indicating that it was completed...." Client G's risk plan indicated "...She is encouraged to wear a hat to prevent her form picking at areas on top of her head. She is followed quarterly by a psychiatrist. Staff are to complete a skin check BID and record their findings in Therap." The 4/17/15 risk plan indicated facility staff were to assess the client's pain level. The note indicated "...They will assess [client G's] vitals with each med pass at (least BID) and record them in Therap. The client's 3/17/14 Risk Plan indicated the following 2/25/15 wound care instructions: "Wound care is to be completed twice a day. (7:00am and 8:00pm) 1. Gently clean the area with soap & water and pat dry. 2. Use Benzocaine spray to the area. This is a topical anesthetic to numb the area. Apply a thin film to the area. 3. Apply Santyl ointment. This is a debriding ointment. This can be applied			

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	with a gauze pad. 4. Apply a wet gauze using saline. 5. Cover with a dry gauze pad. 6. Wrap/secure the dressing with an Ace bandage. Document the appearance of the wound in the skin/wound in therap with each dressing change. Report any concerns, skin changes, s/s (signs/symptoms) infection to the HM who will consult with MD (medical doctor)/nurse. Assess prior to her dressing changes as these may cause her discomfort. Document the effectiveness of the pain medication as we want to ensure we are treating her pain effectively." Client G's April 2015 MAR indicated facility staff documented they assessed client G for pain at each medication pass. The 4/15 MAR indicated "Pain assessment to be completed at least 3 times a daily with med pass and PRN (as needed) if [client G] indicates or shows signs of pain. Pain assessment tool will be posted in the med room. Pain will be scored per med passer's observations. The score will be documented in detailed mode on MAR and addressed as necessary. If a PRN medication for pain is needed, document effectiveness 1 hour after administration." Client G's 4/15 MAR indicated the client received Acetaminophen 325 mg on 4/1/15 and on 4/14/15. Client G's MAR indicated the			

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	facility did not fill out the pain assessment detail on the Therap MAR on 4/1 and 4/14/15. The facility's Inservice Meeting records were reviewed on 4/22/15 at 10:55 AM. Client G's client specific training did not include wound care. The facility failed to ensure its nursing services trained staff in regard to wound care, cleaning open wounds, and to ensure staff competency in wound care. The facility neglected to ensure facility staff were trained in regard to documenting appearances/information in regard to wounds, and to facility staff notified nursing services with concerns in regard to client G's head wound. Interview with nurse staff #1 on 4/29/15 at 10:47 AM, by phone, indicated client G had an open area at the top of her head and the client was going to the wound center for treatment. When asked who trained staff in regard to wound care, nurse staff #1 stated the home manager "originally did the training." Nurse staff #1 stated "I came by one day and manager showed me. I asked her if she felt comfortable training staff. She said she did." Nurse staff #1 indicated she had not trained staff in regards to wounds/open wounds, care of wounds (how to document and what they were to look for in regard to potential problems			

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	with wounds). Nurse staff #1 indicated facility staff had not demonstrated competency training in regard to wound care. Nurse staff #1 indicated facility staff were to clean client G's wound prior to applying any new medication. Nurse staff #1 indicated facility staff were to use soap and water when cleaning the client's wound. Nurse staff #1 stated "Staff were afraid of hurting her." Nurse staff #1 indicated facility staff should give the client Tylenol 30 minutes prior to doing the wound care treatment. Nurse staff #1 indicated she had removed some of the topical's and past treatment from the house as the group home staff were still using the Benzocaine numbing spray. Nurse staff #1 stated "We do not have an order to use the Benzocaine spray." Nurse staff #1 indicated the skin wound assessments were completed by the staff at the group home. Nurse staff #1 stated "Skin wound documentation not up to date." Nurse staff #1 indicated facility staff was not always documenting how the wound looked. 3/17/15 in Therap, nurse staff #1 stated "It was scanned on 4/26/15." Nurse staff #1 indicated she was still trying to get a hold of the doctor "to see if dressing change is to be PRN." Nurse staff #1 indicated facility staff had been putting the medication back on the wound. Nurse staff #1 indicated client G's MAR			

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	indicated how facility staff were to clean client G's wound. 2. During the 4/20/15 observation period between 4:25 PM and 9:14 PM, at the group home, client B had a Hoyer Lift in his bedroom. During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the group home, staff #2 assisted client B to get up and dressed for the day, Staff #2 asked staff #1 for assistance when using the Hoyer Lift. Client B's record was reviewed on 4/27/15 at 2:41 P.M. Client B's record indicated he had the following, but not limited to, diagnoses; quadriplegia, abnormal involuntary movements, cerebral palsy, neuralgia, tonic flexion of bi-lateral wrists, hands and knees, scoliosis, with a history of traumatic skin changes, sacral decubitus ulcer, chronic ulcers from biting himself and incontinence of bowel and bladder. Client B's risk plans dated 1/22/15 included a plan for impaired skin integrity, "...[Client B] is wheelchair bound and utilizes a secured harness for safety. He is transferred using a hoyer lift to prevent falls/injury. [Client B] is to be transferred with the Hoyer lift. 2 staff			

