

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 10/6, 10/7, 10/8 and 10/16/15.</p> <p>Facility number: 000685 Provider number: 15G666 AIM number: 100474600</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed by #09182 on 11/04/2015.</p>	W 0000		
W 0157 Bldg. 00	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 1 of 8 allegations of abuse and/or neglect reviewed, the facility failed to implement its recommended corrective action in regard to a medication error involving client #4.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on</p>	W 0157	<p>CORRECTION:</p> <p><i>If the alleged violation is verified, appropriate corrective action must be taken. Specifically, the staff responsible for Client #4's medication error has been retrained on approved medication administration procedures.</i></p> <p>PREVENTION:</p>	11/15/2015

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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W 0159 Bldg. 00	<p>10/6/15 at 11:40 AM. The facility's 9/29/15 reportable incident report indicated "[Client #4] (individual supported by ResCare) was given the wrong medications at bedtime med pass. [Client #4] took buspirone 15mg (milligrams), divalproex 250mg, Topiramate 25mg and ziprasidone 80mg (all behavior medications). [Client #4] was taken to [name of hospital] to be checked over. [Client #4] was treated and there was (sic) no adverse effects to the medications he was given. Doctor informed staff to take him home and let him sleep it off. Staff has been retrained on procedures of a med pass. Administration team facility nurse have been notified of the incident."</p> <p>Interview with Clinical Supervisor (CS) #1 on 10/8/15 at 1:35 PM indicated he would check to see when staff was retrained. CS #1 did not provide any additional information in regard to the corrective action.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p>		<p>When staff training needs are identified during the course of investigations, the QIDP or the clinical supervisor as appropriate will establish time frames for the prompt completion of required training. During weekly meetings with supervisors and the QIDP, the Clinical Supervisor will review documentation from the previous week to assure recommended training has occurred as directed. Training documentation will be turned in to the Program Manager monthly for further follow-up as needed.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team, Director of Operations/General Manager</p>	

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	<p>Based on observation, record review and interview for 3 of 4 sampled clients the QIDP (Qualified Intellectual Disabilities Professional) failed to ensure the clients' objectives were reviewed and/or monitored for progress, regression in skills and/or training toward new objectives as there were no monthly summaries to review in regard to the clients' Individual Support Plan (ISP) objectives. The QIDP failed to monitor a client's ISP to ensure the facility had October objective sheets in place to collect the client's ISP data. The QIDP failed to ensure a client's identified behavioral need had been addressed. The QIDP failed to ensure facility staff implemented clients' objectives and/or behavior plans when training opportunities existed. The QIDP failed to ensure a client's one to one staffing was clearly defined and to ensure a client's informed consent skills/needs were assessed in regard to the need for a legal guardian/health care representative. The QIDP failed to ensure a client was assessed in regard to speech, sensorimotor skills/needs and hearing after being admitted to the group home within 30 days of admission. The QIDP failed to coordinate clients' programs to ensure its Human Rights Committee reviewed and approved all restrictive programs and to obtain written informed</p>	W 0159	<p>CORRECTION: <i>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Active treatment observations and a review of facility support documents indicated that this deficient practice affected four additional individuals –Clients 5 – 8. Therefore the following corrections will be implemented systemically. The facility has employed a new QIDP tasked with integrating, coordinating and monitoring the active treatment programs for all clients. Specifically:</i></p> <p>The QIDP will complete monthly and quarterly summaries as required.</p> <p>The QIDP has put data collection grids and methodologies in place for all current prioritized learning objectives for all clients.</p> <p>The QIDP will assure that the team obtains a PT assessment for Client #3 to evaluate his mobility needs and that the team obtains a speech assessment for Client #2. A review of facility assessment data indicated this deficient practice did not affect any additional clients.</p>	11/15/2015

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	<p>consent for a client's restrictive medication increases.</p> <p>Findings include:</p> <p>1. Client #2's record was reviewed on 10/8/15 at 11:33 AM. Client #2's 4/2/15 ISP client #2 had the following objectives:</p> <p>-To identify her Depakote (seizures) 20% (percent) of the time with 3 verbal prompts for 3 consecutive months.</p> <p>-To learn the basic value of coins with 3 verbal prompts 25% of the time for 3 consecutive months.</p> <p>-To prepare her meal when she was ready to eat with 1 verbal prompt 20% of the time for 3 consecutive months.</p> <p>-To independently communicate using words or sign language with her picture book 50% of the time for 3 consecutive months.</p> <p>-To use the toilet without assistance from others with 3 verbal prompts 40% of the time for 3 consecutive months.</p> <p>-To complete her hygiene independently with 3 verbal prompts 50% of the time for 3 consecutive months.</p>		<p>The QIDP will direct the facility in completing an informed consent assessment for Client #2. A review of facility assessment data indicated this deficient practice did not affect any additional clients.</p> <p>The QIDP will modify Client #1's Behavior Support Plan (BSP) to include proactive and reactive strategies that address screaming.</p> <p>The QIDP has incorporated the definition and procedures for one to one staffing into Client #1's Behavior Support Plan (BSP).</p> <p>All direct support staff will be retrained and receive ongoing face to face coaching from supervisors regarding the need to provide consistent, aggressive and continuous active treatment for all clients including but not limited to implementation of prioritized learning objectives and behavior supports, meal preparation, family style dining, other domestic skills and meaningful leisure activities. Additionally, the Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty between 6:00 AM and 8:00 AM to provide active treatment during morning medication administration,</p>	

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	<p>Client #2's October 2015 data book indicated client #2 did not have any current data sheets in place for the above mentioned ISP objectives as of 10/8/15 for staff to collect/document data on. Client #2's record also indicated the QIDP failed to monitor client #2's above mentioned objectives in regard to progress, regression, and/or loss of skills as there were no QIDP reviews since client #2's 4/2/15 ISP was developed.</p> <p>Interview with Clinical Supervisor (CS) #1 on 10/8/15 at 2:00 PM indicated the facility's QIDP was not available to interview as the QIDP was at a meeting for a client. CS #1 indicated client #2's October data sheets were in the process of being put in place. CS #1 indicated there had been a change in the QIDPs for the group home and there were no reviews QIDP review of client #2's status.</p> <p>2. Client #1's record was reviewed on 10/7/15 at 2:35 PM. Client #1's 2/28/15 ISP indicated the client had the following objectives:</p> <p>-To brush his teeth with 3 verbal prompts 75% of the time for 3 consecutive months.</p>		<p>morning hygiene and breakfast.</p> <p>The QIDP will obtain Human rights Committee Approval for all restrictive programs for all Client #1 and Client #2. Through review of facility documentation, the governing body has determined that this deficient practice did not affect any additional clients.</p> <p>Written informed consent for restrictive programs has been obtained from Client #2 for the use of Valium for control of aggressive behavior. A review of documentation indicated that no additional clients were affected by this deficient practice.</p> <p>PREVENTION: The facility's new QIDP will be trained regarding the need to evaluate each client's progress no less than monthly and to modify supports accordingly. The QIDP will turn in copies of Monthly QIDP Summaries to the Clinical Supervisor for review and tracking.</p> <p>Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will review support documents and medical records no less than monthly to assure that data collection grids for current</p>	

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	<p>-To independently communicate using sign language along with a picture book 50% of the time for 3 consecutive months.</p> <p>-To prepare a simple dish with 3 verbal prompts 20% of the time for 3 consecutive months.</p> <p>-To identify basic coins up to \$1.00 with 3 verbal prompts 50% of the time for 3 consecutive months.</p> <p>-To identify his medication 50% of the time with 3 verbal prompts for 3 consecutive months.</p> <p>-To look both directions when crossing the street 50% of the time for 3 consecutive months.</p> <p>Client #1's record indicated the QIDP failed to monitor client #1's above mentioned objectives in regard to progress, regression, and/or loss of skills as there were no QIDP reviews since client #1's 2/28/15 ISP was developed.</p> <p>Interview with CS #1 on 10/8/15 at 2:00 PM indicated the facility's QIDP was not available to interview as the QIDP was at a meeting for a client. CS #1 indicated there had been a change in the QIDPs for the group home and there were no</p>		<p>prioritized learning objectives are in place and being properly utilized by direct support staff.</p> <p>The facility's new QIDP will be trained regarding the need to assure all needed assessments are completed within 30 days of admission. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will review support documents and medical records no less than monthly to assure that initial and ongoing assessment occurs as required.</p> <p>The facility's new QIDP will be trained regarding the need to assure that assessment of cognitive development including the ability to give informed consent occurs for all clients. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will review support documents and medical records no less than monthly to assure that initial and ongoing assessment, including but not limited to cognitive development, occurs as required.</p> <p>The facility's new QIDP will be trained regarding the need to assure that Behavior Support Plan address all current and emerging aberrant behaviors. Members of</p>	

