

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/29/2016
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NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 KENTUCKY AVE MADISON, IN 47250
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W 0000  Bldg. 00	<p>This visit was for a recertification and state licensure survey. This visit included the investigation of complaint #IN00196910.</p> <p>Complaint #IN00196910: Substantiated, Federal/State deficiencies related to the allegations are cited at W149 and W156.</p> <p>Dates of survey: April 25, 26, 27, 28, and 29, 2016.</p> <p>Facility Number: 001021 Provider Number: 15G507 AIM Number: 100245130</p> <p>These federal deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/11/16.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 4 of 4 sampled clients (A, B, C and D), and</p>	W 0104	<b>W104:</b> The governing body must exercise general policy, budget, and operating direction over the	05/29/2016

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

TITLE

(X6) DATE

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

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	<p>3 additional clients (E, F and G), the facility's governing body failed to ensure the facility's environment was kept sanitary and in good repair.</p> <p>Findings include:</p> <p>Observations were conducted in the facility where clients A, B, C, D, E, F, and G lived on 4/25/16 from 3:10 PM until 7:30 PM and on 4/26/16 from 5:30 AM until 7:30 AM.</p> <p>The tile in the kitchen area was discolored. The exhaust fan did not work in the first bathroom. The washer was not working and soiled laundry was accumulating in the hallway which housed the washer/dryer. The carpeting in the bedrooms of clients B and E and C and D was stained and starting to fray at the doorways.</p> <p>Interview with Qualified Intellectual Disabilities Professional/QIDP staff #1 on 4/25/16 at 4:00 PM indicated the washing machine had malfunctioned on 4/23/16 and it had been reported to the administrator.</p> <p>9-3-1(a)</p>		<p>facility. <b>Corrective Action:</b> <b>(Specific):</b> The tile in the kitchen will be replaced, the carpets in client B, E C and D's room will be replaced with new flooring and the washer was replaced on 4/26/2016. <b>How others will be identified: (Systemic):</b> The Residential Manager will be in the home at least five times weekly and complete an environmental inspection checklist at least weekly and notify the maintenance coordinator of any issues needing addressed. The Maintenance Coordinator will be in the home at least twice monthly to complete an environmental inspection checklist. Any identified areas needing service will be addressed immediately.</p> <p><b>Measures to be put in place:</b> The tile in the kitchen will be replaced and the carpets in client B, E C and D's room will be replaced with new flooring and the washer was replaced on 4/26/2016. <b>Monitoring of Corrective Action:</b> The Residential Manager will be in the home at least five times weekly and complete an environmental inspection checklist at least weekly and notify the maintenance coordinator of any issues needing addressed. The Maintenance Coordinator will be in the home at least twice monthly to complete an environmental inspection checklist. Any identified areas needing service will be addressed immediately.</p>	

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W 0125 Bldg. 00	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients, (A, B, C and D) and 3 additional clients (E, F and G), the facility failed to ensure the clients or their surrogates had given permission for the use of door buzzers on all exit doors of the facility.</p> <p>Findings include:</p> <p>During observations at the facility on 4/25/16 from 3:10 PM until 7:30 PM and on 4/26/16 from 5:30 AM until 7:30 AM, all five exit doors were observed to be wired with door buzzers. When exit doors were opened, a buzzer would sound. At 5:30 AM on 4/26/16, staff #6 indicated the patio door was left slightly open so the buzzer would not sound and disturb the clients' sleep in the event staff needed to access the patio area.</p> <p>Review of client A's record on 4/27/16 at</p>	W 0125	<p><b>Completion date: 5/29/2016</b></p> <p><b>W125:</b> The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States including the right to file complaints, and the right to due process.</p> <p><b>Corrective Action: (Specific):</b> All client plans and assessments will be reviewed to determine if door alarms are needed. If door alarms are needed, approval from guardians and HRC will be obtained and if not the door alarms will be removed. All staff in the home will be in serviced on the operation standard for reporting and investigating abuse, neglect, exploitation, mistreatment or violation of the individual rights.</p> <p><b>How others will be identified: (Systemic):</b> The QIDP will be at the home at least weekly to ensure that</p>	05/29/2016
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	<p>10:27 AM indicated an Individual Support Plan/ISP dated 4/19/16 and a Behavior Action Plan/BAP dated 4/19/16. The ISP/BAP indicated no consent from client A or her surrogate for the use of door alarms. Door alarms were not part of her programs.</p> <p>Review of client B's record on 4/27/16 at 12:30 PM indicated an ISP and BSP (Behavior Support Plan) both dated 4/19/16. The ISP indicated no consent from client B or his surrogate for door alarms. His programs did not contain door alarms or specify a need for them.</p> <p>Client C's record was reviewed on 4/26/16 at 2:28 PM and indicated a 4/15/16 ISP. The ISP indicated no consent from client C or his surrogate for door alarms. His program did not contain door alarms or specify a need for them.</p> <p>Client D's record reviewed on 4/27/16 at 11:35 AM. The review indicated an ISP and BSP dated 4/19/16. The ISP indicated no consent from client D or his surrogate for door alarms. His programs did not contain door alarms or specify a need for them.</p> <p>Review of client E's record was done on 4/26/16 at 11:37 AM. The review indicated an ISP of 4/16. The ISP</p>		<p>any restriction has the necessary approvals and that all restrictions are warranted as it relates to clients plans and assessments. All client plans and assessments will be reviewed at least quarterly with the team.</p> <p><b>Measures to be put in place:</b> All client plans and assessments will be reviewed to determine if door alarms are needed. If door alarms are needed, approval from guardians and HRC will be obtained and if not the door alarms will be removed. All staff in the home will be in serviced on the operation standard for reporting and investigating abuse, neglect, exploitation, mistreatment or violation of the individual rights.</p> <p><b>Monitoring of Corrective Action:</b> The QIDP will be at the home at least weekly to ensure that any restriction has the necessary approvals and that all restrictions are warranted as it relates to clients plans and assessments. All client plans and assessments will be reviewed at least quarterly with the team.</p> <p><b>Completion date: 5/29/2016</b></p>	

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	<p>indicated no consent from client E or his surrogate for door alarms. His programs did not contain door alarms or specify a need for them.</p> <p>Review of client F's record was done on 4/26/16 at 12:40 PM. The client had an ISP dated 4/19/16. The review indicated no consent from client F or her surrogate for door alarms. Her program did not indicate a need for door alarms.</p> <p>Client G's record was reviewed on 4/27/16 at 1:15 PM. The record indicated an ISP dated 4/19/16 which did not indicate a need for door alarms. The record review indicated no consent for the alarms from client G or his surrogate.</p> <p>Interview with Qualified Intellectual Disabilities Professional/QIDP staff #1 was conducted on 4/27/16 at 1:00 PM. The interview indicated the door alarms had been in place before QIDP was in charge of programming for the facility. QIDP #1 was unable to find consents for the door alarms in the clients' records.</p> <p>9-3-2(a)</p>			

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W 0140  Bldg. 00	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on observation, record review and interview for 4 of 4 sampled clients (A, B, C and D), and 4 additional clients (E, F, G and H), the facility failed to ensure the clients money was accounted for completely.</p> <p>Findings include:</p> <p>Review of reportable incidents and investigations on 4/25/16 at 1:00 PM and on 4/28/16 at 10:00 AM indicated an investigation dated 7/19/15 to 7/25/15 regarding missing client money from their accounts kept at the facility. Client A was missing \$63.00. Client B was missing \$20.00. Client D was missing \$18.00. Client E was missing \$77.00. Client F was missing \$20.00. Client G was missing \$22.00. Client H (discharged client) was missing \$27.00.</p> <p>Qualified Intellectual Disabilities Professional/QIDP #1 and the surveyor went into the office area of the facility on 4/25/16 at 3:40 PM. \$9.30 in cash was</p>	W 0140	<p><b>W140:</b> The facility must establish and maintain a system that assures a full and complete accounting of clients personal funds entrusted to the facility on behalf of clients.</p> <p><b>Corrective Action: (Specific):</b> A new manager has been hired for the home. All staff in the home will be in serviced on the operation standard for client finance management, no more than \$50.00 per client should be in the home at any time, immediate cashing of client checks as soon as they are received and assisting the client to spend funds to ensure that there is not a large sum of money in the home. All staff in the home will be in serviced on the operation standard for reporting and investigating abuse, neglect exploration mistreatment or violation of an individual's rights. All staff will be in-serviced on appropriate use of client personal funds and the approval process for fund requests. All clients who used personal funds to do laundry will be reimbursed. The missing funds from 7/19/2015 were reimbursed and the investigation could not determine who took the client funds.</p>	05/29/2016

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	<p>observed to be on the desk. The door to the office area was unlocked so clients and staff could access the office area. There was a receipt from a grocery store for 3 cases of soda in the amount of \$10.70 which was for client E. Three cases of soda were stacked on a chair in the office area. The \$9.30 was said by QIDP #1 to be the change from the purchase of soda using \$20.00 at the grocery store.</p> <p>A yellow sticky type note was observed to be on the desk in the office and contained the following: "[Client B] 5.00, [Client E] 25.00, [Client C] 5.00, [Client A] 10.00, [Client G] 5.00, [Client F] 8.00 (and), [Client D] 5.00."</p> <p>The sticky note was discussed (4/25/16 3:45 PM) with QIDP #1 and it was theorized these were amounts of pocket and soda money for the clients. Acting House Manager/AHM #1 was interviewed on 4/25/16 at 4:30 PM and she stated the yellow sticky note was a list of clients' "money" that was used by staff #3 to do the clients' "laundry" on 4/24/16. The facility's washer had ceased to work on 4/23/16 so the accumulated</p>		<p><b>How others will be identified:</b> <b>(Systemic):</b> The residential Manager will complete an audit of all client finances at least five times weekly and document the audit on the client finance record and if there is a discrepancy the manager will report it to QA immediately. The QIDP will visit the home at least twice weekly to complete an audit of all client finances and document the audit on the client finance record. The Program Manager will visit the home at least weekly to complete and audit of all client finances and document the audit on the client finance record.</p> <p><b>Measures to be put in place:</b> A new manager has been hired for the home. All staff in the home will be in serviced on the operation standard for client finance management, no more than \$50.00 per client should be in the home at any time, immediate cashing of client checks as soon as they are received and assisting the client to spend funds to ensure that there is not a large sum of money in the home. All staff in the home will be in serviced on the operation standard for reporting and investigating abuse, neglect exploration mistreatment or violation of an individual's rights. All staff will be in-serviced on appropriate use of client personal funds and the approval process for fund requests. All clients who used personal funds to do laundry will be reimbursed. The missing funds from 7/19/2015</p>	