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	should be present during transfer, if possible for safety purposes. However, staff are trained on doing independently if circumstances do not allow for 2 staff to be present." The facility's Inservice Meeting records were reviewed on 4/22/15 at 10:55 AM. The facility's client specific training Inservice Meeting notes (from 4/14 to 5/14) indicated facility staff was trained by the manager and not nursing services. Interview with staff #2 on 4/21/15 at 9:49 AM indicated client B used the Hoyer Lift at the group home. Staff #2 indicated client B could be transferred with the Hoyer Lift by one person. Interview with staff #1 on 4/22/15 at 8:55 AM when how many staff client B required to transfer with the Hoyer Lift, staff #1 stated "Was 2 but now 1." Staff #1 indicated if facility staff needed help with transferring client B, staff would ask for help. Staff #1 indicated facility staff are trained on how to use the Hoyer Lift after they first start working at the group home. Staff #1 indicated the home managers trained staff, and the day program staff. Interview with nurse staff #1 on 4/29/15 at 10:47 AM, by phone, indicated facility			

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	staff were trained by the manager on how to use the Hoyer Lift. This federal tag relates to complaint #IN00171811. 9-3-6(a)			
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on observation, interview and record review for 3 of 4 sampled clients (B, C and D) and for 2 additional clients (F and G), the facility failed to ensure staff followed doctor's orders in regard to medication administration: Findings include: During the 4/22/15 observation period between 6:25 AM and 7:38 AM, at the group home, client B was sitting at the dining room table having breakfast upon arrival to the group home. Client B sat in his wheelchair until the client left for the day program. The client did not get any medications (8 AM medications). Staff #2 passed clients' medications in the group home on 4/22/15. Interview with staff #1 on 4/22/15 at 7:40 AM by phone indicated client B received his 8 AM	W 0368	**W368 Drug Administration** The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. **1. What corrective action will be accomplished?** · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency.	06/12/2015

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	morning medications Oxcarbazepine 600mg tablet (for seizures) and Reno Caps Softgel 1 mg (for ulcer healing) after client B got up on 4/22/15 around 6 AM. Staff #1 indicated client B would have behaviors if they gave him the medications before he left for work. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 4/21/15 at 1:45 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following medication errors: 1. On 2/14/15, "It was reported on Sunday February 15, 2015 at 8pm (sic) that the 8am medications at Selma on February 14, 2015 were not passed. This med (medication) error occurred due to new staff and that this med pass was to occur during a shift change. All staff were reminded to follow the 6 rights of medication administration. All staff were reminded to check the MAR (medication administration record) at the beginning of their shift. No side effects were seen after this med error. The prescribing doctor was not contacted. Nurse and Program Director (PD) were contacted about this med error. As of 3pm on Monday February 16, 2015, there were still no side effects from this med error."		· A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth medication error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will review the MAR daily when in the home for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication	

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	The facility's 2/14/15 reportable incident reports indicated clients B, C, D, F and G did not receive their medications. The facility's 2/18/15 Investigation Summaries for clients B, C, D, F and G indicated staff #2 made the 2/14/15 medication errors. The facility's 2/18/15 investigations indicated in the Factual Findings section "Interview with [staff #2] (DSP) (Direct Support Professional) on February 17, 2015 -Stated that this consumer (clients C, D, F and G on 4 separate summaries) didn't have a med error. -Stated that she (staff #2) doesn't have Therap (facility computerized record system) access and couldn't record on the M.A.R...." The facility's 2/18/15 investigations indicated staff #3 and #4 indicated the clients did not receive their medications, and were not present when staff #2 administered the medications. The facility's investigations indicated clients C, D, F and G were not interviewed. Client B's 2/18/15 Investigation Summary under the section entitled Factual Findings, indicated "Interview with [staff #2] (DSP) on February 17, 2015 -Stated this consumer didn't get his medications because she (staff #2) was		practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency.	

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	waiting to do it when the next staff came in to assist her. -Stated that she forgot to do it when the next staff came in. -Stated that she doesn't have Therap access and couldn't record on the MAR...." The facility's 2/18/15 investigation summaries indicated the facility's investigation did not indicate what records were reviewed, and/or indicate how the facility was assured the clients' medications had been administered. The facility's investigation and/or reportable incident report failed to indicate what medications did not get administered at the 8 AM medication pass. 2. On 2/18/15, "It was reported to the HM (home manager) on Wednesday February 18, 2015 at 8:15pm that [client C] was accidentally given her 8am medications (due on 2-19-15) at the 4pm med pass on 2-18-15. This med error occurred due staff not have her full concentration and focus on this med error at the time (sic)...." The facility's 2/24/15 Investigation Summary indicated staff #5 made the medication error. The facility's 2/18/15 investigation indicated staff #5 "...Stated that she would be willing to go thru (sic) additional training for med passes...."		· A fourth medication error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will review the MAR daily when in the home for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors.	