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	<p>reviews QIDP review of client #1's status.</p> <p>3. Client #4's record was reviewed on 10/8/15 at 11:36 AM. Client #4's 5/3/15 ISP indicated the client had the following ISP objectives:</p> <ul style="list-style-type: none"> -To swab his mouth with hand over hand assistance 100% of the time with 1 verbal prompt for 3 consecutive months. -To put soap on his washcloth to wash his body with 3 verbal prompts 100% of the time for 3 consecutive months. -To repeat the word "quarter" while holding the coin with 1 model and 2 verbal prompts 80% of the time for 3 consecutive months. -To pour or stir a part of the lunch or dinner meal with hand over hand assistance 70% of the time for 3 consecutive months. -To be given 3 choices of activities with 3 verbal prompts and choose a leisure activity to participate in 100% of the time for 3 consecutive months. -To use 2 words to communicate a want, a need or emotion with 4 verbal prompts 100% of the time for 3 consecutive 		<p>the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility twice weekly for the next 21 days and weekly visits for an additional 60 days to assure appropriate supports are included in each client's support plan. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility.</p> <p>The facility's new QIDP will be trained regarding the need to incorporate all relevant interventions into support plans based on ongoing assessment and interdisciplinary input.</p> <p>The facility's new QIDP will be trained regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs for all clients. The QIDP, facility nurse and Human Rights Committee liaison will each maintain copies of Human rights Committee approval forms to assure the ability to reproduce copies of HRC records for surveyors upon request. The agency has</p>	

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	<p>months.</p> <p>Client #4's record indicated the QIDP failed to monitor client #4's above mentioned objectives in regard to progress, regression, and/or loss of skills as there were no QIDP reviews since client #4's 5/3/15 ISP was developed.</p> <p>Interview with CS #1 on 10/8/15 at 2:00 PM indicated the facility's QIDP was not available to interview as the QIDP was at a meeting for a client. CS #1 indicated there had been a change in the QIDPs for the group home and there were no reviews QIDP review of client #4's status.</p> <p>4. The QIDP failed to assess client #2's sensorimotor skills and/or speech within 30 days of being admitted to the group home, and to re- assess client #3's mobility needs in regard to the constant use of a wheelchair versus the need for a walker. Please see W210.</p> <p>5. The QIDP failed to assess client #2's ability to make informed consent decisions in regard to the client's psychotropic medications, restrictive behavior plans and health. Please see W222.</p> <p>6. The QIDP failed to address client #1's</p>		<p>established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility three times weekly for the next 30 days and twice weekly visits for an additional 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility.</p> <p>When guardians and healthcare representatives are unable to attend team meetings face to face, consent forms will be sent via postal mail for review and signature, along with a stamped envelope addressed to the facility. If consents are not returned to the facility in a timely manner via standard postal mail, the QIDP will send the forms to the appropriate legal representative via registered mail to assure the documents have been delivered and received. Members of the Operations Team will review restrictive programs on an ongoing basis to assure</p>		

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	<p>identified behavioral need. Please see W227.</p> <p>7. The QIDP failed to indicate how client #1's one on one staffing (1 staff to 1 client) was defined. Please see W240.</p> <p>8. The QIDP failed to ensure clients' Individual Support Plan (ISP) objectives and/or Behavior Support Plan (BSPs) were implemented when formal and/or informal training opportunities existed for clients #1, #2, #3 and #4. Please see W249.</p> <p>9. The QIDP failed to ensure the facility's Human Rights Committee reviewed and/or approved client #1 and #2's restrictive programs. Please see W262</p> <p>10. The QIDP failed to obtain client #2's written informed consent for the client's behavioral medication. Please see W263.</p> <p>9-3-3(a)</p>		<p>prior written informed consent has been obtained. Initially administrative monitoring will occur with increased frequency as follows: Members of the Operations Team and the QIDP will conduct active treatment observations and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility.</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring the provision of continuous active treatment. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to implementation of prioritized</p>	

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			<p>learning objectives and behavior supports, meal preparation, family style dining, other domestic skills and meaningful leisure activities. Members of the Operations Team and the QIDP will conduct observations during active treatment sessions no less than twice weekly for the next 21 days, and no less than weekly for an additional 60 Days At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring</p>	

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			<p>will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i>.</p> <p>Administrative support at the home will include but not be limited to:</p> <ol style="list-style-type: none"> 1. Direct face to face assessment of clients to compare observed behaviors and needs with current support documents and making recommendations for revisions as appropriate. 2. Assuring staff provide continuous active treatment during formal and informal opportunities. 3. Review of Human Rights 	

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W 0210 Bldg. 00	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN</p> <p>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, interview and record review for 2 of 4 sampled clients (#2 and #3), the clients' IDTs (interdisciplinary teams) failed to assess the client's sensorimotor skills and/or speech within 30 days of being admitted to the group home, and to re- assess a client's mobility needs in regard to the constant use of a wheelchair versus the need for a walker.</p> <p>Findings include:</p> <p>1. During the 10/6/15 observation period between 4:20 PM and 6:36 PM and the 10/7/15 observation period between 5:47 AM and 9:00 AM, at the group home, client #3 sat in and used a wheelchair as</p>	W 0210	<p>Committee records to assure appropriate approvals have been obtained.</p> <p>4. Other document and documentation reviews as described above.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION: <i>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Specifically, the team will obtain a PT assessment for Client #3 to evaluate his mobility needs and the team will obtain a speech assessment for Client #2. A review of facility assessment data indicated this deficient practice did not affect any additional clients.</i></p> <p>PERVENTION: A new QIDP is in place at the facility and will be trained regarding the need to assure all needed assessments are completed within 30 days of admission. Members of the</p>	11/15/2015

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	<p>his primary means of mobilization. Client #3 used his feet to move himself in the wheelchair. Client #3 attempted one time to transfer himself from his wheelchair to a dining room chair. Client #3 did not use any other means an assistive device (walker) to ambulate with during the above observation periods. During the 10/6/15 and 10/7/15 observation periods, client #3 also wore a gait belt around his waist while using the wheelchair.</p> <p>Client #3's record was reviewed on 10/7/15 at 2:07 PM. Client #3's Record Of Visits (ROVs) indicated the following (not all inclusive):</p> <p>-1/16/15 Client #3 went to the emergency room due to fall where the client fractured his second and fourth metatarsals (any bones of the foot) on his right foot. The ROV indicated "Non-weight bearing...."</p> <p>-1/29/15 Client #3 saw his primary care doctor for the fractured foot. The ROV indicated "...off work until Feb. (February) 3, 2015. Wheelchair usage for duration of healing."</p> <p>-2/17/15 Client #3 saw a Physical Therapist (PT) due to the client's foot fracture. The PT ROV indicated</p>		<p>Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will review support documents and medical records no less than monthly to assure that initial and ongoing assessment occurs as required.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>"...Patient would benefit from a wheelchair for current mobility and long distances mobility (due to) unsteadiness on feet and weight bearing restrictions. Wheelchair for current mobility...."</p> <p>-4/7/15 Client #3 saw his PT. The ROV indicated "He would benefit for a (R) (right) Forearm attachment for his walker."</p> <p>-4/20/15 "Post fracture care, Right foot...healed...."</p> <p>Client #3's 2/20/15 physician's order indicated "Evaluation to be fitted for a new wheelchair due to increased falls."</p> <p>Client #3's 8/26/15 physician's order indicated "Use gait belt for ambulation and transfers."</p> <p>Client #3's 9/1/15 physician's order indicated under "Adaptive Equipment" the client had a walker.</p> <p>Client #3's 9/2/15 Fall risk plan indicated client #3 utilized a wheelchair when the client's fractured foot was healing. The Fall assessment indicated "...Wheelchair to be used while in the community to ensure safety and reduce [client #3's] risks of fall and injury...Use gait belt for ambulation and transfers...." Client #3's</p>			