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	<p>laundry was done and paid for by the clients.</p> <p>Review of client in home cash accounts on 4/25/16 at 3:40 PM with QIDP #1 indicated the following:</p> <p>Client A's April 2016 "Client Financial Record" (CFR) indicated on 4/13/16 the last balance recorded was \$92.75. The actual amount was \$82.75. The \$10.00 was not listed on the CFR.</p> <p>Client B's April 2016 "Client Financial Record" (CFR) indicated on 4/13/16 \$10.20 was the balance of cash on hand. When his money was counted it was \$5.20. No entry was on the CFR to account for \$5.00.</p> <p>Client C's April 2016 CFR indicated on 4/13/16 the balance was \$31.41. The money was counted as \$26.41; no entry was on the CFR regarding \$5.00.</p> <p>Client D's April 2016 CFR indicated on 4/13/16 a balance of \$11.41. The actual amount counted was \$6.41. No entry was on his CFR to account for the missing \$5.00.</p> <p>Client E's April 2016 CFR indicated on 4/13/16 a balance of \$108.25. The actual cash on hand was counted as \$83.25.</p>		<p>were reimbursed and the investigation could not determine who took the client funds.</p> <p><b>Monitoring of Corrective Action:</b> The residential Manager will complete an audit of all client finances at least five times weekly and document the audit on the client finance record and if there is a discrepancy the manager will report it to QA immediately. The QIDP will visit the home at least twice weekly to complete an audit of all client finances and document the audit on the client finance record. The Program Manager will visit the home at least weekly to complete and audit of all client finances and document the audit on the client finance record.</p> <p><b>Completion date: 05/29/16</b></p>		

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	<p>The grocery store receipt and the change of \$9.30 were not listed on the record. There was no record of a \$25.00 withdrawal on the CFR.</p> <p>Client F's April 2016 CFR indicated on 4/13/16 a balance \$18.17. When counted the actual cash on hand was \$10.17. The discrepancy of \$8.00 was not accounted for on the CFR.</p> <p>Client G's April 2016 CFR indicated his cash on hand was \$11.06 on 4/13/16. When counted, the actual cash on hand amount was \$6.06, the missing \$5.00 was not accounted for on his CFR.</p> <p>Interview with QIDP #1 on 4/25/16 at 4:15 PM indicated she had last audited the clients' accounts on 4/13/16. The interview indicated Acting Home Manager #1 and the QIDP only had access to the key which unlocked the clients' money to keep it safe. The interview indicated the clients' CFRs had not been kept up to date. The interview indicated clients were not supposed to have over \$50.00 in the home accounts unless a shopping trip was scheduled.</p> <p>9-3-2(a)</p>			

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W 0149  Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 4 of 4 sampled clients (A, B, C and D), and 4 additional clients (E, F, G and H), the facility failed to ensure the facility's neglect policy was implemented in regards to supervising clients, keeping client funds safe, investigating and reporting alleged financial exploitation of clients and investigating allegations of abuse/neglect.</p> <p>Findings include:</p> <p>1. Review of reportable incidents and investigations on 4/25/16 at 1:00 PM and on 4/28/16 at 10:00 AM indicated an investigation dated 7/19/15 to 7/25/15 regarding missing client money from their accounts kept at the facility. Client A was missing \$63.00. Client B was missing \$20.00. Client D was missing \$18.00. Client E was missing \$77.00. Client F was missing \$20.00. Client G was missing \$22.00. Client H (discharged client) was missing \$27.00.</p> <p>2. Qualified Intellectual Disabilities</p>	W 0149	<p><b>W149:</b> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p><b>Corrective Action: (Specific):</b> All staff in the home will be in serviced the operation standard for client finance management and the operation standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual rights. The QA manager will be in-serviced on timely completion of investigations and reporting the findings to the administrator within 5 business days. Due to inability to reach an outside individual that was part of the investigation the investigation was not able to be completed within the allotted time frame. Going forward QA will finalize the investigation if possible and make specific notes as to when attempts to contact were made.</p> <p><b>How others will be identified: (Systemic):</b> The Program Manager</p>	05/29/2016

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	<p>Professional/QIDP #1 and the surveyor went into the office area of the facility on 4/25/16 at 3:40 PM. \$9.30 in cash was observed to be on the desk. The door to the office area was unlocked so clients and staff could access the office area. There was a receipt from a grocery store for 3 cases of soda in the amount of \$10.70 which was for client E. Three cases of soda were stacked on a chair in the office area. The \$9.30 was said by QIDP #1 to be the change from the purchase of soda using \$20.00 at the grocery store.</p> <p>A yellow sticky type note was observed to be on the desk in the office and contained the following: "[Client B] 5.00, [Client E] 25.00, [Client C] 5.00, [Client A] 10.00, [Client G] 5.00, [Client F] 8.00 (and), [Client D] 5.00."</p> <p>The sticky note was discussed (4/25/16 3:45 PM) with QIDP #1 and it was theorized these were amounts of pocket and soda money for the clients. Acting House Manager/AHM #1 was interviewed on 4/25/16 at 4:30 PM and she stated the yellow sticky note was a list of clients' "money" that was used by</p>		<p>will meet with QA at least twice weekly to follow up on any pending investigations and ensure that investigations are completed timely and findings are reported to the administrator within 5 business days. The residential Manager will complete an audit of all client finances at least five times weekly and document the audit on the client finance record. The QIDP will visit the home at least twice weekly to complete an audit of all client finances and document the audit on the client finance record. The Program Manager will visit the home at least weekly to complete and audit of all client finances and document the audit on the client finance record.</p> <p><b>Measures to be put in place :)</b> All staff in the home will be in serviced the operation standard for client finance management and the operation standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual rights. The QA manager will be in-serviced on timely completion of investigations and reporting the findings to the administrator within 5 business days. Due to inability to reach an outside individual that was part of the investigation the investigation was not able to be completed within the allotted time frame. Going forward QA will finalize the investigation if possible and make specific notes as</p>	

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	<p>staff #3 to do the clients' "laundry" on 4/24/16. The facility's washer had ceased to work on 4/23/16 so the accumulated laundry was done and paid for by the clients.</p> <p>AHM #1 indicated the laundry money would be reimbursed to the clients and the incident would be reported to administrative staff.</p> <p>Interview with Quality Assurance/QA staff #10 on 4/28/16 at 4:27 PM indicated the clients paying for their own laundry had not been reported to QA and it not been reported to BDDS.</p> <p>3. Review of facility incidents, investigations and Bureau of Developmental Disabilities Services/BDDS reports on 4/25/16 at 1:00 PM and 4/28/16 at 10:00 AM and 1:00 PM indicated the following:</p> <p>A BDDS report dated 3/24/16 indicated an incident on 3/24/16 at 11:50 AM. The local workshop had reported facility staff had left clients A and B alone on the facility van with the engine running while staff went into the workshop to get client F.</p> <p>The investigation dated 3/24/16 to 4/29/16 was reviewed on 4/29/16 at 1:12 PM.</p> <p>It was substantiated staff #10 left clients A and B alone in the running van.</p>		<p>to when attempts to contact were made.</p> <p><b>Monitoring of Corrective Action:</b> The Program Manager will meet with QA at least twice weekly to follow up on any pending investigations and ensure that investigations are completed timely and findings are reported to the administrator within 5 business days. The residential Manager will complete an audit of all client finances at least five times weekly and document the audit on the client finance record. The QIDP will visit the home at least twice weekly to complete an audit of all client finances and document the audit on the client finance record. The Program Manager will visit the home at least weekly to complete and audit of all client finances and document the audit on the client finance record.</p> <p><b>Completion date: 05/29/2016</b></p>	

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	<p>A BDDS report dated 4/14/16 indicated an incident on 4/14/16 at 9:29 AM wherein House Manager/HM #2 allegedly took client D's jacket and did not return it. The follow-up BDDS report dated 4/21/16 indicated the investigation was ongoing. At the time of the survey, this investigation had not been completed.</p> <p>A BDDS report dated 4/14/16 indicated an incident on 4/14/16 at 9:29 AM wherein House Manager/HM #2 allegedly yelled at clients D and B, and grabbed client B by his jacket. The follow-up BDDS report dated 4/21/16 indicated the investigation was ongoing. At the time of the survey, this investigation had not been completed.</p> <p>BDDS reports for clients A, B, C, D, E, F, and G dated 4/21/16 indicated allegations made by workshop staff (former facility staff) on 4/20/16 at 3:30 PM. The BDDS reports indicated the following allegations which were being investigated: inappropriate staff conduct (possible drug use, entertaining friends at work), staff being verbally abusive, staff being neglectful by not providing food, medications or proper hygiene for clients, and not changing urine soaked clients</p>			