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	3. On 2/26/15, "It was reported that on Thursday February 26, 2015 at 8pm that staff (staff #5) completed a med error with [client G] (client G). Staff forgot to give [client G] one of her medications. This med error occurred due to staff not realizing that [client G] had this medication....." The facility's 3/3/15 follow-up to the 2/26/15 reportable incident report indicated client G did not receive her ordered Xanax .25 milligrams (controlled substance-skin picking). 4. On 3/1/15, "It was reported that on Sunday March 1, 2015 at 8pm that staff (staff #4) completed a med error with [client G]. Staff forgot to give [client G] her Xanax (Alprazolam) .25mg tablet. [Client G] is to receive this medication 2 times a day...." 5. On 3/14/15, "It was discovered that at 11am on Saturday March 14, 2015 that [client B] had a med error. [Client B's] Oxcarbazepine 600mg tablet (for seizures) and Reno Caps Softgel 1 mg (for ulcer healing) were not passed. The weekend day staff discovered this med error. Normally the 3rd (third) shift staff (staff #2) passes the morning 8am medications. [Client B] was the only consumer in this house that 3rd shift staff		**1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth medication error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members.	

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	forgot to pass the medications for...." 6. On 3/23/15, "It was reported on Monday March 23, 2015 at 8pm that [client F] didn't receive his 8am medications that morning. Those missed medications include (Chlorhexidine 0.12% Rinse-15ml (milliliters) (Gingivitis); Invega ER 9 MB tablet (psychosis); Lisinopril 10 mg-(Hypertension); and Topiramate 50 MG tablet (Mood stabilizer)...." 7. On 4/5/15, "It was reported on Sunday April 5, 2015 at 4pm that the 8am medications for [client B] were not passed earlier that day...This med error occurred due to confusion of who was going to pass his medications...." 8. On 4/12/15, "It was reported that [client B] was not given his 8am on Sunday April 12th. [Client B] did not receive the following medications. OXCARBAZEPINE 600 MG TABLET for seizures & RENO CAPS SOFTGEL 1mg for Ulcer Healing. Late reporting of this BDDS report due to staff late reporting to the Program Director. The med error occurred due (sic) confusion between the 3rd shift staff and the day shift staff who was going to pass [client B's] medications...."		· The IDT will convene to discuss identified needs as necessary. · Program Coordinator will review the MAR daily when in the home for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently.	

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	Client G's record was reviewed on 4/22/15 at 5:05 PM. Client G's April's 2015 MAR indicated client G received Alprazolam (skin picking) 0.25 milligrams, Artificial tears (dry eyes) daily at 8:00 Baclofen (Cerebral Palsy) 10 milligrams, Calcium 500+D (Menopause) two times a day, Citalopram HBR(hydrobromide) 40 milligrams (Depressive Disorder), Cranberry Juice three times a day, Divalproex Sod DR (delayed release) 500 milligrams (Seizure Control), Ocala (stool softener)100 milligrams daily, Loratadine (allergy) 10 milligrams, Oxybutynin CL (chloride-incontinence) ER (extended release) 5 milligrams and Santyl (wound care dressing) dressing. Client G's April, 2015 MAR indicated client G did not receive her morning medications at the 8 AM medication pass on 4/22/15 as there was no documentation/initials for the medication pass. Client B's record was reviewed on 4/23/15 at 10:35 AM. Client B's 2/13/15 Quarterly physical (physician's order) indicated client B received Oxcarbazepine 600 milligrams in the morning and 1 Reno Caps daily. Client B's April 2015 MAR indicated client B received the Reno Capsule in the morning at 8 AM. Client B's 2/13/15		· One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth medication error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will review the MAR daily when in the home for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication	

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	Quarterly Physical indicated client B's diagnosis included, but was not limited to, Epilepsy Unspecified. Client C's April 2015 MAR was reviewed on 4/23/15 at 7:15 AM. Client C's April 2015 MAR indicated client C received the following medications at the 8:00 AM medication pass: Calcium Carb/D 500-400 (supplement) chew three times a day, Polyethylene Glycol (constipation) daily at 8 AM, Primidone (Seizures) 250 and milligrams two times a day. Client D's April 2015 MAR was reviewed on 4/23/15 at 7:15 AM. Client D's April 2015 MAR indicated client D received the following medications at 8:00 AM: Calcium Carb (nutritional supplement) 500 milligrams, Carnation Instant Breakfast (supplement) and Chlorhexidine Rinse 0.12% for periodontal disease. Client F's April 2015 MAR was reviewed on 4/23/15 7:15 AM. Client F's April 2015 MAR indicated client F received the following 7:00 AM and 8:00 AM medications: Chlorhexidine Rinse (gingivitis), Invega (Psychosis) ER 9 milligrams, Lisinopril (Hypertension) once daily and Topiramate (mood) 50 milligrams two times a day.		practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015	