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	<p>9/2/15 risk plan also indicated "...[Client #3] would benefit from the use of a wheelchair for current mobility and likely for longer distances and community mobility once weight bearing restrictions have been removed...."</p> <p>Client #3's 9/24/15 Individual Support Plan (ISP) indicated client #3 was transferred from another Voca group home to his current group home on 9/24/15. Client #3's 9/24/15 ISP indicated the client had a walker. Client #3's ISP indicated he had an objective to utilize his walker. Client #3's 9/2/15 Fall Risk Plan and/or 9/24/15 ISP did not indicate the client's gait/mobility had been reassessed to determine if the client's walker and/or wheelchair were to be used for the client's primary means of mobility.</p> <p>Interview with staff #6 on 10/7/15 at 8:22 AM and 8:35 AM stated client #3 used a wheelchair "Mostly in house." Staff #6 indicated client #3 was also able to ambulate. Staff #6 stated "But we help him or he will not go."</p> <p>Interview with the LPN and Clinical Supervisor (CS) #1 on 10/8/15 at 2:00 PM indicated client #3 had a wheelchair. CS #1 indicated client #3 used a wheelchair for his primary means of</p>			

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	<p>ambulation since the client transferred to the group home on 9/24/15. LPN #1 indicated the client was not to use his wheelchair unless it was for long distances. LPN #1 indicated client #3 used a walker at his prior group home and was to be using a walker for his primary means of ambulation.</p> <p>2. During the 10/6/15 observation period between 4:20 PM and 6:36 PM and the 10/7/15 observation period between 5:47 AM and 9:00 AM, at the group home, client #2 had limited verbal skills of basic words.</p> <p>Client #2's 4/2/15 ISP indicated client #2 was admitted to the group home on 3/2/15. Client #2's ISP and/or record indicated the facility did not obtain an initial communication/speech assessment, hearing/audiological assessment, or an initial assessment gross/fine motor or sensorimotor skills within 30 days of the client being admitted to the group home.</p> <p>Interview with the LPN and CS #1 indicated client #2 was a new admission to the group home in 3/15. The LPN indicated she got an order for client #2 to obtain a speech evaluation. LPN #1 indicated the speech therapy agency the facility used would not accept the physician's order. The LPN indicated</p>			

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W 0222 Bldg. 00	<p>they told her she did not have the correct order. CS #1 and LPN #1 indicated client #2's communication skills, audiological, gross/fine motor or sensorimotor skills/needs had not been assessed.</p> <p>9-3-4(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include cognitive development. Based on observation, interview and record review for 1 of 4 sampled clients (#2), the facility failed to assess the client's ability to make informed consent decisions in regard to the client's psychotropic medications, restrictive behavior plans and health.</p> <p>Findings include:</p> <p>During the 10/6/15 observation period between 4:20 PM and 6:36 PM and the 10/7/15 observation period between 5:47 AM and 9:00 AM, at the group home, client #2 had limited communication in that the client knew a few words but was basically non-verbal in communication.</p> <p>Client #2's record was reviewed on 10/8/15 at 11:33 AM. Client #2's 9/1/15 physician's orders indicated client #2</p>	W 0222	<p>CORRECTION:</p> <p><i>The comprehensive functional assessment must include cognitive development. Specifically, the facility will complete an informed consent assessment for Client #2. A review of facility assessment data indicated this deficient practice did not affect any additional clients.</i></p> <p>PERVENTION:</p> <p>A new QIDP is in place at the facility and will be trained regarding the need to assure that assessment of cognitive development including the ability to give informed consent occurs for all clients. Members of the</p>	11/15/2015

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	<p>received Diazepam, Geodon (behaviors) and Halcion (pre-sedation) 1 hour before dental appointments</p> <p>Client #2's 4/2/15 Individual Support Plan (ISP) indicated client #2 was her own guardian.</p> <p>Client #2's 4/2/15 Behavior Support Plan (BSP) indicated client #2 was 19 years old and was transferred to an adult group home from a children's facility. Client #2's BSP indicated client #2 demonstrated self-injurious behavior, physical aggression, verbal aggression, non-compliance and elopement. Client #2's BSP indicated the facility staff could utilize You're Safe, I'm Safe (YSIS) (restraint techniques) when the client demonstrated continued SIB and/or physical aggression. Client #2's BSP indicated "...[Client B] does speak a few words; she uses profanity...She typically does not communicate in more than one word at a time...."</p> <p>Client #2's 4/15 Comprehensive Functional Assessment indicated the facility did not assess the client's ability to make and/or give written informed consent for the client's restrictive program, health and/or medications.</p> <p>Interview with the Clinical Supervisor</p>		<p>Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will review support documents and medical records no less than monthly to assure that initial and ongoing assessment, including but not limited to cognitive development, occurs as required.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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W 0227 Bldg. 00	<p>(CS) #1 on 10/8/15 at 2:00 PM indicated client #2 had a guardian prior to moving to the group home on 3/2/15. CS #1 indicated client #1's guardianship stopped once the client left the other agency. CS #1 indicated client #2's ability to make informed decisions/choices and/or to give written informed consent had not been completed/assessed.</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 of 4 sampled clients (#1), the client's Individual Support Plan (ISP) failed to address the client's identified behavioral need.</p> <p>Findings include:</p> <p>During the 10/6/15 observation period between 4:20 PM and 6:36 PM and the 10/7/15 observation period between 5:47 AM and 9:00 AM, at the group home, client #1 had one to one staffing (1 staff to 1 client). During the 10/6/15 observation period at 4:20 PM and 6:36 PM, client #1 would yell and/or scream</p>	W 0227	<p>CORRECTION:</p> <p><i>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment. Specifically, the interdisciplinary team will modify Client #1's Behavior Support Plan (BSP) to include proactive and reactive strategies that address screaming.</i></p> <p>PERVENTION:</p>	11/15/2015

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W 0240 Bldg. 00	<p>while the client sat at the dining room table.</p> <p>Client #1's record was reviewed on 10/7/15 at 2:35 PM. Client #1's 2/28/15 ISP and/or 9/24/15 Behavior Support Plan (BSP) indicated client #1 demonstrated Self-Injurious Behavior and physical aggression. Client #4's BSP and/or ISP did not address the client's identified behavioral need (screaming).</p> <p>Interview with staff #7 on 10/7/15 at 8:14 AM indicated client #1's yelling/screaming would upset some of the clients.</p> <p>Interview with Clinical Supervisor (CS #1) on 10/8/15 at 2:00 PM stated client #2 would yell and scream as a way of "communication." CS #1 indicated client #1's behavior of yelling/screaming had not been addressed.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and</p>	W 0240	<p>A new QIDP is in place at the facility and will be trained regarding the need to assure that Behavior Support Plan address all current and emerging aberrant behaviors. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility twice weekly for the next 21 days and weekly visits for an additional 60 days to assure appropriate supports are included in each client's support plan. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p>	11/15/2015			

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	<p>record review for 1 of 4 sampled clients (#1), the client's Individual Support Plan (ISP) failed to indicate how the client's one on one staffing (1 staff to 1 client) was defined.</p> <p>Findings include:</p> <p>During the 10/6/15 observation period between 4:20 PM and 6:36 PM and the 10/7/15 observation period between 5:47 AM and 9:00 AM, at the group home, client #1 had one to one staffing. On 10/6/15, staff #3 was client #1's one to one staff person. Staff #3 stayed within arm's reach of the client.</p> <p>During the 10/7/15 observation period between 5:47 AM and 9:00 AM, client #1 came out of his bedroom at 6:40 AM. No staff was around or near the client. Client #1 came out of his bedroom carrying his padded mitts. Staff #7, who was client #1's one on one staff person, was in the bathroom with client 6. Staff #7 came out of the bathroom, looked into client #1's bedroom and did not see the client. Staff #7 went into the kitchen area and saw client #1. Staff #7 held client #1 by the hand and walked the client back to his bedroom to assist the client to get ready for the day.</p> <p>Client #1's record was reviewed on</p>		<p><i>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment. Specifically, the interdisciplinary team will modify Client #1's Behavior Support Plan (BSP) to include proactive and reactive strategies that address screaming.</i></p> <p>PERVENTION:</p> <p>A new QIDP is in place at the facility and will be trained regarding the need to assure that Behavior Support Plan address all current and emerging aberrant behaviors. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility twice weekly for the next 21 days and weekly visits for an additional 60 days to assure appropriate supports are included in each client's support plan. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing</p>	