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	<p>while in bed at night. Clients did not go on outings, wheelchair straps not in good repair in the facility van, menus and dining plans not followed, putting clients to bed early, and staff prompting client A to walk on client B when he was lying on the floor. At the time of the survey, this investigation had not been completed because QA #1 was unable to complete all staff interviews so the investigation could be thorough (interview with QA #1 on 4/28/16 at 4:27 PM).</p> <p>The "Abuse/Neglect/Exploitation Policy and Procedure" component of the agency's 8/01/07 Operational Policy and Procedure Manual (revised 01/09/2015) was reviewed on 4/28/2016 at 11:45 AM. The review indicated the agency prohibited staff neglect/abuse/exploitation of clients. The policy indicated all allegations would be investigated and addressed. The definitions of neglect and exploitation was as follows:</p> <p>"E. Abuse-Exploitation Definition 1. An act that deprives an individual of real or personal property by fraudulent or illegal means. 2. Utilization of another person for selfish purposes."</p>			
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W 0153  Bldg. 00	<p>"F. Neglect--Program Implementation/Intervention Definition: 1. Failure to provide goods and/or services necessary for the individual to avoid physical harm. 2. Intentional failure to implement a support plan, inappropriate application of intervention, etc. which may result in jeopardy without qualified person notification/review."</p> <p>"G Neglect--Medical Definition: 1. Failure to provide goods and/or services necessary for the individual to avoid physical harm. 2. Failure to provide necessary medical attention, proper nutritional support or administering medication as prescribed."</p> <p>This federal tag relates to Complaint #IN00196910.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law</p>			

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	<p>through established procedures.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (A, B, C and D), and 4 additional clients (E, F, G and H), the facility failed to ensure allegations of financial exploitation were reported to the Bureau of Developmental Disabilities Services/BDDS.</p> <p>Findings include:</p> <p>Qualified Intellectual Disabilities Professional/QIDP #1 and the surveyor went into the office area of the facility on 4/25/16 at 3:40 PM. \$9.30 in cash was observed to be on the desk. The door to the office area was unlocked so clients and staff could access the office area. There was a receipt from a grocery store for 3 cases of soda in the amount of \$10.70 which was for client E. Three cases of soda were stacked on a chair in the office area. The \$9.30 was said by QIDP #1 to be the change from the purchase of soda using \$20.00 at the grocery store.</p> <p>A yellow sticky type note was observed to be on the desk in the office and contained the following: "[Client B] 5.00, [Client E] 25.00, [Client C] 5.00, [Client A] 10.00,</p>	W 0153	<p><b>W153:</b> The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p><b>Corrective Action: (Specific):</b> A new manager has been hired for the home. All staff in the home will be in serviced on the operation standard for client finance management, no more than \$50.00 per client should be in the home at any time, immediate cashing of client checks as soon as they are received and assisting the client to spend funds to ensure that there is not a large sum of money in the home. All staff in the home will be in serviced on the operation standard for reporting and investigating abuse, neglect exploration mistreatment or violation of an individual's rights and the BDDS reporting policy and procedure. All staff will be in-serviced on appropriate use of client personal funds and the approval process for fund requests. All clients who used personal funds to do laundry will be reimbursed. The washer was replaced on 4/26/16.</p>	05/29/2016

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	<p>[Client G] 5.00, [Client F] 8.00 (and), [Client D] 5.00."</p> <p>The sticky note was discussed (4/25/16 3:45 PM) with QIDP #1 and it was theorized these were amounts of pocket and soda money for the clients.</p> <p>Acting House Manager/AHM #1 was interviewed on 4/25/16 at 4:30 PM and she stated the yellow sticky note was a list of clients' "money" that was used by staff #3 to do the clients' "laundry" on 4/24/16. The facility's washer had ceased to work on 4/23/16 so the accumulated laundry was done and paid for by the clients.</p> <p>AHM #1 indicated the laundry money would be reimbursed to the clients and the incident would be reported to administrative staff.</p> <p>Interview with Quality Assurance/QA staff #10 on 4/28/16 at 4:27 PM indicated the clients paying for their own laundry had not been reported to QA and it had not been reported to BDDS.</p> <p>9-3-2(a)</p>		<p><b>How others will be identified:</b> <b>(Systemic):</b> The residential Manager will complete an audit of all client finances at least five times weekly, document the audit on the client finance record and if there is a discrepancy the manager will report it to QA immediately. The QIDP will visit the home at least twice weekly to complete an audit of all client finances, document the audit on the client finance record and report any discrepancies to QA immediately. The Program Manager will visit the home at least weekly to complete and audit of all client finances, document the audit on the client finance record and report any discrepancies to QA immediately.</p> <p><b>Measures to be put in place:</b> A new manager has been hired for the home. All staff in the home will be in serviced on the operation standard for client finance management, no more than \$50.00 per client should be in the home at any time, immediate cashing of client checks as soon as they are received and assisting the client to spend funds to ensure that there is not a large sum of money in the home. All staff in the home will be in serviced on the operation standard for reporting and investigating abuse, neglect exploration mistreatment or violation of an individual's rights and the BDDS reporting policy and procedure. All staff will be</p>	

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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		<p>in-serviced on appropriate use of client personal funds and the approval process for fund requests. All clients who used personal funds to do laundry will be reimbursed. The washer was replaced on 4/26/16.</p> <p><b>Monitoring of Corrective Action:</b> The residential Manager will complete an audit of all client finances at least five times weekly, document the audit on the client finance record and if there is a discrepancy the manager will report it to QA immediately. The QIDP will visit the home at least twice weekly to complete an audit of all client finances, document the audit on the client finance record and report any discrepancies to QA immediately. The Program Manager will visit the home at least weekly to complete and audit of all client finances, document the audit on the client finance record and report any discrepancies to QA immediately.</p> <p><b>Completion date: 05/29/16</b></p>	

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	<p>accordance with State law within five working days of the incident.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (A, B, C and D), and 4 additional clients (E, F, G and H), the facility failed to ensure their investigative findings of alleged staff to client abuse/neglect were reported to the administrator in 5 business days.</p> <p>Findings include:</p> <p>Review of facility incidents, investigations and Bureau of Developmental Disabilities Services/BDDS reports on 4/25/16 at 1:00 PM and 4/28/16 at 10:00 AM and 1:00 PM indicated the following:</p> <p>A BDDS report dated 3/24/16 indicated an incident on 3/24/16 at 11:50 AM. The local workshop had reported facility staff had left clients A and B alone on the facility van with the engine running while staff went into the workshop to get client F.</p> <p>The investigation dated 3/24/16 to 4/29/16 was reviewed on 4/29/16 at 1:12 PM.</p> <p>It was substantiated staff #10 left clients A and B alone in the running van. The investigation's results had not been reported to the administrator in five business days.</p>	W 0156	<p><b>W156:</b> The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five days of the incident.</p> <p><b>Corrective Action: (Specific):</b> The QA Manager will be in serviced on timely completion of investigations and reporting investigation findings to the administrator within five business days.</p> <p><b>How others will be identified: (Systemic):</b> The Program Manager will meet with QA at least twice weekly on Tuesday and Thursday to follow up on any pending investigations and ensure that investigations are completed timely and findings are reported to the administrator within 5 business days. The review with QA and the Program Manager will be documented to verify the meeting.</p> <p><b>Measures to be put in place:</b> The QA Manager will be in serviced on timely completion of investigations and reporting investigation findings to the administrator within five business days.</p> <p><b>Monitoring of Corrective Action:</b> The Program Manager will meet with QA at least twice weekly on Tuesday</p>	05/29/2016

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	<p>A BDDS report dated 4/14/16 indicated an incident on 4/14/16 at 9:29 AM wherein House Manager/HM #2 allegedly took client D's jacket and did not return it. The follow-up BDDS report dated 4/21/16 indicated the investigation was ongoing. At the time of the survey, this investigation had not been completed.</p> <p>A BDDS report dated 4/14/16 indicated an incident on 4/14/16 at 9:29 AM wherein House Manager/HM #2 allegedly yelled at clients D and B, and grabbed client B by his jacket. The follow-up BDDS report dated 4/21/16 indicated the investigation was ongoing. At the time of the survey, this investigation had not been completed.</p> <p>BDDS reports for clients A, B, C, D, E, F, and G dated 4/21/16 indicated allegations made by workshop staff (former facility staff) on 4/20/16 at 3:30 PM. The BDDS reports indicated the following allegations which were being investigated: inappropriate staff conduct (possible drug use, entertaining friends at work), staff being verbally abusive, staff being neglectful by not providing food, medications or proper hygiene for clients, and not changing urine soaked clients</p>		<p>and Thursday to follow up on any pending investigations and ensure that investigations are completed timely and findings are reported to the administrator within 5 business days. The review with QA and the Program Manager will be documented to verify the meeting.</p> <p><b>Completion date: 05/29/2016</b></p>		

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W 0192 Bldg. 00	<p>while in bed at night. Clients did not go on outings, wheelchair straps not in good repair in the facility van, menus and dining plans not followed, putting clients to bed early, and staff prompting client A to walk on client B when he was lying on the floor. At the time of the survey, this investigation had not been completed.</p> <p>Interview with QA staff #10 on 4/25/16 at 1:00 PM and on 4/28/16 at 4:27 PM indicated the staff in question continued to be suspended from duty and had no contact with the clients. The three investigations had not been completed because one staff could not be contacted for interview despite repeated attempts.</p> <p>This federal tag relates to Complaint #IN00196910.</p> <p>9-3-2(a)</p> <p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients, (A, B, C and D), and 1 additional client (G), the facility failed to ensure staff were sufficiently trained to administer medications, do documentation,</p>	W 0192	<p><b>W192:</b> For employees who work with clients, training must focus on skills and competencies directed toward clients health needs.</p>	05/29/2016

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	<p>implement health care programs, and ensure nutritional supplements were dispensed to clients correctly.</p> <p>Findings include:</p> <p>1. Staff #2 was observed to administer medications to client D on 4/26/16 at 7:33 AM. Client D received clonazepam (behavior/anxiety) 1.0 mg/milligrams. Review of client D's record on 4/27/16 at 11:35 AM indicated he received clonazepam (behavior/anxiety) 1.0 mg/milligrams twice daily. The record indicated a 4/16 descending controlled drug count record sheet for the clonazepam but it was blank (not initialed by staff #2) on 4/26/16 at 7:00 AM.</p> <p>Acting House Manager/AHM #1 and Nursing Manager (LPN) #1 were interviewed and audited client D's medications on 4/27/16 at 2:13 PM. Client D had received the clonazepam, but staff #2 had failed to document appropriately on the descending controlled medication count sheet. Acting House Manager #1 and Nursing Manager (LPN) #1 were interviewed and audited client D's medications on 4/27/16 at 2:13 PM. Client D still had 1/2 prednisone tablet which should have been</p>				<p><b>Corrective Action: (Specific):</b> All staff at the home will be in-serviced on Medication Administration Operation Standards, all clients risk plans and following all nursing recommendations and physician orders.</p> <p><b>How others will be identified: (Systemic):</b> The Residential Manager will be at the home at least five times weekly to ensure that all staff is following all client risk plans as written and all operation standards for medication administration. The nurse will visit the home at least weekly to ensure that all staff are following all client risk plans as written and following all operation standards for medication administration.</p> <p><b>Measures to be put in place:</b> All staff at the home will be in-serviced on Medication Administration Operation Standards, all clients risk plans and following all nursing recommendations and physician orders.</p> <p><b>Monitoring of Corrective Action:</b> The Residential Manager will be at</p>		