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	The facility's End of Shift (EOS) reports were reviewed on 4/23/15 at 10:45 AM. The facility's 3/1/15 report indicated "...I (staff #7) came across [client E's] medication that is on hold was passed this morning. there (sic) is (sic) only supposed to be 56 left and there is (sic) 50 left. The hole for this morning was also marked on the MAR...." Confidential interview A indicated facility staff documented medications were given when clients' medications had not been administered. Confidential interview A indicated there had been more medication errors at the group home than had been reported. Confidential interview A indicated when meds were not given, they would be returned to the pharmacy. Confidential interview E indicated the third shift staff would make medication errors on the weekend. Interview with the Area Director (AD) and the Program Director (PD) on 4/21/15 at 3:00 PM indicated they were aware the home was having problems with medication errors. The PD indicated they had discussed and retrained staff in regard to the medication administration policy at staff meetings			

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	and by doing medication practicums. The PD and the AD stated the group home manager was doing one "random" medication practicum a week. The PD and the AD indicated they were not aware of any false documentation in the group home. Interview with the PD on 4/22/15 at 11:01 AM stated the facility just started doing the "random" Medication Practicums one to one and a half weeks ago. The PD indicated the manager had only done 1 random practicum and that was on 3/4/15. The other medication practicums were done last week with different staff. When asked if client G received her AM medications on 4/22/15, the PD indicated she had asked the manager and the manager indicated staff #2 did administer client G's medications but did not sign the MAR. When asked how they knew she administered the medications, the PD indicated the medication sticker/label was in the book which came off the medication packet. The PD indicated the manager stated staff #2 passed the medications. The PD indicated it did not appear the manager was with staff #2 when staff #2 passed the medications. Interview with the State Director on 4/22/15 at 11:55 AM indicated she was			

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	15G364		05/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	10311 E JACKSON SELMA, IN 47383

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	told the facility was monitoring staff #2 and she was not to pass medications unless the manager was present with her. The State Director indicated this was to have started a week ago. Interview with nurse staff #1 on 4/22/15 at 4:26 PM, by phone, nurse staff #1 indicated she was not always informed when a medication error occurred. Nurse staff #1 stated "Only if informed of med errors." Nurse staff #1 stated she was aware of a medication error with client B in April, but "it was after the fact." Nurse staff #1 indicated client B did not get his medications on a Saturday and a Sunday. Nurse staff #1 indicated she would check the MARs when she was in the group home. Nurse staff #1 indicated there may have been some medication errors in the group home in March 2015. Nurse staff #1 indicated the group home's medication errors were due to staff signing/initialing the MAR as if the medications were given, but they had not been given. This federal tag relates to complaint #IN00171811. 9-3-6(a)			
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must			

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	assure that all drugs, including those that are self-administered, are administered without error. Based on observation, interview and record review for 1 of 14 medications administered, the facility failed to administer client G's medication without error. Findings include: During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the group home, client G ate her breakfast at 6:49 AM. Staff #1 indicated she was going to pass medications on 4/21/15 and give staff #2 a "break." Client G came to the medication room to get her morning medications at 7:25 AM. Client G assisted staff in administering her own medications as staff #1 would hold a pill bottle (one at a time) and hand it to client G to get a pill out of the bottle. Client G received Omeprazole 40 milligrams 1 tablet at the morning medication pass. Client G's Omeprazole DR (non erosive gastritis) bottle indicated the client was to receive the medication 20 minutes prior to meals. Interview with staff #1 on 4/21/15 at 7:50 AM indicated when asked why client G's Omeprazole was administered after breakfast, staff #1 stated "If she does not take with other meds she will not take it. Our nurse gave	W 0369	**W369 Drug Administration** The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. **1. What corrective action will be accomplished?** · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth medication error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan	06/12/2015

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	us permission to give it after meals versus before meals." Client G's record was reviewed on 4/22/15 at 5:05 PM. Client G's April's 2015 MAR indicated client G received Alprazolam (skin picking) 0.25 milligrams, Artificial tears (dry eyes) daily at 8:00 Baclofen (Cerebral Palsy) 10 milligrams, Calcium 500+D (Menopause) two times a day, Citalopram HBR(hydrobromide) 40 milligrams (Depressive Disorder), Cranberry Juice three times a day, Divalproex Sod DR (delayed release) 500 milligrams (Seizure Control), Ocala (stool softener)100 milligrams daily, Loratadine (allergy) 10 milligrams, Oxybutynin CL (chloride-incontinence) ER (extended release) 5 milligrams and Santyl (wound care dressing) dressing. Client G's April, 2015 MAR indicated client G did not receive her morning medications at the 8 AM medication pass on 4/22/15 as there was no documentation/initials for the medication pass. Interview with nurse staff #1 on 4/22/15 at 4:26 PM, by phone, when asked when client G should take her Omeprazole, nurse staff #1 indicated it would probably be before she ate breakfast, but it would depend how it was written on the		monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will review the MAR daily when in the home for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective**	