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W 0249 Bldg. 00	<p>10/7/15 at 2:35 PM. Client #1's 7/24/15 Record Of Visit (doctor's note) indicated client "...Needs 24 hour 'one on one' (1 staff to 1 client) care to prevent injury to self..."</p> <p>Client #1's 9/24/15 Behavior Support Plan (BSP) and/or 2/28/15 ISP did not indicate/define client #1's one to one staffing.</p> <p>Interview with staff #7 on 10/7/15 at 8:14 PM stated client #1 was to have one on one staffing "at all times." Staff #7 indicated client #1 would get up at night. Staff #7 stated "When [client #1] is in his room, we have to be there all the time."</p> <p>Interview with the Clinical Supervisor (CS) #1 on 10/8/15 at 2:00 PM stated client #1's one on one staffing was to be with client #1 "at all times." CS #1 indicated client #1's ISP and/or BSP did not specifically define client #1's one on one staffing to ensure facility staff would be near the client to prevent his self-injury behavior.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan,</p>		<p>support needed at the facility.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>		

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	<p>each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to ensure clients' Individual Support Plan (ISP) objectives and/or Behavior Support Plan (BSPs) were implemented when formal and/or informal training opportunities existed.</p> <p>Findings include:</p> <p>1. During the 10/6/15 observation period between 4:20 PM and 6:36 PM, at the group home, staff #2 prepared the dinner meal which consisted of baked fish, mixed vegetables and broccoli without involving clients #1, #2, #3, #4, #5, #6, #7 and #8. Although staff #2 verbally prompted client #8 to help cook, client #8 left the kitchen and staff #2 continued to custodially cook the meal. Client #1, who was sitting at the dining room table, went into the kitchen numerous times, staff #1 and/or staff #3 would redirect client #1 to leave the kitchen. Staff #2 did not encourage client #1 to help with the meal preparations.</p> <p>During the 10/7/15 observation period</p>	W 0249	<p>CORRECTION:</p> <p><i>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. Specifically, all direct support staff will be retrained and receive ongoing face to face coaching from supervisors regarding the need to provide consistent, aggressive and continuous active treatment for all clients including but not limited to implementation of prioritized learning objectives and behavior supports, meal preparation, family style dining, other domestic skills and meaningful leisure activities. Additionally, the Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty between 6:00 AM and 8:00 AM to provide active treatment during morning</i></p>	11/15/2015

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	<p>between 5:47 AM and 9:00 AM staff #6 made oatmeal while clients #1, #2, #3, #4, #5, #6, #7 and #8 were still in bed and/or getting up. Staff #6 made juice and set it on the table. Staff #1 came in for the day and threw out the oatmeal staff #6 had made as it was burned. Staff #1 custodially made a smaller pan of oatmeal on the stove. Staff #1 had client #8 help put bagels in the toaster. Staff #1 made juice as clients started coming to the table for breakfast as staff #1 did not know staff #6 had already made the juice which was already on the table. Client #8 helped butter the bagels as staff #6 placed oatmeal in clients #1, #2, #3 and #8's bowls without involving the clients. Staff #7, who was also at the table, poured juice for clients #1, #2, #3, #4, #5, #6 and #8 as client #7 indicated she did not want any juice. Staff #7 did not encourage clients to pour their own juice and/or assist the clients to pour their juice. Staff #6 then picked up a bottle of syrup and walked around to clients' bowls and poured syrup into the clients' oatmeal without encouraging clients to do it themselves. At one point during the breakfast meal, staff #6 wiped client #4's mouth with a napkin. Staff #6 did not encourage client #4 to wipe is own mouth. Once the breakfast was finished, staff #1 custodially did the dishes without encouraging client #1, #2, #3,#4, #5, #6 ,</p>		<p>medication administration, morning hygiene and breakfast.</p> <p>PREVENTION:</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring the provision of continuous active treatment. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to implementation of prioritized learning objectives and behavior supports, meal preparation, family style dining, other domestic skills and meaningful leisure activities. Members of the Operations Team and the QIDP will conduct observations during active treatment sessions no less than twice weekly for the next 21 days, and no less than weekly for an additional 60 Days At the conclusion of this period of intensive administrative monitoring and support, the</p>	

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	<p>#7 and/or #8 to assist with the dishes and/or meal cleanup.</p> <p>Client #3's record was reviewed on 10/7/15 at 2:07 PM. Client #3's 9/24/15 Individual Support Plan (ISP) indicated client #3 had an objective to independently prepare his meal anytime he was ready to eat.</p> <p>Client #1's record was reviewed on 10/7/15 at 2:35 PM. Client #1's 2/28/15 ISP indicated client #1 had an objective to prepare a simple food dish.</p> <p>Client #4's record was reviewed on 10/8/15 at 11:36 AM. Client #4's 5/3/15 ISP indicated client #4 had an objective to stir part of the meal during lunch or dinner.</p> <p>Client #2's record was reviewed on 10/8/15 at 11:33 AM. Client #2's 4/2/15 ISP objective was to prepare her meal any time she is ready to eat.</p> <p>Interview with staff #1 on 10/7/15 at 8:45 AM indicated clients should be encouraged to serve themselves and to pour their own drinks with hand over hand assistance.</p> <p>Interview with Clinical Supervisor (CS) #1 on 10/8/15 at 1:35 PM indicated</p>		<p>Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks</p>	

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	<p>clients #1, #2, #3 and #4 should be involved with their meal preparation and their meal time objectives should be implemented.</p> <p>2. During the 10/7/15 observation period between 5:47 AM and 9:00 AM, at the group home, client #4, a person with blindness, sat in the living room rocking in a rocking chair, rocked and/or held stuffed animals. Facility staff did not provide any training with the client other to encourage the client to get his morning medication. During the above mentioned observation period and the 10/6/15 observation period between 4:20 PM and 6:36 PM, at the group home, client #4 was not encouraged to speak except to say something about food during the 10/6/15 observation period.</p> <p>Client #4's record was reviewed on 10/8/15 at 11:36 AM. Client #4's 5/3/15 ISP indicated client #4 had objectives to repeat the word "quarter" when held, to participate in a leisure activity when given 3 choices and an objective to use 2 words to communicate a want, need and/or an emotion. Facility staff did not implement the objectives when opportunities for formal and/or informal training existed.</p> <p>Interview with CS #1 on 10/8/15 at 2:00</p>		<p>at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i>. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>PM indicated client #4's ISP objectives should be implemented as scheduled in the client's ISP and throughout the day when training was presented.</p> <p>3. During the 10/6/15 observation period between 4:20 PM and 6:36 PM and the 10/7/15 observation period between 5:47 AM and 9:00 AM, at the group home, client #1 had one to one staffing (1 staff to 1 client). During the 10/6/15 observation period between 4:20 PM and 6:36 PM, client #1 sat at the dining room table and scream/yelled. Facility staff #3 did not encourage client #1 to use a picture book to communicate and/or to encourage the client to sign. When client #1 attempted to hit himself in his head/face, staff #3 would verbally and/or physically redirect the client to not hit himself, but no alternate activity and/or training was provided/offered.</p> <p>Client #1's record was reviewed on 10/7/15 at 2:35 PM. Client #1's 2/28/15 ISP indicated the client had an objective to identify basic coins, and to communicate using sign language along with a picture communication book which facility staff did not implement when opportunities for formal and/or informal training existed.</p> <p>Interview with CS #1 on 10/8/15 at 2:00</p>			

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	<p>PM indicated client #1's ISP objectives should be implemented as scheduled in the client's ISP and throughout the day when training was presented.</p> <p>4. During the 10/7/15 observation period between 5:47 AM and 9:00 Am, at the group home, client #2 called client #5 a "b....." Client #2 then picked up the remote to the TV and placed it in her mouth. Client #5 yelled for staff and told them what client #2 was doing. Client #2 took the remote and threw at client #5 and client #5 threw it back at client #2. Staff #6 then redirected client #2 to the dining room table to sit down.</p> <p>During the 10/6/15 observation period between 4:20 PM and 6:36 PM and the 10/7/15 observation period between 5:47 AM and 9:00 AM, at the group home, client #2 had limited communication in that the client knew a few words but was basically non-verbal in communication.</p> <p>Client #2's record was reviewed on 10/8/15 at 11:35 AM. Client #2's 4/2/15 Behavior Support Plan (BSP) indicated when client #2 demonstrated verbal aggression, staff was to prompt other clients to ignore the client and ask them to leave the area for a while. The BSP indicated facility staff would let "...[client #2] know that her language is not</p>			