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	<p>given to him on 4/26/16 at 7:00 AM. Client D's 4/26/16 MAR 6:00 AM levothyroxine was initialed by staff #2 as having been given. The staff audit of the clients' levothyroxine blister package verified the medication had not been given and the MAR was initialed in error.</p> <p>2. Review of client B's record on 4/27/16 at 12:30 PM indicated he received lorazepam 0.5 mg. twice daily at 7:00 AM and 8:00 PM (anti-anxiety for behavior). The record review indicated a descending count sheet for the lorazepam which indicated the 4/26/16 7:00 AM dosage was not documented as having been dispensed. AHM #1 (4/27/16 at 1:45 PM to 2:13 PM) counted the medication and confirmed the lorazepam count was off by one so the 4/26/16 AM dosage had not been given by staff #2 to client B.</p> <p>3. Acting House Manager #1 and Nursing Manager (LPN) #1 were interviewed and audited clients A's controlled medication (Norco/hydrocodone for dental pain) on 4/27/16 at 1:45 PM until 2:13 PM. The observation/review of the medication container indicated a bottle containing 23 of the hydrocodone pills dispensed (bottle of 30, 5 milligram tablets) on 3/3/16 at a local pharmacy after client A</p>		<p>the home at least five times weekly to ensure that all staff is following all client risk plans as written and all operation standards for medication administration. The nurse will visit the home at least weekly to ensure that all staff are following all client risk plans as written and following all operation standards for medication administration.</p> <p><b>Completion date: 05/29/2016</b></p>	

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	<p>had dental surgery. There was no controlled medication descending count sheet with the medication. Staff had been writing on the bottle when they gave client A a pill. The label reviewed by AHM #1 indicated staff dispensed pain pills to client A on 3/4/16 at 7AM and 1 PM, 3/5/16 at 7 AM, 3/6/16 at 7:00 AM, 1 on 3/20/16 no time indicated, 1 on 3/21/16 no time indicated, and 1 on 4/17/16 at 2 AM.</p> <p>Review (4/27/16 at 10:27 AM) of client A's record indicated the 3/16 and 4/16 Medication Administration Records/MARs. The 3/16 PRN (as needed medication) documentation sheets indicated staff had dispensed one of the hydrocodone on 3/4/16, 3/20/16, and 3/21/16 at 6:30 AM. None of the other times the medication had been dispensed were documented; except on the pill container. The record review indicated the dental surgeon had prescribed the hydrocodone 5.0 milligram pain medication for client A on 3/3/16 1-2 tablets every 6 hours as needed for pain.</p> <p>LPN #1 contacted LPN #3 on 4/27/16 at 2:13 PM to see if staff had called on 4/17/16 at 2:00 AM to get permission to give client A a Norco. The call indicated no one had called the on call LPN #3 on 4/17/16 regarding dispensing a Norco</p>			

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	<p>pain pill to client A.</p> <p>Interview with LPN #1 on 4/27/16 at 2:13 PM indicated staff were to document dispensing the Norco on the MAR and the controlled medication count sheet. The interview indicated the staff should have gotten permission from the on call nurse before dispensing it on 4/17/16.</p> <p>4. On the morning of 4/26/16, staff #2 took client G a bottle of Boost (nutritional supplement) into the dining room to him during the breakfast meal at 6:55 AM. Client G told staff #2 he was supposed to get "a can." Staff #2 found a supplement in a can, Ensure plus, and served it to client G. Review of client G's record on 4/27/16 at 1:15 PM indicated he used to get Glucerna supplement (was in a can) but he was to get Boost supplement twice daily now.</p> <p>5. Observations of the morning routine were conducted at the facility on 4/26/16 from 5:30 AM until 7:40 AM. Staff #2 and #6 were working with clients. Staff #6 indicated (4/26/16 at 6:10 AM) he had taken the medication administration classes, CORE A/B; but he had not completed the necessary 3 observations to be able to administer medications to clients independently. Staff #2</p>			
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	<p>administered medications while staff #6 got clients up, assisted with hygiene and stripped wet (urine) beds and replaced bedding. At 6:18 AM, client C was being assisted by staff #6 in his bedroom. Staff #6 went to the medication room and asked staff #2 for client C's topical ointment (anti-fungal cream/Nystatin) prescribed by the physician. Staff #6 went to client C's bedroom and applied the ointment wearing gloves and returned the ointment tube to the medication room where QIDP #1 and staff #2 were. QIDP #1 stated to staff #2 not to: "forget to mark the MAR on it." Staff #2 initialed client C's 7:00 AM application of the Nystatin cream. Interview with Nursing Manager/LPN #1 on 4/26/16 at 3:15 PM indicated staff #2 should have administered the Nystatin cream to client C since staff #6 had not completed training. LPN #1 indicated staff who administer medications are the ones who sign for them; without exception.</p> <p>6. During the medication administration on 4/26/16 at 7:38 AM, client D was given a sinus rinse solution by staff #2. Client D went to the bathroom alone and rinsed his nose with the solution. On 4/26/16 during the 4:00 PM medication administration, staff #5 gave client D his sinus rinse solution and he went to the bathroom alone to rinse his nose.</p>			

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	<p>LPN #1 indicated to staff #5 client D's sinus rinse treatment should be witnessed by staff since it was a doctor's order.</p> <p>7. Review of client B's record on 4/27/16 at 12:30 PM indicated an ISP and BSP (Behavior Support Plan) both dated 4/19/16. Client B's diagnosis included, but was not limited to, Polydipsia (behavior of drinking to excess). The review indicated a Dining Plan dated 4/19/16 which indicated client B had a 2000 cc (cubic centimeters) daily fluid limit. Staff were to fill a pitcher to a prescribed amount and every time client B had a beverage a like amount of fluid was to be poured from the pitcher to keep track of his fluid intake. Staff #5 showed the surveyor and LPN #1 the pitcher of water used in client B's program on 4/26/16 at 4:30 PM. The pitcher was filled to a marked line to 2000 cc and in the refrigerator. No water had been poured out although client B had been receiving fluids at meals. Client B's pitcher of water was observed on 4/27/16 at 1:30 PM and was still filled to the 2000 cc mark.</p> <p>9-3-3(a)</p>				

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W 0249 Bldg. 00	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (A, B, C and D), and three additional clients (E, F and G), the facility failed to ensure staff provided supervision and implementation of programming.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 4/25/16 from 3:10 PM until 7:30 PM. Clients A, B, C, D, E, F and G were observed during the above time period, had medications, and their evening meal. Staff #5 came to work at 4:00 PM when staff #2 left (both staff routinely worked at the facility). Acting House Manager/HM) #1 had taken client B on an appointment and they returned to</p>	W 0249	<p><b>W249:</b> As soon as the interdisciplinary team has formulated a clients' individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p><b>Corrective Action: (Specific):</b> All staff at the home will be in-serviced on all client program plans and the implementation of all program objectives and goals for all clients. All staff at the home will be in-serviced on active treatment.</p> <p><b>How others will be identified: (Systemic):</b> A new manager has been hired for the home. The</p>	05/29/2016

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	<p>the facility between 4:15 and 4:30 PM. AHM #1 had to leave the facility at approximately 5:00 PM. Staff #8, who worked at another facility within the agency, came to work between 4:30 to 4:45 PM. Qualified Intellectual Disabilities Professional/QIDP staff #1 was at the facility during observations as was the Nursing Manager, LPN #1. Two direct contact staff were present (#5 and #8) to supervise the seven clients when AHM #1 left for the day. At 4:10 PM, staff #5 administered medications to clients. During this time period, clients were left alone in the living room, on the patio, or in their bedrooms while staff #5 did medications, prepared food (baked chicken and pudding) and beverages or assisted clients with bathing (A). Staff #8 prepared macaroni salad and carrots for the evening meal. Client C sat in his wheelchair on the patio from 3:10 PM until dinner time at 6:15 PM when staff assisted him to come to the dining room. Client C was unable to mobilize himself independently in the wheelchair. Client F was done bathing at 5:00 PM and then sat in her room and she and client G were observed to sit in their bedrooms watching television or listening to music. Client B sat in the living room or on the patio smoking until mealtime. Client E sat in the living room reading, then fell asleep and was snoring at 5:09 PM.</p>		<p>Residential Manager will be at the home at least five times weekly at various times on all shifts to ensure that all clients' program plans are being implemented as written and that active treatment plans are being followed. The QIDP will be at the home at least twice weekly to ensure that all clients' program plans are being implemented as written and that active treatment plans are being followed. The Program Manager will be at the home at least weekly to ensure that all clients' program plans are being implemented as written and that active treatment plans are being followed. The nurse will be in the home at least weekly to ensure that medication administration operation procedures are being followed and that risk plans are being implemented as written.</p> <p><b>Measures to be put in place:</b> <b>Corrective Action: (Specific):</b> All staff will be in-serviced on the implementation of all program objectives and goals for all clients and active treatment. A schedule will be developed that will include a specific time and day that each client to assist with meal prep, cooking, clean up, laundry and house hold chores. All staff will be in-serviced on all clients dining plans and the interventions within those plans</p> <p><b>Monitoring of Corrective Action:</b> A new manager has been hired for the home. The Residential Manager will be at the home at least five times</p>	