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	physician's orders. When asked if she gave staff permission to give client G the Omeprazole after breakfast when she had an order to be administered 20 minutes before her meal, nurse staff #1 stated "No." Nurse staff #1 indicated there would have to be an order to do that. Nurse staff #1 indicated she may have given permission one time for them to do that, but it would have been for that one time. Nurse staff #1 indicated she could not remember doing that. This federal tag relates to complaint #IN00171811. 9-3-6(a)		**action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth medication error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to	

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			discuss identified needs as necessary. · Program Coordinator will review the MAR daily when in the home for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently.	

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			· One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth medication error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will review the MAR daily when in the home for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication	

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			practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Staff training has been completed by facility nurse regarding medication administration procedures. · All new staff will have 3 medication practicums before passing medications independently. · One medication error will result in a Record of Discussion, suspension from passing medications and a medication practicum with the nurse will be completed to ensure competency. · A second medication error will result in a written warning, suspension from passing medications and a med practicum with the nurse to ensure competency. · A third medication error will	

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			result in a final warning, suspension from passing medications until the successful completion of Core A and B. The nurse will supervise at least 3 medication practicums to ensure competency. · A fourth medication error will result in severing the employment relationship with that employee. · Nurse staff will monitor the medication administration plan monthly and communicate with the IDT the outcomes. · Nurse staff will monitor the MAR at a minimum weekly and communicate findings via email to necessary team members. · The IDT will convene to discuss identified needs as necessary. · Program Coordinator will review the MAR daily when in the home for accurate completion of documentation. · Program Coordinator will complete a medication cabinet check daily for two weeks and thereafter weekly. · Program Coordinator will complete one random medication practicum weekly for one month, thereafter monthly. · Program Director/QIDP will monitor the completion of a medication practicum monthly. · Program Director/QIDP will monitor the completion of medication cabinet check daily for two weeks and thereafter weekly. · Area Director will monitor the completion of a medication practicum monthly, medication	

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			cabinet check daily for two weeks and thereafter weekly. · Program Director/QIDP will be trained regarding thoroughly investigating all incidents of medication errors. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015	
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT 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. Based on observation, interview and record review for 1 of 4 sampled clients (B), who had adaptive equipment, the facility failed to ensure the client had a wedge pillow for repositioning. Findings include: During the 4/20/15 observation period between 4:25 PM and 9:14 PM, the 4/21/15 observation period between 5:40 AM and 8:30 AM and on 4/22/15 between 6:25 AM and 7:38 AM, at the group home, client B sat upright in his wheelchair for all observation periods. Client B had a blue pillow behind his	W 0436	**W436 Space and Equipment** The facility must furnish, maintain in good repair, and teach clients to sue and to make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devices identified by the interdisciplinary team as needed by the client. **1. What corrective action will be accomplished?** · A wedge pillow will be purchased for Client B. · Staff will be retrained on Client B's repositioning plan and schedule, including use of the wedge pillow. · Staff will be retrained on	06/12/2015

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	legs on the leg rests. Facility staff did not change/adjust client B's wheelchair to a different position, move the client to an alternate surface and/or use a wedge pillow under the client's hips. Client B's record was reviewed on 4/27/15 at 2:41 PM. Client B's risk plans dated 1/22/15 included a plan for impaired skin integrity, "...The key to keeping the skin intact is keeping it dry and pressure free...Pressure can be relieved by repositioning the client and encouraging functional alignment when sitting upright...How to re-position [client B] while in wheelchair (every two hours). Staff will use wedge pillow and place under hip and rotate sides, ensuring proper body alignment. Staff will place [client B's] chair in reclining position to relieve pressure...." Client B's Repositioning records on the MAR for April 2015 indicated client B was to be provided incontinence care and repositioned every two hours. An interview was conducted with Program Director (PD) #2 on 4/28/15 at 4:55 P.M. When asked about client B's repositioning schedule being documented, PD #2 stated, "The only place it is documented is on the MAR and it is not that specific. I could see		documenting Client B's repositioning plan and schedule, including how to document client refusals. · Program Coordinator will monitor use of the bed wedge daily when in the home. · Program Coordinator will review documentation of repositioning plan and schedule for Client B daily when in the home. · Program Director will monitor documentation of repositioning plan and schedule for Client B monthly. · Nursing staff will monitor documentation of repositioning plan and schedule for Client B weekly. · Nursing staff will verify use of bed wedge and repositioning plan and schedule when completing monthly nursing assessments with Client B. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Staff will be retrained on Client B's repositioning plan and schedule, including use of the wedge pillow. · Staff will be retrained on documenting Client B's repositioning plan and schedule, including how to document client refusals. · Program Coordinator will monitor use of the bed wedge daily	