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	<p>appropriate. Staff will ignore the language until she has finished then when [client #2] has stopped staff will explain why the language was not appropriate and talk with [client #2] to find out what is bothering her. Staff will talk with [client #2] to discuss better ways to handle problems than verbal aggression." Client #2's BSP indicated when the client demonstrated physical aggression staff were to remove the other clients and attempt to figure out what was wrong with client #2. Client #2's BSP indicated the staff were to help the client find a solution or an "alternative."</p> <p>Client #2's ISP indicated the client had an objective to communicate using words, sign language and/or a picture communication book which facility staff did not implement and/or encourage.</p> <p>Interview with CS #1 on 10/8/15 at 2:00 PM indicated client #2's ISP communication objective should be implemented throughout the day.</p> <p>5. During the 10/7/15 observation period between 5:47 AM and 9:00 AM, at the group home, client #3 sat in a wheelchair and/or maneuvered the wheelchair for his primary means of mobilization/ambulation. During the 10/7/15 observation period, staff #8</p>			

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W 0262 Bldg. 00	<p>retrieved client #3's eyeglasses from his bedroom, cleaned the eyeglasses and handed them to client #3 to put on.</p> <p>Client #3's record was reviewed on 10/7/15 at 2:07 PM. Client #3's 9/24/15 ISP indicated client #3 had an objective to independently clean his eyeglasses and an objective to utilize his walker which facility staff did not implement when opportunities for training existed.</p> <p>Interview with CS #1 on 10/8/15 at 2:00 PM indicated client #1's ISP objectives should be implemented as scheduled in the client's ISP and throughout the day when training was presented.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on interview and record review for 2 of 3 sampled clients (#1 and #2) with restrictive programs, the facility's Human Rights Committee (HRC) failed to review and/or approve the clients' restrictive programs.</p>	W 0262	<p>CORRECTION:</p> <p><i>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of</i></p>	11/15/2015

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	<p>Findings include:</p> <p>1. Client #1's record was reviewed on 10/7/15 at 2:35 PM. Client #1's 9/22/15 physician's orders indicated "Pt (patient) to wear Posey mitts due to SIB (self-injurious behavior): Only to wear when showing signs of agitation mitts not to be worn for more than 2 hours."</p> <p>Client #1's 7/24/15 record Of Visit indicated client "...Needs 24 hour 'one on one' (1 staff to 1 client) care to prevent injury to self...."</p> <p>Client #1's 9/24/15 Behavior Support Plan (BSP) indicated client #1 demonstrated SIB. Client #1's 9/24/15 BSP and/or record did not indicate client #1's restrictive Posey mitts and/or one on one staffing had been approved and/or reviewed by the facility's HRC.</p> <p>Interview with the Clinical Supervisor (CS) #1 on 10/8/15 at 2:00 PM indicated he would check to see when the client's restrictive one on one staffing and Posey mitts had been approved by the facility's HRC. CS #1 did not provide any additional documentation client #1's restrictions had been reviewed and approved by the facility's HRC.</p> <p>2. Client #2's record was reviewed on</p>		<p><i>the committee, involve risks to client protection and rights.</i></p> <p>Specifically, the QIDP will obtain Human rights Committee Approval for all restrictive programs for all Client #1 and Client #2. Through review of facility documentation, the governing body has determined that this deficient practice did not affect any additional clients.</p> <p>PREVENTION:</p> <p>The QIDP will be retrained regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs for all clients. The QIDP, facility nurse and Human Rights Committee liaison will each maintain copies of Human rights Committee approval forms to assure the ability to reproduce copies of HRC records for surveyors upon request. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support</p>	

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W 0263 Bldg. 00	<p>10/8/15 at 11:33 AM. Client #2's 4/2/15 BSP indicated client #2 demonstrated SIB, verbal aggression, physical aggression, non-compliance and elopement. Client #2's BSP indicated the facility staff could utilize You're Safe, I'm Safe (YSIS) (restraint techniques) when the client demonstrated continued SIB and/or physical aggression. Client #2's BSP and/or record indicated the facility failed to have its facility's HRC review and approve client #2's restrictive program.</p> <p>Interview with the CS #1 on 10/8/15 at 2:00 PM indicated he would check to see when the client's restrictive 4/2/15 BSP had been approved. CS #1 did not provide any additional documentation client #2's restrictive behavior program had been reviewed and approved by the facility's HRC.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on interview and record review for 1 of 3 sampled clients with restrictive programs (client #2), the facility failed to</p>	W 0263	<p>documents into visits to the facility three times weekly for the next 30 days and twice weekly visits for an additional 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include review of Human Rights Committee records to assure appropriate approvals have been obtained.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p>	11/15/2015	

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	<p>ensure the client gave consent for the client's Diazepam (Valium).</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 10/8/15 at 11:33 AM. Client #2's 9/1/15 physician's orders indicated client #2 received Valium 2 milligrams 2 times a day for behaviors.</p> <p>Client #2's 4/2/15 Behavior Support Plan (BSP) indicated client #2 received Geodon for Intermittent Explosive Behavior. Client #2's BSP did not include the use of Valium for behaviors.</p> <p>Client #2's 4/2/15 Individual Support Plan (ISP) indicated client #2 was her own guardian. Client #2's ISP indicated client #2 gave written informed consent for her restrictive program on 4/2/15, but had not given written informed consent for the use of the Valium ordered on 8/21/15.</p> <p>Interview with Clinical Supervisor (CS) #1 on 10/8/15 at 2:00 PM indicated he would check to see if client #2 gave written informed consent for the start of the Valium. CS #1 did not provide any additional information in regard to the client's written informed consent for the Valium.</p>		<p><i>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Specifically, written informed consent for restrictive programs has been obtained from Client #2 for the use of Valium for control of aggressive behavior. A review of documentation indicated that no additional clients were affected by this deficient practice.</i></p> <p>PREVENTION:</p> <p>When guardians and healthcare representatives are unable to attend team meetings face to face, consent forms will be sent via postal mail for review and signature, along with a stamped envelope addressed to the facility. If consents are not returned to the facility in a timely manner via standard postal mail, the QIDP will send the forms to the appropriate legal representative via registered mail to assure the documents have been delivered and received. Members of the Operations Team will review restrictive programs on an ongoing basis to assure prior written informed consent has been obtained. Initially administrative monitoring will</p>	

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W 0289 Bldg. 00	<p>9-3-4(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on observation and interview for 1 of 4 sampled clients (#2), the facility failed to incorporate specific restraint techniques which could be utilized with the client when she demonstrated</p>	W 0289	<p>occur with increased frequency as follows: Members of the Operations Team and the QIDP will conduct active treatment observations and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p><i>The use of systematic interventions to manage inappropriate client behavior</i></p>	11/15/2015

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	<p>physical aggression.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 10/8/15 at 11:33 AM. Client #2's 4/2/15 Behavior Support Plan (BSP) indicated client #2 demonstrated self-injurious behavior, physical aggression, verbal aggression, non-compliance and elopement. Client #2's BSP indicated the facility staff could utilize You're Safe, I'm Safe (YSIS) (restraint techniques) when the client demonstrated continued SIB and/or physical aggression. Client #2's BSP did not indicate the specific type of YSIS restraints which could be used when client #2 demonstrated SIB and/or physical aggression.</p> <p>Interview with the Clinical Supervisor (CS) #1 on 10/8/15 at 2:00 PM indicated client #2's 4/2/15 BSP should include the type of restraints facility staff could use with client #2 when she demonstrated SIB and/or physical aggression toward others.</p> <p>9-3-5(a)</p>		<p><i>must be incorporated into the client's individual program plan. Specifically, the QIDP will modify Client #2's Behavior Support Plan (BSP) to include specific instructions for implementing agency approved restraint techniques when Client #2 demonstrates physical aggression and less restrictive reactive strategies have not resulted in Client #2 de-escalating.</i></p> <p>PREVENTION:</p> <p>A new QIDP is in place at the facility and will be trained regarding the need to develop specific reactive strategies to assist staff with supporting clients to control their aggressive behavior. The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff implement behavior supports as written.</p> <p>The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per</p>		

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			<p>week, on varied shifts to assist with and monitor skills training including but not limited to assuring staff implement behavior supports as written. Members of the Operations Team and the QIDP will conduct observations during active treatment sessions no less than twice weekly for the next 21 days, and no less than weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and</p>	

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			<p>hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will include assuring staff provide continuous active treatment during formal and</p>	