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	<p>Client A sat in the living room or her bedroom, did her chore of gathering trash and bathed with assistance at 5:30 PM. Staff #5 and #8 prepared baked chicken for the clients by taking it off of the bone and placing it on clients (G, A, F, and C) plate custodially. Staff #5 pureed chicken for client E and placed it on his plate. Clients B and D were served two chicken legs. Staff #5 and #8 carried prepared plates to the dining room and served clients in a custodial manner. Staff prepared beverages and served them custodially. Staff #8 walked around the table serving clients macaroni salad and carrots. Milk was not served to any clients. Client C was observed to eat his meal using a built up, large handled spoon, deep divided dish and a large covered mug with a straw. At 6:25 PM, staff #8 sat in the dining area, but did not reinforce dining plans or mealtime objectives. Client E pushed his plate away, then spit food back into it and the plate was removed by staff. At 6:35 PM, staff #5 prepared a blueberry muffin and pudding for client E. LPN #1 prompted client E to bite, chew and swallow before taking another bite of food. At 6:45 PM, client D was offered mixed vegetables (with input by LPN #1 for food substitutions) when he said he did not like carrots. Client C was back out on the patio at 7:00 PM, then indicated he</p>		<p>weekly at various times on all shifts to ensure that all clients' program plans are being implemented as written and that active treatment plans are being followed. The QIDP will be at the home at least weekly to ensure that all clients' program plans are being implemented as written and that active treatment plans are being followed. The Program Manager will be at the home at least weekly to ensure that all clients' program plans are being implemented as written and that active treatment plans are being followed. The nurse will be in the home at least weekly to ensure that medication administration operation procedures are being followed and that risk plans are being implemented as written.</p> <p><b>Completion date: 05/29/16</b></p>	

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	<p>needed to use the restroom, he had not used the restroom since observations began at 3:10 PM. Staff #5 and QIDP #1 assisted client C with transferring from his wheelchair to his bed, then to an adapted chair for toileting in the bathroom. Client C was observed to hold onto the Hoyer lift (mechanical lifting device for persons who cannot safely transfer independently) for standing with staff assistance for moving, he was not lifted by means of the lift mechanism by harness or sling appliance. Staff #8 was in the kitchen washing dishes and clients A, B, E, F and G were not engaged with dishwashing and were in the living room, their bedrooms or the patio without constant supervision. At 7:11 PM, client D was still at the dining room table alone eating mixed vegetables. Client D coughed and stated "I'm done, I'm stuffed," then coughed again. Staff #8 was still washing dishes in the kitchen. At 7:18 PM, QIDP #1 and staff #5 were still in the bedroom/bathroom area assisting client C.</p> <p>Observations of the morning routine were conducted at the facility on 4/26/16 from 5:30 AM until 7:40 AM. Staff #2 and #6 were working with clients. Staff #6 started getting clients up for the day at 6:00 AM. Client's beds were made with</p>			

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	<p>extra padding in case of incontinence. Clients A, B, C, and E's beds were urine soaked when they were awakened on 4/26/16. At 6:35 AM on 4/26/16, staff #6 stated clients' bedding was "generally soaked" in the mornings and he cleaned and made the beds with incontinence padding.</p> <p>Review of client A's record on 4/27/16 at 10:27 AM indicated an Individual Support Plan/ISP dated 4/19/16 and a Behavior Action Plan/BAP dated 4/19/16. The ISP/BAP indicated client A's diagnoses included, but were not limited to, Bipolar, Schizophrenia, Tardive Dyskinesia, and GERD (Gastro Esophageal Reflux Disease). The ISP/BAP indicated the client received psychotropic medications to manage her inappropriate behaviors. The record review indicated ISP training programs to sign her full name, increase safe pedestrian skills, bring fluids to the medication room, brush gums/dentures daily (she was edentulous), wipe the counters after dinner, take soiled laundry to the laundry room, and communicate with staff a choice of recreational outing. The record contained a dining plan dated 4/24/15 which indicated client A's food was to be cut into bite size pieces, and she was to be given a can of Ensure plus nutritional supplement every morning.</p>			

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	<p>Review of client B's record on 4/27/16 at 12:30 PM indicated an ISP and BSP (Behavior Support Plan) both dated 4/19/16. The ISP indicated client B's diagnoses included, but were not limited to, Parkinson's Disorder (neurological disorder affecting movement) Schizophrenia, and Polydipsia (behavior of drinking to excess). The ISP indicated the client received psychotropic medications to manage his inappropriate behaviors. The ISP contained the following training programs: wash clothes, communicate where he would like to go on a outing to staff, brush gums/tongue daily, knock before entering the restroom, follow smoking schedule, walk twice weekly for exercise and try to calm himself if he becomes aggressive. The review indicated a Dining Plan dated 4/19/16 which indicated client B had a 2000 cc (cubic centimeters) daily fluid limit. Staff were to fill a pitcher to a prescribed amount and every time client B had a beverage a like amount of fluid was to be poured from the pitcher to keep track of his fluid intake. His diet was a mechanical soft with chopped meats, thin liquids and he was to be encouraged to eat slowly (edentulous).</p> <p>Client C's record was reviewed on 4/26/16 at 2:28 PM and indicated a</p>			

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	<p>dining program dated 10/27/15 which indicated client C ate in a family style dining manner and his only adaptive equipment was a rocker knife. He used a regular cup. The dietary review dated 6/9/15 indicated client C received a regular diet with thin liquids. The record indicated his diagnoses included, but were not limited to, Infantile Cerebral Palsy, paraplegia, and mild level of Intellectual Disability. The record contained an ISP dated 4/15/16 which indicated client C was non-ambulatory and used a manual wheelchair. The nursing component of the 4/15/16 ISP indicated client C was to be transferred by means of the Hoyer lift (using the harness/sling device) with the assistance of two staff. The ISP objectives were to identify dollar bills, identify and tell why he took docusate (stool softener), increase communication skills by telling staff where he would like to go for recreation, and display mealtime safety and etiquette skills by taking small, slow, bites of food, chewing food with mouth closed,utensil down between bites, and wipe face with napkin.</p> <p>Client D's record reviewed on 4/27/16 at 11:35 AM indicated a dining plan dated 8/13/14 which indicated he required prompting to eat slowly, needed assistance to cut up his food and he</p>			

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	<p>sometimes refused to wear his lower dentures. The record contained risk plans dated 8/19/15 which indicated he had the potential for choking and staff were to monitor and verbally prompt him to take small food bites. The review indicated an ISP and BSP dated 4/19/16. The ISP indicated client D's diagnoses included, but were not limited to, Schizo affective disorder, anxiety disorder, moderate level of Intellectual Disability, and COPD (Chronic Obstructive Pulmonary Disease). Client D had ISP objectives of discussing his nervousness with staff, to participate in painting with his roommates, identify his colace medication, and to sweep/mop the dining area.</p> <p>Review of client E's record was done on 4/26/16 at 11:37 AM. The review indicated client E's diagnoses included, but were not limited to, GERD, diverticulosis, sleep apnea, gingival hyperplasia (an overgrowth of soft gum tissue which promotes drooling). The record indicated a dining plan dated 4/28/15. The Dining Plan indicated staff should check client E's mouth for phlegm or obstruction prior to meals and snacks. He should drink water before and during meals. Staff were to monitor client E during eating and cue him to slow down.</p>			

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	<p>Review of client F's record was done on 4/26/16 at 12:40 PM. The review indicated client F's diagnoses included, but were not limited to, Thoracic Kyphoscoliosis (curvature of the spine), restrictive airway disease, nocturnal hypoxemia (oxygen levels would drop during sleep), acid reflux, history of bowel obstruction and constipation. The review indicated a health risk plan dated 7/14/15 for acid reflux which indicated client F was to remain upright at least one hour after eating. The goal of the risk plan was zero episodes of epigastric pain or vomiting through 7/16. The record review indicated a Dining Plan dated 7/15/15 that indicated client F's diet order was for a mechanical soft with thin liquids. The client should take small bites of food and swallow completely. The client had an ISP dated 4/19/16 which included the following objectives: to identify synthroid (thyroid hormone), do physical therapy/PT exercises, state her phone number with verbal prompting, assist with cooking and doing laundry, state where she would like to go on an outing, and wear her hearing aids two hours daily.</p> <p>Client G's record was reviewed on 4/27/16 at 1:15 PM. The record indicated an ISP dated 4/19/16 and the following training objectives: mealtime safety and</p>			

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W 0264 Bldg. 00	<p>etiquette, taking appropriate sized bites of food with small utensil, chew with mouth closed, put spoon down between bites, drink after bites, and wipe face, identify flomax medication (for urinary retention), state address, wash hair daily, communicate to staff recreational outing choice, and do PT exercises. The record review indicated 4/21/15 health risk plans for hiatal hernia and GERD. Client G was to stay up for one hour after eating. The review indicated client G was to receive Boost nutritional supplement twice daily.</p> <p>Interview with Qualified Intellectual Disabilities Professional/QIDP staff #1 on 4/28/16 at 4:00 PM indicated clients were to be involved in activities and training objectives were to be implement/reinforced at all times of opportunity.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(iii) PROGRAM MONITORING &amp; CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious</p>			

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	<p>stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients, (A, B, C and D) and 3 additional clients (E, F and G), the facility's specially constituted committee (HRC/Human Rights Committee) failed to ensure the clients' rights by failing to review/monitor/approve the practice of using alarms/buzzers on all exit doors of the facility.</p> <p>Findings include:</p> <p>During observations at the facility on 4/25/16 from 3:10 PM until 7:30 PM and on 4/26/16 from 5:30 AM until 7:30 AM, all five exit doors were observed to be wired with door buzzers. When exit doors were opened, a buzzer would sound. At 5:30 AM on 4/26/16, staff #6 indicated the patio door was left slightly open so the buzzer would not sound and disturb the clients' sleep in the event staff needed to access the patio area.</p> <p>Review of client A's record on 4/27/16 at 10:27 AM indicated an Individual Support Plan/ISP dated 4/19/16 and a Behavior Action Plan/BAP dated 4/19/16. The ISP/BAP indicated no oversight by the facility's HRC regarding</p>	W 0264	<p><b>W264:</b> The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds and any other areas that the committee believes need to be addressed.</p> <p><b>Corrective Action: (Specific):</b> All client plans and assessments will be reviewed to determine if door alarms are needed. If door alarms are needed, approval from guardians and HRC will be obtained and if not the door alarms will be removed. All staff in the home will be in serviced on the operation standard for reporting and investigating abuse, neglect, exploitation, mistreatment or violation of the individual rights.</p> <p><b>How others will be identified: (Systemic):</b> The QIDP will be at the home at least weekly to ensure that any restriction has the necessary approvals and that all restrictions are warranted as it relates to clients plans and assessments. All client plans and assessments will be reviewed at least quarterly with the team. The Program Manager will meet with the QIDP at least twice weekly for the</p>	05/29/2016