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	where it would be beneficial to document what side he is positioned in so it is alternated." An interview was conducted with nurse staff #1 on 4/29/15 at 10:47 AM, by phone. Nurse staff #1 indicated client B had a history of skin break downs. Nurse staff #1 indicated client B should be repositioned and toileted every 2 hours. Nurse staff #1 indicated facility staff were to use a wedge pillow under the hip of the client, transfer the client to a recliner and/or mat. Nurse staff #1 indicated recently staff told her they do not use a wedge pillow. Nurse staff #1 stated facility staff indicated "They do not know where it is." Nurse staff #1 also indicated facility staff told nurse staff #1 client B would refuse to be placed on a mat and/or sit in the recliner. Nurse staff #1 indicated she was not aware of this, as the facility staff were not documenting the refusals. Nurse staff #1 indicated the facility staff were initialing client B was being repositioned, but nurse staff #1 did not know how the client was being repositioned. 9-3-7(a)		when in the home. · Program Coordinator will review documentation of repositioning plan and schedule for Client B daily when in the home. · Program Director will monitor documentation of repositioning plan and schedule for Client B monthly. · Nursing staff will monitor documentation of repositioning plan and schedule for Client B weekly. · Nursing staff will verify use of bed wedge and repositioning plan and schedule when completing monthly nursing assessments with Client B. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · A wedge pillow will be purchased for Client B. · Staff will be retrained on Client B's repositioning plan and schedule, including use of the wedge pillow. · Staff will be retrained on documenting Client B's repositioning plan and schedule, including how to document client refusals. · Program Coordinator will monitor use of the bed wedge daily when in the home. · Program Coordinator will review documentation of repositioning plan and schedule for Client B daily when in the home. · Program Director will monitor documentation of	

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			repositioning plan and schedule for Client B monthly. · Nursing staff will monitor documentation of repositioning plan and schedule for Client B weekly. · Nursing staff will verify use of bed wedge and repositioning plan and schedule when completing monthly nursing assessments with Client B. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Staff will be retrained on Client B's repositioning plan and schedule, including use of the wedge pillow. · Staff will be retrained on documenting Client B's repositioning plan and schedule, including how to document client refusals. · Program Coordinator will monitor use of the bed wedge daily when in the home. · Program Coordinator will review documentation of repositioning plan and schedule for Client B daily when in the home. · Program Director will monitor documentation of repositioning plan and schedule for Client B monthly. · Nursing staff will monitor documentation of repositioning plan and schedule for Client B weekly. · Nursing staff will verify use of bed wedge and repositioning plan and schedule when completing monthly nursing assessments with Client B.	

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			1.What is the date by which the systemic changes will be completed? · June 12, 2015	
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to hold evacuation drills at least quarterly for each shift of personnel at the group home where 4 of 4 sampled clients lived (clients A, B, C and D) and 3 of 3 additional clients lived (clients E, F and G). Findings include: Facility evacuation drills held at the group home where 4 of 4 sampled clients lived (clients A, B, C and D) and 3 of 3 additional clients lived (clients E, F and G) for the past year were reviewed on 4/22/15 at 1:20 P.M. The first shift drills were held on 4/20/14 a fire drill at 3:45 P.M., 1/5/15 a tornado drill at 8:15 A.M. and 1/5/15 a fire drill at 8:00 A.M. The second shift drills were held on 5/1/14 a fire drill at 5:02 P.M., 2/13/15 a fire drill at 3:00 P.M. and 2/23/15 a tornado drill at 3:35 P.M. There were no third shift drills available for review.	W 0440	**W440 Evacuation Drills** The facility must hold evacuation drills at least quarterly for each shift of personnel. **1. What corrective action will be accomplished?** · Evacuation drill schedule will be implemented in the home to ensure each shift of personnel practices evacuation skills quarterly. · Program Coordinator will receive training on emergency drill expectations, timeliness and documentation. · Training regarding the importance of ensuring emergency drills are ran each month for the appropriate time period will be completed with staff. · Program Director will monitor the emergency drills monthly. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same	06/12/2015

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	An interview was conducted with Program Director (PD) #2 on 4/28/15 at 4:55 P.M. When asked how frequently evacuation drills were to be held in the group home, the PD stated " I think the regulations indicate they are to be held quarterly on each shift." When asked if the facility had held evacuation drills quarterly on each shift, the PD stated "According to the drills available for review, no we did not meet the regulation." An interview was conducted with the Area Director (AD) on 4/28/15 at 5:21 P.M. When asked if the evacuation drills were held according to the regulations, the AD stated, "We do not have any more drills available for you to review." 9-3-7(a)		deficient practice. · Evacuation drill schedule will be implemented in the home to ensure each shift of personnel practices evacuation skills quarterly. · Program Coordinator will receive training on emergency drill expectations, timeliness and documentation. · Training regarding the importance of ensuring emergency drills are ran each month for the appropriate time period will be completed with staff. · Program Director will monitor the emergency drills monthly. · Quarterly Health and Safety assessments will be completed. The assessment includes ensuring evacuation drills are completed as scheduled. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Evacuation drill schedule will be implemented in the home to ensure each shift of personnel practices evacuation skills quarterly. · Program Coordinator will receive training on emergency drill expectations, timeliness and documentation. · Training regarding the importance of ensuring emergency drills are ran each month for the appropriate time period will be completed with staff. · Program Director will	