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W 0312 Bldg. 00	<p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 2 of 3 clients on behavioral medications (#1 and #2), the facility failed to ensure behavioral medications were part of the clients' plans and/or failed to ensure the client had an active treatment program for which the medications were prescribed.</p> <p>Findings include:</p> <p>1. Client #2's record was reviewed on 10/8/15 at 11:33 AM. Client #2's 9/1/15 physician's orders indicated client #1 received Halcion 0.25 milligrams "Give one tablet by mouth one hour before</p>	W 0312	<p>informal opportunities, including but not limited to assuring staff implement behavior supports as written.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION: <i>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Specifically the team will modify Client #1 and Client #2's Behavior Support Plans (BSP) to include desensitization plans to support them toward being able to tolerate medical procedures without the use of sedation. A review of facility support documents indicated that this deficient practice did not affect any additional clients.</i></p> <p>PERVENTION: A new QIDP is in</p>	11/15/2015

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	<p>appointment." Client #2's physician's orders also indicated client #2 received Valium 2 milligrams 2 times a day for behaviors.</p> <p>Client #2's 4/2/15 Behavior Support Plan (BSP) indicated client #2 demonstrated physical aggression, verbal aggression, self-injurious behavior, non-compliance and elopement. Client #2's BSP indicated client #2 received Depakote for her seizures. Client #2's BSP did not include the use of the Halcion and/or Valium. Client #2's BSP also did not include an active treatment/desensitization program for medical appointments for the use of the Halcion.</p> <p>Interview with Clinical Supervisor (CS) #1 and the LPN on 10/8/15 at 2:00 PM indicated client #2 should have a desensitization plan for the use of the Halcion for appointments. CS #1 indicated client #2's behavioral medications should be a part of the client's BSP.</p> <p>2. Client #1's record was reviewed on 10/7/15 at 2:35 PM. Client #1's 7/24/15 Record Of Visit indicated client #1 was placed on Risperdal 1 milligrams at bedtime due to the client's self-injurious behavior.</p>		<p>place at the facility and will be trained regarding the need to assure that active treatment programs are in place to support the reduction and eventual elimination of all currently prescribed psychotropic medications. Additionally, members of the Operations Team (including Clinical Supervisor, the Program Manager, Nurse Manager and Executive Director) will review facility Behavior Support Plans no less than monthly and to assure the plans include active treatment programs designed to reduce and eventually eliminate the use of behavior controlling medications.</p> <p>RESPONSIBLE PARTIES: Health Services Team, QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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W 0331	<p>Client #1's 9/1/15 physician's orders indicated client #1 received Halcion 1 milligram 1 hour prior to dental appointments and received Diazepam 5 milligrams 1 to 2 tablets for anxiety prior to podiatry appointments.</p> <p>Client #1's 2/28/15 Desensitization Plan for appointments indicated the client's as needed medications for dental and/or podiatry appointments were not part of the client's 2/28/15 plan.</p> <p>Client #1's 9/24/15 BSP indicated client #1's Risperdal was not part of the client's BSP as the client had an active treatment program for his self-injurious behavior.</p> <p>Interview with the LPN and CS #1 on 10/8/15 at 2:00 PM indicated client #1 received the Risperdal for his self-injurious behavior until client #1 could be seen by his psychiatrist in December 2015. CS #1 and the LPN indicated the use of Halcion and Diazepam for the client's medical and dental appointments were not part of the client's desensitization plan and/or BSP.</p> <p>9-3-5(a)</p> <p>483.460(c) NURSING SERVICES</p>			

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Bldg. 00	<p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 2 of 4 sampled clients (#1 and #3), the facility's nursing services failed to meet the nursing needs of the clients. The facility's nurse failed to periodically monitor, assess and/or document information in regard to the clients' health issues and/or needs. The facility's nursing services failed to ensure a client's shoulder injury was re-assessed when needed, failed to ensure a client obtained a timely referral as recommended, and failed to ensure a client wore ordered adaptive equipment (mitts) as ordered.</p> <p>Findings include:</p> <p>1. During the 10/6/15 observation period between 4:20 PM and 6:36 PM and the 10/7/15 observation period between 5:47 AM to 9:00 AM, at the group home, client #1 wore padded Posey mitts on both hands. Client #1 also wore a helmet on his head with a partial face mask. During the 10/6/15 observation period, client #1 would raise his padded mitt hand to his himself in hit head and/or face. Client #1's one on one staff (one staff to one client-staff #3) would verbally redirect client #1 to not hit himself in the face and/or in his head.</p>	W 0331	<p>CORRECTION:</p> <p><i>The facility must provide clients with nursing services in accordance with their needs. Specifically, the Governing Body has hired a new nurse to oversee the facility's medical needs. The nurse has obtained a clarified order for the use of Client #1's protective mitts which will be incorporated into his Comprehensive High Risk Plan and Behavior Support Plan. For Client #3, the nurse will facilitate reassessment of Client #3's right shoulder to assure that current supports remain appropriate. The nurse will be trained regarding the need to include documentation of all face to face nursing assessments in the monthly nursing summary as well as the need to assess all relevant acute and chronic medical conditions.</i></p> <p>PERVENTION:</p> <p>The QIDP will assure that the nursing team is included in all discussions/decisions relevant to clients' health and safety and modifications will be made to Comprehensive High Risk Plans</p>	11/15/2015
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	<p>Client #1 attempted self-injurious behavior (SIB) throughout the observation period. Client #1 wore the padded mitts throughout the observation period except for when facility staff removed the mitts for a couple of minutes. Client #1 would hold out his hands to have staff put the mitts back on.</p> <p>During the 10/8/15 observation period between 9:10 AM and 10:35 AM, at the facility's owned day program, client #1 arrived to the day program at 9:30 AM. Client #1 did not have his padded mitts on when he came into the day program. Shortly after arrival to the day program, client #1 held out his hands to staff #9 and the staff placed the padded mitts on the client's hands. Client #1 walked over to a mat on the floor, laid down, covered up and closed his eyes with his padded mitts on and his helmet. Client #1 was not demonstrating SIB when the client arrived to the day program and/or when the client laid down on the mat.</p> <p>Client #1's record was reviewed on 10/7/15 at 2:35 PM. Client #1's 9/22/15 physician's orders indicated "Pt (patient) to wear Posey mitts due to SIB (self-injurious behavior): Only to wear when showing signs of agitation mitts not to be worn for more than 2 hours."</p>		<p>accordingly. The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans.</p> <p>Members of the Operations Team (including Clinical Supervisors, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility twice weekly for the next 21 days and weekly visits for an additional 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include review of healthcare records and nursing summaries to assure that all chronic and acute medical needs are assessed and that nursing documentation includes sufficient detail to facilitate the development of appropriate supports.</p>	

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	<p>Client #1's 7/29/15 Dental Summary Progress Report indicated the client saw his dentist for dental work on 7/29/15. The dental report indicated "We was (sic) unable to work on patient was pre-med (medicated) (2) tab (tablets) of halcion was referral (sic) to [name of doctor]. Pt was referred out to [name of doctor]." An undated hand written note indicated "[Client #1] Dental Visit for the referral is Nov. (November) 23 @ (at) 10 am." Client #1's record indicated the facility failed to set up a timely referral to another dentist as recommended.</p> <p>Interview with staff #8 on 10/7/15 at 8:09 AM indicated client #1 was to wear his Posey mitts when he demonstrated SIB.</p> <p>Interview with staff #7 on 10/7/15 at 8:14 AM indicated client #1 wore the padded mitts due to the client's SIB behavior. Staff #7 indicated client #1 was only to wear the mitts when the client demonstrated SIB. Staff #7 stated "When no behavior pull off."</p> <p>Interview with Clinical Supervisor (CS) #1 and the LPN on 10/8/15 at 2:00 PM indicated client #1 would hit himself on his head and face. CS #1 and the LPN indicated client #1 had a physician's order for the Posey mitts. The LPN indicated client #1</p>		<p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team</p>	
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	<p>was not to wear the mitts when he did not demonstrate SIB. The LPN indicated the client was to wear the mitts for no more than 1 hour at a time. The LPN and CS #1 indicated they would have to check to see if the client had been referred out to a different dentist.</p> <p>2. Client #1's record was reviewed on 10/7/15 at 2:35 PM. Client #1's 9/1/15 physician's orders indicated client #1's diagnoses included, but were not limited to, Congenital hypothyroidism, Constipation and Autism. Client #1's 9/1/15 physician orders indicated client #1 received ONFI (medication for Lennox-Gastaut Syndrome-rare severe kind of epilepsy).</p> <p>Client #1's Record Of Visits (ROVs) indicated the following (not all inclusive):</p> <p>-7/22/15 Client #1 went to ER due to facial swelling. The ROV indicated client #1 was diagnosed with Periorbital Cellulitis (inflammation/infection of the eyelid and portions of the skin around the eye).</p> <p>-7/24/15 Client #1 saw his primary care doctor. The ROV indicated client #1 had been exhibiting self-abusive behavior over the past 1 to 2 weeks. The ROV</p>			