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	<p>the use of door alarms. Door alarms were not part of her programs.</p> <p>Review of client B's record on 4/27/16 at 12:30 PM indicated an ISP and BSP (Behavior Support Plan) both dated 4/19/16. The ISP indicated no oversight by the facility's HRC regarding the use of door alarms. His programs did not contain door alarms or specify a need for them.</p> <p>Client C's record was reviewed on 4/26/16 at 2:28 PM and indicated a 4/15/16 ISP. The ISP indicated no oversight by the facility's HRC regarding the use of door alarms. His program did not contain door alarms or specify a need for them.</p> <p>Client D's record reviewed on 4/27/16 at 11:35 AM. The review indicated an ISP and BSP dated 4/19/16. The ISP indicated no oversight by the facility's HRC regarding the use of door alarms. His programs did not contain door alarms or specify a need for them.</p> <p>Review of client E's record was done on 4/26/16 at 11:37 AM. The review indicated an ISP of 4/16. The ISP indicated no oversight by the facility's HRC regarding the use of door alarms. His programs did not contain door alarms</p>		<p>next 30 days then weekly thereafter to review all client program plans and ensure accuracy.</p> <p><b>Measures to be put in place:</b> All client plans and assessments will be reviewed to determine if door alarms are needed. If door alarms are needed, approval from guardians and HRC will be obtained and if not the door alarms will be removed. All staff in the home will be in serviced on the operation standard for reporting and investigating abuse, neglect, exploitation, mistreatment or violation of the individual rights.</p> <p><b>Monitoring of Corrective Action:</b> The QIDP will be at the home at least weekly to ensure that any restriction has the necessary approvals and that all restrictions are warranted as it relates to clients plans and assessments. All client plans and assessments will be reviewed at least quarterly with the team. The Program Manager will meet with the QIDP at least twice weekly for the next 30 days then weekly thereafter to review all client program plans and ensure accuracy.</p> <p><b>Completion date: 05/29/2016</b></p>	

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W 0368	<p>or specify a need for them.</p> <p>Review of client F's record was done on 4/26/16 at 12:40 PM. The client had an ISP dated 4/19/16. The review indicated no oversight by the facility's HRC regarding the use of door alarms. Her program did not indicate a need for door alarms.</p> <p>Client G's record was reviewed on 4/27/16 at 1:15 PM. The record indicated no oversight by the facility's HRC regarding the use of door alarms in his 4/19/16 ISP. The record review indicated no need for client G to have alarms on the exit doors of the facility.</p> <p>Interview with Qualified Intellectual Disabilities Professional/QIDP staff #1 was conducted on 4/27/16 at 1:00 PM. The interview indicated the door alarms had been in place before QIDP was in charge of programming for the facility. QIDP #1 was unable to find any overview or consent from the facility's HRC for the door alarms in the clients' records.</p> <p>9-3-4(a)</p> <p>483.460(k)(1)</p>				

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Bldg. 00	<p><b>DRUG ADMINISTRATION</b></p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 1 of 4 sampled clients (B), the facility failed to ensure medications were given according to the physician's orders without error.</p> <p>Findings include:</p> <p>Review of client B's record on 4/27/16 at 12:30 PM indicated he received lorazepam 0.5 mg. twice daily at 7:00 AM and 8:00 PM (anti-anxiety for behavior). The record review indicated a descending count sheet for the lorazepam which indicated the 4/26/16 7:00 AM dosage was not documented as having been dispensed.</p> <p>Acting House Manager/AHM #1 was interviewed and audited client B's medications on 4/27/16 at 1:45 PM until 2:13 PM. AHM #1 counted the medication and confirmed the lorazepam count was off by one so the 4/26/16 AM dosage had not been given by staff #2 to client B.</p> <p>9-3-6(a)</p>			W 0368	<p><b>W368:</b> The system for drug administration must assure that all drugs are administered in compliance with physician orders.</p> <p><b>Corrective Action:</b> <b>(Specific):</b> All staff at the home will be in-serviced on the medication administration operation standards which include Medication Administration, General Guidelines for Medication Administration, Ordering and Accounting of Medications, Medication Destruction and Medication Storage and Disposal.</p> <p><b>How others will be identified:</b> <b>(Systemic):</b> A new manager has been hired for the location. The nurse will be at the home at least weekly to complete random medication observation checklists on staff and review the medication administration documentation and complete a controlled substance inventory audit to ensure that all medication administration operation standards are being followed. The Program Manger will be at the home at least weekly to complete random medication observation checklists on staff and review the medication administration documentation and complete a controlled substance inventory audit to ensure that all medication administration</p>		05/29/2016

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			<p>operation standards are being followed. to ensure that all medication administration operation standards are being followed. <b>Measures to be put in place:</b> All staff at the home will be in-serviced on the medication administration operation standards which include Medication Administration, General Guidelines for Medication Administration, Ordering and Accounting of Medications, Medication Destruction and Medication Storage and Disposal.</p> <p><b>Monitoring of Corrective Action:</b> A new manager has been hired for the location. The nurse will be at the home at least weekly to complete random medication observation checklists on staff and review the medication administration documentation and complete a controlled substance inventory audit to ensure that all medication administration operation standards are being followed. The Program Manger will be at the home at least weekly to complete random medication observation checklists on staff and review the medication administration documentation and complete a controlled substance inventory audit to ensure that all medication administration operation standards are being followed. to ensure that all medication administration operation standards are being</p>	

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W 0369  Bldg. 00	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 4 of 30 medications observed (clients D and F), the facility failed to ensure medications were given according to the physician's orders without error.</p> <p>Findings include:</p> <p>1. Staff #2 was observed to administer medications to client F on 4/26/16 from 7:00 AM until 7:19 AM. Client F did not receive levothyroxine 25 mcg. (micrograms) (hormone) or sulcrafate 1 gram (acid reflux). Review of client F's MAR/Medication Administration Record on 4/26/16 at 7:23 AM indicated she received levothyroxine 25 mcg. daily at 6:00 AM, an hour before food or medications. Client F received sulcrafate 1 gram every six hours (6AM, 12 PM, 6PM, 12AM) for GERD (Gastro Esophageal Reflux Disease). The medications were not initialed as having been given in the MAR for 6:00 AM on 4/26/16.</p> <p>Interview with staff #2 on 4/26/16 at 7:25</p>	W 0369	<p>followed. <b>Completion date: 05/29/2016</b></p> <p><b>W369:</b> The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error</p> <p><b>Corrective Action: (Specific):</b> All staff at the home will be in-serviced on the medication administration operation standards. The staff that made the errors was identified and either no longer works for the company or has been re-trained on the medication administration operation standards and was observed by the nurse passing medications to demonstrate competency.</p> <p><b>How others will be identified: (Systemic):</b> The Residential Manager will be at the home at least five times weekly to ensure that all medication administration operation standards are being followed. The nurse will be at the home at least twice weekly to ensure that all</p>	05/29/2016

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	<p>AM indicated he had not given client F any 6:00 AM medications; he was passing 7:00 AM medications. When asked if anyone had given 6:00 AM medications to client F, staff #2 stated "Not to my knowledge."</p> <p>2. Staff #2 was observed to administer medications to client D on 4/26/16 at 7:33 AM.</p> <p>Client D did not receive prednisone (corticosteroid used for a skin condition) or levothyroxine (hormone). Review on 4/27/16 at 11:35 AM of client D's record indicated his 4/16 MAR which indicated client D was to receive levothyroxine 125 mcg. daily at 6:00 AM an hour before food or other medications. Client D was also prescribed prednisone for a skin condition. He was being tapered off of the prednisone (dosage unknown). The 4/16 MAR indicated, on the morning of 4/26/16 at 7:00 AM client D was supposed to receive 1/2 of a tablet. The MAR had not been signed signifying the 1/2 tablet had been given.</p> <p>Acting House Manager #1 and Nursing Manager (LPN) #1 were interviewed and audited client D's medications on 4/27/16 at 1:45 PM until 2:13 PM. Client D still had 1/2 prednisone tablet which should have been given to him on 4/26/16 at 7:00 AM.</p>		<p>medication administration operation standards are being followed by review of medication audits, medication administration records and controlled substance inventory records and will complete medication administration observations on the staff working at the home during the visit. The Program Manger will be at the home at least weekly to ensure that all medication administration operation standards are being followed by review of medication audits, medication administration records and controlled substance inventory records.</p> <p><b>Measures to be put in place:</b> All staff at the home will be in-serviced on the medication administration operation standards. The staff that made the errors was identified and either no longer works for the company or has been re-trained on the medication administration operation standards and was observed by the nurse passing medications to demonstrate competency.</p> <p><b>Monitoring of Corrective Action:</b> The Residential Manager will be at the home at least five times weekly to ensure that all medication administration operation standards are being followed. The nurse will be at the home at least twice weekly to</p>				