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			monitor the emergency drills monthly. · Quarterly Health and Safety assessments will be completed. The assessment includes ensuring evacuation drills are completed as scheduled. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Coordinator will monitor monthly after each drill is to be ran to ensure completion. · The Program Director will monitor on a monthly basis. · The Quality Assurance Specialist will monitor as the quarterly health and safety assessments are completed. **1.What is the date by which the systemic changes will be completed?** a. June 12, 2015	
W 0488 Bldg. 00	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, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients (E, F and G), the facility failed to allow and/or encourage clients to participate in all aspects of meal preparation, and to allow/encourage	W 0488	**W488 Dining Areas and Service** The facility must assure that each client eats in a manner consistent with his or her developmental level. **What corrective action will be accomplished?** · Programming will be	06/12/2015

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	clients to feed themselves with assistance. Findings include: During the 4/20/15 observation period between 4:25 PM and 9:14 PM, at the group home, staff #10 custodially prepared client A, B, C, D, E and F's lunch, for 4/21/15, which consisted of Tuna salad sandwiches, tomatoes and peaches while clients B and C sat in the dining room area at the dining room table and/or clients E and F sat and drank coffee, that client F made when the client came home from the workshop/day program. Staff #1 placed the peaches into individual containers without involving the clients. Staff #1 made the tuna fish sandwiches and wrapped them in foil as client A was in her bedroom watching TV, client F was in and out of the dining room area as client D walked around the house with his walker and/or stood looking into the kitchen as the food cooked. At 5:00 PM, client F was asked to help set the table for dinner. Staff #1 custodially cooked the potatoes and broccoli. Staff #1 opened cans of pineapple and placed them into a serving bowl without involving clients A, B, C, D, E and/or F. Client D attempted to walk into the kitchen when client E physically redirected client D to leave the		implemented for Clients A, B, C, D, E, F and G to participate in dining skills and/or meal preparation · Staff will be retrained on the importance of ensuring family style dining, active treatment during meal preparation and proper supervision of the client's needs during the meal. · Staff will be retrained on client's meal time objectives and dining plans **1. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Staff will be retrained on the importance of ensuring family style dining, active treatment during meal preparation and proper supervision of the client's needs during the meal. · Staff will be retrained on client's meal time objectives and dining plans · Program Director/QIDP will monitor the residents programming and behavior needs on monthly basis. As needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Staff will be retrained on the	

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	kitchen. Client D became upset and bit his arm. Staff #1 redirected client E and returned to cooking. Staff did not encourage client E to assist/help. At 5:10 PM, client D attempted to return to the kitchen area/counter, but staff #1 stated "No." Client E placed silverware on the table after client F placed the plates and cups on the table. At 5:40 PM, a second staff (staff #9) came into the kitchen to assist with washing dishes while staff #1 was pouring tomato juice into 2 containers and placed the food into serving bowls. The pork chops and gravy had been fixed earlier by staff #1. Client A, who was also in the kitchen, stood and watched staff #9 wash the dishes. At 5:55 PM, staff prompted clients to start washing their hands. At 6:12 PM, staff carried and placed all the serving bowls on the dining room table as clients A, B, C, D, E and F sat at the table and watched. Client A independently served herself, and client G independently served herself broccoli. Staff fixed client C's plate without involving the client. As staff #4 sat next to client C, client C ate with her hands before she was redirected to use her spoon with hand over hand assistance. Client C also placed large bites of food in her mouth without staff redirection. Staff #4 wiped client C's mouth without involving and/or encouraging client C to wipe her own		importance of ensuring family style dining, active treatment during meal preparation and proper supervision of the client's needs during the meal. ·Staff will be retrained on client's meal time objectives and dining plans. · Program Director/QIDP will monitor the residents programming and behavior needs on monthly basis. As needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · Program Coordinator will informally monitor family style dining, active treatment with meal preparation and formal dining objectives daily when in the home. · Program Coordinator will complete a weekly meal observation for one month. After one month, Program Coordinator will complete and document one meal observation per month. · Program Director/QIDP will review weekly meal observations for one month and monthly thereafter. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · Program Coordinator will informally monitor family style dining, active treatment with meal preparation and formal dining objectives daily when in the home · Program Coordinator will complete a weekly meal observation for one month. After one month, Program Coordinator will complete	