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	<p>indicated client #1 had bruising and swelling to his forehead and around his eye. The ROV indicated "...Self abusive behavior (with) trauma to eye & (and) forehead...Needs 24 hour 'one on one' (1 staff to 1 client) care to prevent injury to self...."</p> <p>-8/30/15 Client #1 was hospitalized with "periorbital edema with possible facial cellulitis."</p> <p>Client #1's 7/6/15 and 9/22/15 Comprehensive High Risk Health Plans indicated the following risk plans:</p> <p>-Potential for Infection "Secondary to open areas form Self Injurious behavior (Biting) (hitting)."</p> <p>-Constipation potential for Bowel Obstruction</p> <p>-Potential for infection related to "presence of Shunt (a fine tube placed in the brain to allow excess spinal fluid to drain out of the brain and into the stomach to relieve pressure inside the head)."</p> <p>-Hypothyroidism</p> <p>Client #1's Nursing Monthly Summaries indicated the following (not all inclusive):</p> <p>-7/20/15 Client #1 was diagnosed with</p>			

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	<p>Periorbital Cellulitis. The monthly note indicated client #1 was started on Risperdal (behavior). The note indicated client #1 was administered an as needed pain medication during the month. The Comments section of the nursing monthly summary was blank.</p> <p>-8/20/15 Client #1 did not have a change in diagnosis and indicated no PRN (as needed) medications were administered. The Comments section of the nursing monthly summary was blank.</p> <p>Client #1's Quarterly/Annual Nursing Assessments indicated quarterly nursing assessments were completed on 4/30/15 and 7/21/15. The quarterly nursing assessments indicated the following:</p> <p>-4/30/15 "Assessment completed."</p> <p>-7/21/15 "Scale not working to obtain wt (weight)." Client #1's monthly notes and/or quarterly assessments indicated the facility's nurse did not document any assessment and/or follow-ups with client #1 regarding the client's 8/15 hospitalization and/or care in regard to the client's Periorbital Cellulitis. The monthly nursing notes and/or quarterly assessments indicated the facility's nurse failed to document any health information in regard to the client's</p>			

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	<p>medical/health diagnoses, and/or failed to document on the client's identified health risks.</p> <p>Interview with the LPN on 10/8/15 at 2:00 PM indicated she was the nurse for the group home. When asked why there was no documentation in regard to client #1's health, the LPN indicated she had been in the home and assessed the client. The LPN stated "He is going to neuro (neurological) visits and he is fine. He goes to labs and appointments. If abnormal I send to doctor." The LPN stated "They (staff) will send emails if things go wrong."</p> <p>3. During the 10/6/15 observation period between 4:20 PM and 6:36 PM and the 10/7/15 observation period between 5:47 AM and 9:00 AM, at the group home, client #3 sat in and used a wheelchair as his primary means of mobilization. Client #3 used his feet to move himself in the wheelchair. Client #3 also wore a shoulder/arm type splint on his right shoulder area which went across the client's chest area. During the 10/7/15 observation period, client #3 made grimace facial expression as if the client was in pain when client #3 attempted to use his right arm/shoulder to unlock wheelchair and when the client attempted to reposition himself in the wheelchair</p>			

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	<p>with his right arm. During the above mentioned observation periods, client #1 also wore a gait belt around his waist.</p> <p>Client #3's record was reviewed on 10/7/15 at 2:07 PM. Client #3's 9/1/15 physician's order indicated client #3's diagnosis included, but was not limited to, History of Left Clavicle Fracture with Open Reduction and Internal Fixation. Client #3's 9/1/15 physician disorder indicated client #3 wore a "Right Shoulder/Arm Sling For Daily Use."</p> <p>Client #3's 7/25/12 ROV indicated client #3 wore the shoulder sling, during the day, for "support."</p> <p>Client #3's 4/7/15 ROV indicated client #3 saw his PT (Physical Therapist). The ROV indicated "He would benefit for (sic) a (R) (right) Forearm attachment for his walker." Attached to the 4/7/15 ROV was an undated leaflet on the client's shoulder support sling. The leaflet indicated client #3's shoulder support sling "Provides support for painful, weak, unstable or hypermobile shoulders."</p> <p>Client #3's Nursing Monthly Summaries from 7/15 to 10/15 indicated the facility's nurse did not document anything concerning and/or about client #3's shoulder and /or pain. Client #1's</p>			

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W 0436 Bldg. 00	<p>9/24/15 Individual Support Plan ISP and/or record did not indicate the facility's nursing services had client #3's shoulder re-evaluated.</p> <p>Interview with the LPN on 10/8/15 at 2:00 PM indicated client #3 wore his shoulder sling to support his shoulder. LPN #1 indicated she was not aware client #3 had been experiencing pain in regard to the client's shoulder. LPN indicated client #3's shoulder had not been re-assessed.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review for 1 of 3 clients with adaptive equipment, (#3), the facility failed to ensure the client had his recommended hearing aids to wear.</p> <p>Findings include:</p> <p>During the 10/6/15 observation period</p>	W 0436	<p>CORRECTION:</p> <p><i>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices</i></p>	11/15/2015

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	<p>between 4:20 PM and 6:36 PM, and the 10/7/15 observation period between 5:47 AM and 9:00 AM, at the group home, client #3 did not wear hearing aids and/or was not encouraged to wear his hearing aids.</p> <p>Client #3's record was reviewed on 10/7/15 at 2:07 PM. Client #3's 9/24/15 Individual Support Plan (ISP) indicated client #3 had/wore hearing aids. Client #3's ISP indicated client #3 was transferred from another one of the facility's group homes to his current group home on 9/24/15.</p> <p>Interview with Clinical Supervisor (CS) #1 and the LPN on 10/8/15 at 2:00 PM indicated client #3 was transferred from another group home to this group in September 2015. CS #1 indicated he did not know client #3 had hearing aids. The LPN indicated client #3 had hearing aids at his previous group home. The LPN stated client #3 should wear his hearing aids "everyday." The LPN indicated client #3's hearing aids should have come with the client when he moved into the group home.</p> <p>9-3-7(a)</p>		<p><i>identified by the interdisciplinary team as needed by the client.</i> Specifically the interdisciplinary team has developed a prioritized learning objective to train Client #3 to wear his hearing aids and staff will be trained on its implementation. A review of facility adaptive equipment needs indicated that this deficient practice did not affect any additional clients.</p> <p>PERVENTION:</p> <p>Facility Professional staff have been retrained regarding the need to furnish all necessary adaptive equipment to all clients. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will review assessment data and compare it to adaptive equipment available at the facility, making recommendations and expediting the acquisition of new and additional adaptive equipment as appropriate. These reviews will occur as needed but no less than quarterly. Additionally, the QIDP has revised each Client's adaptive equipment checklist to include more detail to assist with maintaining equipment in good repair.</p>	

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W 0460 Bldg. 00	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation interview and record review for 1 of 4 sampled clients (#4) and for 1 additional client (#5), the facility failed to ensure the clients' prescribed modified diets were followed as ordered.</p> <p>Findings include:</p> <p>1. During the 10/6/15 observation period between 4:20 PM and 6:36 PM, at the group home, client #5 ate a pureed diet at the dinner meal.</p> <p>During the 10/7/15 observation period between 5:47 AM and 9:00 AM, at the group home, client #5 ate a bowl of oatmeal and a toasted bagel for breakfast. Staff #6 cut client #5's bagel up into several pieces for client #5 to consume. Also, during the 10/7/15 observation period, staff #6 administered 12 morning pills into a cup for client #5 to take.</p>	W 0460	<p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p><i>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Specifically, the Clinical Supervisor has provided a set of current menus to the facility. All staff have been retrained regarding the need to assist clients with preparing and serving modified texture diets as prescribed. Additionally, the Residential Manager and Team Lead will assure that menued food items are available in the home to prepare as scheduled.</i></p> <p>PREVENTION:</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per</p>	11/15/2015	