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	9-3-6(a)		ensure that all medication administration operation standards are being followed by review of medication audits, medication administration records and controlled substance inventory records and will complete medication administration observations on the staff working at the home during the visit to . The Program Manger will be at the home at least weekly to ensure that all medication administration operation standards are being followed by review of medication audits, medication administration records and controlled substance inventory records.  <b>Completion date: 05/29/2016</b>		
W 0385  Bldg. 00	483.460(l)(3) DRUG STORAGE AND RECORDKEEPING The facility must maintain records of the receipt and disposition of all controlled drugs.  Based on observation, record review and interview for 1 of 4 sampled clients (A), the facility failed to ensure the disposition of the client's controlled drug was documented correctly.  Findings include:	W 0385	<b>W385:</b> The facility must maintain records of the receipt and disposition of all controlled drugs.  <b>Corrective Action: (Specific):</b> All staff at the home will be in-serviced	05/29/2016	

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	<p>Acting House Manager #1 and Nursing Manager (LPN) #1 were interviewed and audited client A's controlled medication (Norco/hydrocodone for dental pain) on 4/27/16 at 1:45 PM until 2:13 PM. The observation/review of the medication container indicated a bottle containing 23 of the hydrocodone pills dispensed (bottle of 30, 5 milligram tablets) on 3/3/16 at a local pharmacy after client A had dental surgery. There was no controlled medication descending count sheet with the medication. Staff had been writing on the bottle when they gave client A a pill. The label reviewed by AHM #1 indicated staff dispensed pain pills to client A on 3/4/16 at 7AM and 1 PM, 3/5/16 at 7 AM, 3/6/16 at 7:00 AM, 1 on 3/20/16 no time indicated, 1 on 3/21/16 no time indicated, and 1 on 4/17/16 at 2 AM.</p> <p>Review (4/27/16 at 10:27 AM) of client A's record indicated the 3/16 and 4/16 Medication Administration Records/MARs. The 3/16 PRN (as needed medication) documentation sheets indicated staff had dispensed one of the hydrocodone on 3/4/16, 3/20/16, and 3/21/16 at 6:30 AM. None of the other times the medication had been dispensed were documented; except on the pill container. The record review indicated the dental surgeon had</p>		<p>on the medication administration operation standards which include Medication Administration, General Guidelines for Medication Administration, Ordering and Accounting of Medications, Medication Destruction and Medication Storage and Disposal.</p> <p><b>How others will be identified:</b> <b>(Systemic):</b> A new manager has been hired for the location. The nurse will be at the home at least weekly to complete random medication observation checklists on staff and review the medication administration documentation and complete a controlled substance inventory audit to ensure that all medication administration operation standards are being followed. The Program Manger will be at the home at least weekly to complete random medication observation checklists on staff and review the medication administration documentation and complete a controlled substance inventory audit to ensure that all medication administration operation standards are being followed.</p> <p><b>Measures to be put in place:</b> All staff at the home will be in-serviced on the medication administration operation standards which include Medication Administration, General Guidelines for Medication</p>	

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	<p>prescribed the hydrocodone 5.0 milligram pain medication for client A on 3/3/16 1-2 tablets every 6 hours as needed for pain.</p> <p>LPN #1 contacted LPN #3 on 4/27/16 at 2:13 PM to see if staff had called on 4/17/16 at 2:00 AM to get permission to give client A a Norco. The call indicated no one had called the on call LPN #3 on 4/17/16 regarding dispensing a Norco pain pill to client A.</p> <p>Interview with LPN #1 on 4/27/16 at 2:13 PM indicated staff were to document dispensing the Norco on the MAR and the controlled medication count sheet. The interview indicated the staff should have gotten permission from the on call nurse before dispensing it on 4/17/16.</p> <p>Review of the Food and Drug Administration's website on 4/28/16 at 2:30 PM indicated the medication Norco/hydrocodone was a schedule II controlled drug.</p> <p>9-3-6(a)</p>		<p>Administration, Ordering and Accounting of Medications, Medication Destruction and Medication Storage and Disposal.</p> <p><b>Monitoring of Corrective Action:</b> A new manager has been hired for the location. The nurse will be at the home at least weekly to complete random medication observation checklists on staff and review the medication administration documentation and complete a controlled substance inventory audit to ensure that all medication administration operation standards are being followed. The Program Manger will be at the home at least weekly to complete random medication observation checklists on staff and review the medication administration documentation and complete a controlled substance inventory audit to ensure that all medication administration operation standards are being followed.</p> <p><b>Completion date: 05/29/2016</b></p>		

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W 0392 Bldg. 00	<p>483.460(m)(3) DRUG LABELING</p> <p>Drugs and biologicals packaged in containers designated for a particular client must be immediately removed from the client's current medication supply if discontinued by the physician.</p> <p>Based on observation, record review and interview, the facility failed to establish a system to insure immediate removal of discontinued medications from the current medication supply to prevent medications being given in error for 1 of 4 sampled clients (client A) after the medications were discontinued by the physician.</p> <p>Findings include:</p> <p>Acting House Manager #1 and Nursing Manager (LPN) #1 were interviewed and audited client A's controlled medication (Norco/hydrocodone for dental pain) on 4/27/16 at 1:45 PM until 2:13 PM. The observation/review of the medication container indicated a bottle containing 23 of the hydrocodone pills dispensed (bottle of 30, 5 milligram tablets) on</p>	W 0392	<p><b>W392:</b> Drugs and biological packaged in containers designated for a particular client must be immediately removed from the client's current medication supply if discontinued by the physician.</p> <p><b>Corrective Action: (Specific):</b> All staff at the home will be in-serviced on the medication administration operation standards which include Medication Administration, General Guidelines for Medication Administration, Ordering and Accounting of Medications, Medication Destruction and Medication Storage and Disposal.</p> <p><b>How others will be identified: (Systemic):</b> A new manager has been</p>	05/29/2016

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	<p>3/3/16 at a local pharmacy after client A had dental surgery. There was no controlled medication descending count sheet with the medication. Staff had been writing on the bottle when they gave client A a pill. The label reviewed by AHM #1 indicated staff dispensed pain pills to client A on 3/4/16 at 7AM and 1 PM, 3/5/16 at 7 AM, 3/6/16 at 7:00 AM, 1 on 3/20/16 no time indicated, 1 on 3/21/16 no time indicated, and 1 on 4/17/16 at 2 AM.</p> <p>Review (4/27/16 at 10:27 AM) of client A's record indicated the 3/16 and 4/16 Medication Administration Records/MARs. The 3/16 PRN (as needed medication) documentation sheets indicated staff had dispensed one of the hydrocodone on 3/4/16, 3/20/16, and 3/21/16 at 6:30 AM. None of the other times the medication had been dispensed were documented; except on the pill container. The record review indicated the dental surgeon had prescribed the hydrocodone 5.0 milligram pain medication for client A on 3/3/16 1-2 tablets every 6 hours as needed for pain. The record review indicated a follow-up appointment with the dental surgeon on 3/11/16 when the pain medication was discontinued.</p> <p>Interview with LPN #1 on 4/27/16 at</p>		<p>hired for the location. The nurse will be at the home at least weekly to complete random medication observation checklists on staff and review the medication administration documentation and complete a controlled substance inventory audit to ensure that all medication administration operation standards are being followed. The Program Manger will be at the home at least weekly to complete random medication observation checklists on staff and review the medication administration documentation and complete a controlled substance inventory audit to ensure that all medication administration operation standards are being followed.</p> <p><b>Measures to be put in place:</b> All staff at the home will be in-serviced on the medication administration operation standards which include Medication Administration, General Guidelines for Medication Administration, Ordering and Accounting of Medications, Medication Destruction and Medication Storage and Disposal.</p> <p><b>Monitoring of Corrective Action:</b> A new manager has been hired for the location. The nurse will be at the home at least weekly to complete random medication observation checklists on staff and review the</p>	

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W 0460	2:13 PM indicated staff were to document dispensing the on the MAR and the controlled medication count sheet. The interview indicated the medication should have been removed from the client's medications and destroyed when it was discontinued, 3/11/16.  9-3-6(a)  483.480(a)(1) FOOD AND NUTRITION SERVICES		medication administration documentation and complete a controlled substance inventory audit to ensure that all medication administration operation standards are being followed. The Program Manger will be at the home at least weekly to complete random medication observation checklists on staff and review the medication administration documentation and complete a controlled substance inventory audit to ensure that all medication administration operation standards are being followed.  <b>Completion date: 05/29/2016</b>		

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Bldg. 00	<p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients, (A, B, C and D) and 3 additional clients (E, F and G), the facility failed to ensure the complete menu was served to the clients.</p> <p>Findings include:</p> <p>On 4/26/16 at 6:07 AM, staff #6 made coffee and put together 7 bowls (not adapted type bowls) of Fruit Loops type cereal with milk together with spoons on the kitchen counter without including clients in the activity. Client D was on the patio with staff #2 and client F was in the living room. The bowls of cereal were placed onto the dining table by staff. Staff #2 made and served clients A, B and D coffee. Staff made tea for client C. Staff #2 also took nutritional supplements to clients, (Boost chocolate) to client D, ensure for client G. Clients A, B, and D ate at the dining table alone while staff #2 was in the kitchen area. Client C was assisted to the dining table by Qualified Intellectual Disabilities/QIDP Professional staff #1. The QIDP left the dining room. Acting house manager #1 arrived at 6:30 AM on 4/26/16 but did not supervise the dining room. Client F was in the dining room</p>	W 0460	<p><b>W460:</b> Each client must receive a nourishing well-balanced diet including modified and specially prescribed diets.</p> <p><b>Corrective Action: (Specific):</b> All staff in the home will be in-serviced on ensuring there is adequate food in the home and food as listed on the menus.</p> <p><b>How others will be identified: (Systemic):</b> The Residential Manager will be in the home at least five times weekly to ensure that there is adequate food in the home and food as listed on the menus. The QIDP will be in the home at least twice weekly to ensure that there is adequate food in the home and food as listed on the menu. The Program Manager will be in the home at least weekly to ensure that there is adequate food in the home and food as listed on the menus.</p> <p><b>Measures to be put in place:</b> All staff in the home will be in-serviced on ensuring there is adequate food in the home and food as listed on the menus.</p> <p><b>Monitoring of Corrective Action:</b> The Residential Manager will be in the home at least five times weekly to ensure that there is adequate food in the home and food as listed on the</p>	05/29/2016