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	mouth. Staff #10 sat next to client D and placed small portions of pureed food onto client D's plate. Once client D ate the amount placed on his plate, staff #10 would scoop more food onto his plate. Client D was able to feed himself. At 6:18 PM, staff #4 started feeding client C versus allowing the client to finish eating with hand over hand assistance. Staff #9 scooped the food onto client B's spoon and assisted the client with hand over hand assistance to feed himself. Once client G was finished eating, client G carried her dishes to the kitchen sink, and client E loaded the dishwasher. During the 4/21/15 observation period between 5:40 AM and 8:30 AM, at the group home, client A independently prepared coffee for her lunch and breakfast. Client A gathered all the lunch/food containers out of the refrigerator and sat them on the table. Client A was prompted to put the containers back into the refrigerator until later. At 5:55 AM, when staff #1 arrived to work, client A removed the lunch/food containers from the refrigerator and handed the items to staff #1 who sat them on the table by client. Client A picked up her containers and retrieved her sandwich wrapped in foil and placed the items into her lunch box. Client A independently retrieved her ice pack and placed it in her		and document one meal observation monthly. · Program Director/QIDP will review weekly meal observations for one month and monthly thereafter. **1.What is the date by which the systemic changes will be completed?** · June 12, 2015	

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	lunch box. Client A then independently filled containers with water and placed the containers on the table. As staff #1 placed the food into clients B, C, D and E's lunch boxes, client A would take the lunch box and sit them neatly onto the counter when done. At 6:18 AM, staff #1 asked client A what choice of cereal the client wanted to eat. Staff #1 pureed client D's cereal as the client walked around the house with his roller walker. Client H attempted to make the juice but was not able to get the frozen juice out of the container. Staff #1 took the container and made the juice. Client F came to the kitchen and packed his containers of food into his lunch box. Staff #1 placed the bread into the toaster and client A independently buttered the toast when it was done. At 6:38 AM, staff #1 also custodially made pancakes for clients A, B, C, D, E and F without involving client A who was in the kitchen. Staff #1 also made scrambled eggs for client B as staff #2 wheeled the client to the dining room area. At 7:00 AM, staff #1 cut up client G's pancakes with a fork and sat the client's plate in the table as client G was still getting dressed for the day. Staff #2 fed client D his pureed food without encouraging the client to feed himself and/or use hand over hand assistance. Staff #2 poured the juice for client D, but client D was able to hold and drink his			

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	juice without staff assistance. Staff #1 also fixed client C's plate without involving the client as client C was in the living room on the couch. Client F independently fixed his own plate. While staff #2 was feeding client D and staff #1 went into the living room to get client C, client F placed a large amount of butter on his bread. Staff #1 encouraged client F not to use all of the butter that was left in the container. As staff #1 was assisting client C to eat her breakfast (a few bites) and staff #2 was feeding client D, client F took 3 large scoops of sugar/sweetener from a bag and placed them into his bowl of cereal before staff could redirect him. Client F asked for more toast, staff #1 stated "What do you have to do to get seconds? Client F stood and went into the kitchen and cleaned off the counters and returned to the dining room table. Client F poured himself a second bowl of cereal and took 2 more toasts. At 7:17 AM, as staff #1 was preparing for the morning medication and staff #2 was feeding client B, client F took a small juice cup and placed it in the bag of sweetener and filled it to the top of the glass. Client F then poured the cup of sweetener onto his cereal and took large bites of his cereal with no redirection. Client B's record was reviewed on 4/23/15 at 10:35 AM and on 4/27/15 at			

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	2:41 PM. Client B's 4/20/15 Individual Support Plan (ISP) indicated the client had an objective to feed himself with physical and verbal prompts. Client B's ISP also indicated client B had an objective to independently prepare his lunch using appropriate choices (pack his lunch with staff assistance). Client A's record was reviewed on 4/28/15 at 3:00 PM. Client A's 12/18/14 ISP indicated the client had an objective to prepare a side dish. Client D's record was reviewed on 4/28/15 at 3:56 PM. Client D's 3/29/15 Dining Plan indicated "[Client D] requires hand over hand assistance from staff while eating. He is able to feed himself with his utensils (once staff have helped him scoop up the food) when he is willing to cooperate. Staff needs to sit by his side when they are assisting him with his meals." Client D's 3/29/15 ISP indicated the client had an objective to independently feed himself at meal times with hand over hand assistance as needed. Interview with client A on 4/21/15 at 5:50 AM indicated facility staff prepared the clients' lunches.			

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	Interview with staff #2 on 4/21/15 at 9:49 AM indicated clients did not prepare their lunches. Staff #2 stated "Some will over pack and some don't know how. The evening staff fixes the lunches." Interview with staff #1 on 4/22/15 at 8:55 AM stated the clients "Normally make lunches in the evening." Staff #1 indicated clients A and F were able to prepare their lunches. Staff #1 stated client F would state "It's a woman's job." Interview with Program Director (PD) #2 on 4/28/15 at 5:10 PM indicated clients should be encouraged to participate in all aspects of the meal preparation and cleanup. 9-3-8(a)			