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	<p>Client #5 spit out 3 of her morning pills. Staff #6 administered client #5's pills with water.</p> <p>Client #5's record was reviewed on 10/8/15 at 1:22 PM. Client #5's 7/20/15 physician's order indicated "Change diet to pureed diet due to full mouth extraction." Client #5's record did not indicate the client's 7/20/15 dietary order had been discontinued.</p> <p>Client #5's 9/1/15 physician's order indicated "May take medications whole in applesauce or pudding." Facility staff did not place the client's pills in applesauce and/or pudding.</p> <p>Interview with staff #6 on 10/7/15 at 8:22 AM indicated client #5 was on a pureed diet and then staff #6 stated "A soft diet." When asked if client #5 could have a bagel, staff #6 stated "If bagel cut into small pieces."</p> <p>Interview with the LPN and the Clinical Supervisor (CS) #1 on 10/8/15 at 2:00 PM indicated client #5 should be receiving a pureed diet. The LPN indicated an order was obtained to place the client on a pureed diet due to client #5's teeth being pulled in July. The LPN stated "A bagel is harder than bread." The LPN indicated client #5 should</p>		<p>week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring the staff assists clients with preparing and serving meals according to prescribed modified texture diets as appropriate. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to assuring the staff assists clients with preparing and serving meals according to prescribed modified texture diets as appropriate.</p> <p>Members of the Operations Team and the QIDP will conduct observations during active treatment sessions no less than twice weekly for the next 21 days, and no less than weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p>	

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	<p>receive a pureed diet as the order had not been discontinued.</p> <p>2. During the 10/6/15 observation period between 4:20 PM and 6:36 PM, at the group home, client #4 ate a pureed apple, baked fish, mixed vegetables and broccoli.</p> <p>During the 10/7/15 observation period between 5:47 AM and 9:00 AM, at the group home, client #5 ate a toasted bagel and oatmeal for his breakfast. Client #5's bagel was cut up into bite size pieces. Client #5's bagel as not moistened in liquid.</p> <p>Client #4's record was reviewed on 10/8/15 at 11:36 AM. Client #9/1/15 physician's orders indicated client #4 received a mechanical soft diet.</p> <p>Interview with the LPN on 10/8/15 at 2:00 PM indicated client #4 was on a mechanical soft diet. The LPN stated a bagel would not be considered a soft diet food item unless the bagel was "soaked" in milk.</p> <p>9-3-8(a)</p>		<p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p>	

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W 0475 Bldg. 00	483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils. Based on observation and interview for 4	W 0475	<p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring the staff assists clients with preparing and serving meals according to prescribed modified texture diets as appropriate.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team, Dietician</p>	11/15/2015

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	<p>of 4 sampled clients (#1, #2, #3, #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to provides forks and/or knives for the clients to eat with.</p> <p>Findings include:</p> <p>During the 10/6/15 observation period between 4:20 PM and 6:36 PM, at the group home, client #7 placed spoons on the table for the dinner meal. Staff #1, #2, #3, #4 and #5 did not prompt and/or encourage client #7 to put forks and knives on the table for the clients to use. Clients #1, #2, #3, #4, #5, #6, #7 and #8 had broccoli, mixed vegetables, baked fish and bread. At one point, during the dinner meal client #4, who was blind, attempted to cut/chop up his fish with his spoon. Staff #1 went to retrieve a fork to assist the client to cut/chop up his fish. Facility staff did not provide and/or offer the other clients a knife and/or fork to eat their fish with.</p> <p>Interview with staff #1 on 10/7/15 at 8:09 AM indicated she got a fork to assist client #4 to cut up his fish. When asked if the facility had forks and/or table knives, staff #1 stated "Yes." Staff #1 stated "It's easier for them to use a spoon."</p> <p>9-3-8(a)</p>		<p>CORRECTION:</p> <p><i>Food must be served with appropriate utensils.</i> Specifically staff have been retrained on the need to assure that each client has a complete place setting (fork, knife, spoon and napkin) at every meal. Administrative staff have confirmed that adequate flatware is present at the facility to accommodate appropriate family style dining.</p> <p>PREVENTION:</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to meal preparation and family style dining.</p> <p>The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to meal preparation and family style dining.</p>				

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			<p>Members of the Operations Team and the QIDP will conduct observations during active treatment sessions no less than twice weekly for the next 21 days, and no less than weekly for an additional 60 Days At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication</p>	

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			<p>administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to meal</p>	

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W 0488 Bldg. 00	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and for 4 additional client (#5, #6, #7 and #8), the facility failed to ensure clients were involved in all aspects of meal preparation and training.</p> <p>Findings include:</p> <p>During the 10/6/15 observation period between 4:20 PM and 6:36 PM, at the group home, staff #2 prepared the dinner meal which consisted of baked fish, mixed vegetables and broccoli without involving clients #1, #2, #3, #4,#5, #6, #7 and #8. Although staff #2 verbally prompted client #8 to help cook, client #8</p>	W 0488	<p>preparation and family style dining, including utilization of complete place settings for all meal participants.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team, Dietician</p> <p>CORRECTION:</p> <p><i>The facility must assure that each client eats in a manner consistent with his or her developmental level. Specifically, staff will be retrained regarding the need to assure all clients participate in all aspects of meal preparation to the extent of their capabilities. Additionally, the facility will modify the staffing matrix to assure that there are no less than two staff on duty at meal times.</i></p> <p>PREVENTION:</p> <p>The Residential Manager will be expected to observe no less than</p>	11/15/2015

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	<p>left the kitchen and staff #2 continued to custodially cook the meal. Client #1, who was sitting at the dining room table, went into the kitchen numerous times, staff #1 and/or staff #3 would redirect client #1 to leave the kitchen. Staff #2 did not encourage client #1 to help with the meal preparations.</p> <p>During the 10/7/15 observation period between 5:47 AM and 9:00 AM staff #6 made oatmeal while clients #1, #2, #3, #4, #5, #6, #7 and #8 were still in bed and/or getting up. Staff #6 made juice and set it on the table. Staff #1 came in for the day and threw out the oatmeal staff #6 had made as it was burned. Staff #1 custodially made a smaller pan of oatmeal on the stove. Staff #1 had client #8 help put bagels in the toaster. Staff #1 made juice as clients started coming to the table for breakfast. Staff #1 did not know staff #6 had already made the juice which was already on the table. Client #8 helped butter the bagels as staff #6 placed oatmeal in client #1, #2, #3 and #8's bowls without involving the clients. Staff #7, who was also at the table, poured juice for clients #1, #2, #3, #4, #5, #6 and #8 as client #7 indicated she did not want any juice. Staff #7 did not encourage clients to pour their own juice and/or assist the clients to pour their juice. Staff #6 then picked up a bottle of</p>		<p>one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to meal preparation and family style dining. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to meal preparation and family style dining.</p> <p>Members of the Operations Team and the QIDP will conduct observations during active treatment sessions no less than twice weekly for the next 21 days, and no less than weekly for an additional 60 Days At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM</p>	

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	<p>syrup and walked around to clients' bowls and poured syrup into the clients' oatmeal without encouraging clients to do it themselves. At one point during the breakfast meal, staff #6 wiped client #4's mouth with a napkin. Staff #6 did not encourage client #4 to wipe is own mouth. Once the breakfast was finished staff #1 custodially did the dishes without encouraging client #1, #2, #3,#4, #5, #6 , #7 and/or #8 to assist with the dishes and/or meal cleanup.</p> <p>Client #3's record was reviewed on 10/7/15 at 2:07 PM. Client #3's 9/24/15 Individual Support Plan (ISP) indicated client #3 had an objective to independently prepare his meal anytime he was ready to eat.</p> <p>Client #1's record was reviewed on 10/7/15 at 2:35 PM. Client #1's 2/28/15 ISP indicated client #1 had an objective to prepare a simple dish.</p> <p>Client #4's record was reviewed on 10/8/15 at 11:36 AM. Client #4's 5/3/15 ISP indicated client #4 had an objective to stir part of the meal during lunch or dinner.</p> <p>Client #2's record was reviewed on 10/8/15 at 11:33 AM. Client #2's 4/2/15 ISP objective to prepare her meal any</p>		<p>and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and</p>		

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	<p>time she was ready to eat.</p> <p>Interview with staff #1 on 10/7/15 at 8:45 AM indicated clients should be encouraged to serve themselves and to pour their own drinks with hand over hand assistance.</p> <p>Interview with Clinical Supervisor (CS) #1 on 10/8/15 at 1:35 PM indicated clients #1, #2, #3, #4, #5, #6, #7 and #8 should be involved with their meal preparation.</p> <p>9-3-8(a)</p>		<p>Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to meal preparation and family style dining.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	