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	<p>alone at 6:45 AM. Client F was drinking a bottle of Boost and client G was eating cereal, ensure and having coffee alone at 6:55 AM on 4/26/16. At 7:00 AM, client E was assisted to the dining room and ate the pre-prepared cereal with a squeeze bottle of beverage. He was not monitored by staff as he ate.</p> <p>Review (4/27/16 at 9:30 AM) of the facility's menu for breakfast on 4/26/16 indicated: 1/2 cup grape juice, 1/2 cup hot or 3/4 cup dry cereal, 1 English Muffin, 1 cup coffee, 1 cup skimmed milk, 2 tablespoons of jelly and 1 teaspoon of margarine.</p> <p>Clients were not served an English Muffin or the jelly/margarine. Hot/cold cereal choice was not provided. Extra cups of milk were not provided. Milk was also on the menu for the evening meal on 4/25/16 but milk was not served. On 4/27/16 at 9:45 AM the refrigerators were observed to have no milk in them.</p> <p>Confidential interview #1 stated the facility's credit card used for grocery and supply shopping was "shut off for updating" and no grocery money would be available for 2 days.</p> <p>9-3-8(a)</p>		<p>menus. The QIDP will be in the home at least twice weekly to ensure that there is adequate food in the home and food as listed on the menu. The Program Manager will be in the home at least weekly to ensure that there is adequate food in the home and food as listed on the menus.</p> <p><b>Completion date: 05/29/2016</b></p>	

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W 0488  Bldg. 00	<p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients, (A, B, C and D) and 3 additional clients (E, F and G), the facility failed to ensure clients participated in family style dining as capabilities permitted.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 4/25/16 from 3:10 PM until 7:30 PM. Clients A, B, C, D, E, F and G's evening meal and its preparation were observed during the above time period.</p> <p>Two direct contact staff were present (#5 and #8) to supervise the seven clients. At 4:10 PM, staff #5 prepared food (baked chicken and pudding) and beverages. Staff #8 prepared macaroni salad and carrots for the evening meal. Clients were not involved in the meal preparation. Staff #5 and #8 prepared baked chicken for the clients by taking it off of the bone and placing it on clients' (G, A, F, and C) plates custodially. Staff #5 pureed chicken for client E and placed it on his plate. Clients B and D were served two chicken legs. Staff #5 and #8</p>	W 0488	<p><b>W488:</b> The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p><b>Corrective Action: (Specific):</b> All staff will be in-serviced on active treatment, family style dining, all client program plans and the implementation of those plans. A schedule will be developed that will include a specific time and day each client will assist with meal preparation, clean up and setting the table.</p> <p><b>How others will be identified: (Systemic)</b> The Residential Manager will be at the home at least five times weekly to ensure that all clients are involved in meal preparation and setting the table according to the schedule and are participating in family style dining. The QIDP will visit the home at least twice weekly to ensure that all clients are involved in meal preparation and setting the table according to the schedule. The Program Manager will visit the home at least weekly to ensure that all clients are involved in meal preparation and setting the table according to the schedule.</p>	05/29/2016

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	<p>carried prepared plates to the dining room and served clients in a custodial manner. Staff prepared beverages and served them custodially. Staff #8 walked around the table serving clients macaroni salad and carrots. Milk was not served to any clients. Client C was observed to eat his meal using a built up, large handled spoon, deep divided dish and a large covered mug with a straw. At 6:25 PM, staff #8 sat in the dining area, but did not reinforce dining plans or mealtime objectives. Client E pushed his plate away, then spit food back into it and the plate was removed by staff. At 6:35 PM, staff #5 prepared a blueberry muffin and pudding for client E. LPN #1 prompted client E to bite, chew and swallow before taking another bite of food. At 6:45 PM, client D was offered mixed vegetables (with input by LPN #1 for food substitutions) when he said he did not like carrots. Staff #8 was in the kitchen washing dishes and clients A, B, E, F and G were not engaged with dishwashing and were in the living room, their bedrooms or the patio without constant supervision. At 7:11 PM, client D was still at the dining room table alone eating mixed vegetables. Client D coughed and stated "I'm done, I'm stuffed," then coughed again. Staff #8 was still washing dishes in the kitchen.</p>		<p><b>Measures to be put in place:</b> <b>Corrective Action: (Specific):</b> All staff will be in-serviced on active treatment, family style dining, all client program plans and the implementation of those plans. A schedule will be developed that will include a specific time and day each client will assist with meal preparation, clean up and setting the table.</p> <p><b>Monitoring of Corrective Action:</b> The Residential Manager will be at the home at least five times weekly to ensure that all clients are involved in meal preparation and setting the table according to the schedule and are participating in family style dining. The QIDP will visit the home at least twice weekly to ensure that all clients are involved in meal preparation and setting the table according to the schedule. The Program Manager will visit the home at least weekly to ensure that all clients are involved in meal preparation and setting the table according to the schedule.</p> <p><b>Completion date: 05/29/2016</b></p>		

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	<p>On 4/26/16 at 6:07 AM, staff #6 made coffee and put together 7 bowls (not adapted type bowls) of Fruit Loops type cereal with milk together with spoons on the kitchen counter without including clients in the activity. Client D was on the patio with staff #2 and client F was in the living room. The bowls of cereal were placed onto the dining table by staff. Staff #2 made and served clients A, B and D coffee. Staff made tea for client C. Staff #2 also took nutritional supplements to clients, (Boost chocolate) to client D, ensure for client G. clients A, B, and D ate at the dining table alone while staff #2 was in the kitchen area. Client C was assisted to the dining table by Qualified Intellectual Disabilities/QIDP Professional staff #1. The QIDP left the dining room. Acting house manager #1 arrived at 6:30 AM on 4/26/16 but did not supervise the dining room. Client F was in the dining room alone at 6:45 AM. Client F was drinking a bottle of Boost and client G was eating cereal, ensure and having coffee alone at 6:55 AM on 4/26/16. At 7:00 AM, client E was assisted to the dining room and ate the pre-prepared cereal with a squeeze bottle of beverage. He was not monitored by staff as he ate.</p> <p>Review of client A's record on 4/27/16 at 10:27 AM indicated an Individual</p>			

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	<p>Support Plan/ISP dated 4/19/16 which contained the objective to wipe the counters after dinner. The record contained a dining plan dated 4/24/15 which indicated client A's food was to be cut into bite size pieces, and she was to be given a can of Ensure plus nutritional supplement every morning.</p> <p>Review of client B's record on 4/27/16 at 12:30 PM indicated an ISP and BSP (Behavior Support Plan) both dated 4/19/16. The ISP indicated client B's diagnoses included, but were not limited to, Parkinson's Disorder (neurological disorder affecting movement) Schizophrenia, and Polydipsia (behavior of drinking to excess). The review indicated a Dining Plan dated 4/19/16 which indicated client B had a 2000 cc (cubic centimeters) daily fluid limit. Staff were to fill a pitcher to a prescribed amount and every time client B had a beverage a like amount of fluid was to be poured from the pitcher to keep track of his fluid intake. His diet was a mechanical soft with chopped meats, thin liquids and he was to be encouraged to eat slowly (edentulous).</p> <p>Client C's record was reviewed on 4/26/16 at 2:28 PM and indicated a dining program dated 10/27/15 which indicated client C ate in a family style</p>			

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	<p>dining manner and his only adaptive equipment was a rocker knife. He used a regular cup. The dietary review dated 6/9/15 indicated client C received a regular diet with thin liquids. The record indicated his diagnosis included, but was not limited to, Infantile Cerebral Palsy. The record contained an ISP dated 4/15/16 which indicated he was to display mealtime safety and etiquette skills by taking small, slow, bites of food, chewing food with mouth closed, utensil down between bites, and wipe face with napkin.</p> <p>Client D's record reviewed on 4/27/16 at 11:35 AM indicated a dining plan dated 8/13/14 which indicated he required prompting to eat slowly, needed assistance to cut up his food and he sometimes refused to wear his lower dentures. The record contained risk plans dated 8/19/15 which indicated he had the potential for choking and staff were to monitor and verbally prompt him to take small food bites. The review indicated an ISP dated 4/19/16 with an objective to sweep/mop the dining area.</p> <p>Review of client E's record was done on 4/26/16 at 11:37 AM. The review indicated client E's diagnoses included, but were not limited to, GERD, diverticulosis, gingival hyperplasia (an</p>			

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	<p>overgrowth of soft gum tissue which promotes drooling). The review indicated a dining plan dated 4/28/15. The Dining Plan indicated staff should check client E's mouth for phlegm or obstruction prior to meals and snacks. He should drink water before and during meals. Staff were to monitor client E during eating and cue him to slow down.</p> <p>Review of client F's record was done on 4/26/16 at 12:40 PM. The review indicated client F's diagnoses included, but were not limited to, Thoracic Kyphoscoliosis (curvature of the spine), acid reflux, history of bowel obstruction and constipation. The review indicated a health risk plan dated 7/14/15 for acid reflux which indicated client F was to remain upright at least one hour after eating, The goal of the risk plan was zero episodes of epigastric pain or vomiting through 7/16. The record review indicated a Dining Plan dated 7/15/15 that indicated client F's diet order was for a mechanical soft with thin liquids. The client should take small bites of food and swallow completely. The client had an ISP dated 4/19/16 which included an objective to assist with cooking.</p> <p>Client G's record was reviewed on 4/27/16 at 1:15 PM. The record indicated an ISP dated 4/19/16 and the following</p>			

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	<p>training objectives: mealtime safety and etiquette, taking appropriate sized bites of food with small utensil, chew with mouth closed, put spoon down between bites, drink after bites, and wipe face. The record review indicated 4/21/15 health risk plans for hiatal hernia and GERD. Client G was to stay up for one hour after eating. The review indicated client G was to receive Boost nutritional supplement twice daily.</p> <p>Interview with Qualified Intellectual Disabilities Professional/QIDP staff #1 on 4/28/16 at 4:00 PM indicated clients were to be involved in activities and training objectives were to be implemented/reinforced at all times of opportunity.</p> <p>9-3-8(a)</p>			