

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G576	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/18/2014
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NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 503 N THIRD ST DECATUR, IN 46733
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: November 12, 13, 14, 17, and 18, 2014.</p> <p>Facility number: 001090 Provider number: 15G576 AIM number: 100245540</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/1/14 by Ruth Shackelford, QIDP.</p>	W000000	<p>Third Street Annual Recertification & Licensure Survey Plan of Correction Survey Event ID UWPP11 November/December 2014</p>	
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based upon observation, record review and interview for 1 of 3 sampled clients (client #1) and 1 additional client (client #4), the facility neglected to implement policy and procedures to protect client #1</p>	W000149	<p>W149 – Staff Treatment of Clients The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Bi-County Services, Inc. (BCS) failed to</p>	12/18/2014

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

TITLE

(X6) DATE

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

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	<p>from the potential for choking by failing to supervise him to prevent access to unsafe food and beverage, failed to supervise client #4 to prevent elopement, failed to ensure staff reported 1 of 1 allegation of abuse immediately to the administrator and failed to document a thorough investigation into 1 of 1 incident of injury of unknown origin involving client #1.</p> <p>Findings include:</p> <p>1. Observations were completed at the group home on 11/12/14 from 6:24 PM until 7:40 PM. During the observation, client #1 picked up a can of soda and drank drops of liquid until it was empty.</p> <p>Staff #2 was interviewed on 11/12/14 at 6:30 PM and indicated the can of soda was probably client #6's.</p> <p>Observations were completed at the group home on 11/13/14 from 6:35 AM until 7:45 AM. Client #1 grabbed a piece of toast from the counter and took a bite out of the toast folded in two. Staff #8 removed the toast from his hand and threw it away.</p> <p>Client #1's record was reviewed on 11/13/14 at 1:32 PM. A Behavior Support Plan (BSP) dated 3/1/14</p>		<p>meet this standard as evidenced through: neglecting to accurately implement a policy that would prevent Client #1 from accessing unsafe food/drink – exposing him to a choking hazard, failing to adequately supervise Client #4 to prevent elopement, failing to ensure staff reported an allegation of abuse to an administrator, and failing to ensure injuries of unknown origin are thoroughly investigated. BCS, through implementation of our written Abuse, Neglect and Exploitation Policy, has set up a structure which is intended to protect all consumers from mistreatment, neglect, or abuse of any kind. We believe that our Policies and Procedures have been successful in their intended purpose under most circumstances, as evidenced by an increased level of transparency/reporting of concerns in a timely manner by direct care staff. However, the above cited incidents do indicate a need for some additional retraining/supports to be put in place to act as further preventative measures. A. Corrective Action and Follow-Up Specific to Consumer #1 (hereafter referred to as C1): 1. On 12/9/14, the Third Street Program Manager developed a "Staff Assignment Protocol" specific to C1. This protocol will be utilized to assure that a specific scheduled</p>		

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	indicated target behaviors of self injurious behavior, physical aggression and eating unsafe foods. The plan indicated client #1 "is directed to follow a pureed diet by his physician due to severe dysphagia resulting from an esophageal stricture...[client #1] frequently attempts to eat food that is not pureed, posing a choking risk due to the unmodified texture. Verbal redirection to deter this behavior is not typically successful with [client #1]. Strategies for changing the meal preparation routine in his group home are available to limit his risk for eating these unsafe foods..." An ISP (Individual Support Plan) dated 4/1/14 indicated "I will remain safe by not eating foods of a regular texture." Strategies indicated "follow guidelines in [client #1's] BSP addressing eating unsafe foods. Assist [client #1] to avoid the kitchen and dining areas while food of a regular texture is being prepared..." The undated Swallow Recommendations indicated "Eliminate distractions during meals. If possible, sit with him 1:1 (one to one) in another area away from others. Eliminate potentials for choking (leaving food/drinks out after mealtimes). Monitor him closely knowing his risk from choking/aspiration...." A Dining plan dated 7/30/14 indicated client #1 was to eat a pureed diet and encouraged to eat 6 small meals daily "due to the modified,		staff is present with C1 at all times, and able to provide him with active treatment that ensures his Risk Plans are being adequately followed consistently. All staff working with C1 began training on the Protocol, and it will be fully implemented by 12/16/14. 2. Additionally, all staff working with C1 will be retrained on Mandt Body Positioning techniques as a way to assist C1 in avoiding unsafe food/drink in a respectful, non-threatening manner. This training will occur at the Third Street House meeting on 12/16/14. Persons responsible: Third Street RMT, Program Director (PD), Residential Administrator (RA), and Administrative Assistant for Quality Assurance (AAQA). Targeted Completion Date: 12/18/14 B. Corrective Action and Follow-Up Specific to Consumer #4 (hereafter referred to as C4): 1. Following the elopement incidents for C4 in August 2014, an immediate set of Safety Guidelines were put in place, which included Line of Sight (LOS) staffing at all times. His Elopement Risk Plan was revised at that time to reflect his needs as well (8/26/14). 2. The LOS requirement for C4 was added to the house duty sheets, effective November 2014. 3. All Third Street DirectCare staff will be retrained on C4's LOS requirements, for home and community, at their house meeting				

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	<p>small size of his stomach," and client #1 was to use a slow flow cup when drinking fluids.</p> <p>The group home nurse was interviewed on 11/13/14 at 2:40 PM and indicated client #1 should be supervised closely to prevent him from getting food not prepared to pureed consistency and offered pureed food instead. The group home nurse indicated staff were to put themselves between food and client #1 to prevent his access.</p> <p>2. The facility's reports to the BDDS (Bureau of Developmental Disabilities Services) were reviewed on 11/13/14 at 11:30 AM and indicated an incident on 10/30/14 involving alleged verbal abuse by staff #9 while at day services. An investigation attached into the incident dated 10/31/14 indicated "On 10/30/14, [staff #11] notified her supervisor that she had witnessed an instance of verbal abuse/mistreatment by [Day Services (DS) Team Leader] toward [client #1]....This information was not reported as per agency Abuse/Neglect policy immediately, but rather 3 hours after the incident had been observed. Two other DS staff members had also observed verbal mistreatment of [client #1] throughout the morning and did not report it to their supervisory who was</p>		<p>on 12/16/14. Persons responsible: Third Street RMT, Program Director (PD), Residential Administrator (RA), and Administrative Assistant for Quality Assurance (AAQA). Targeted Completion Date: 12/18/14</p> <p>C. Corrective Action Specific to All Third Street Consumers:</p> <p>1. To effectively address the lack of reporting allegations of abuse, neglect or exploitation in a timely manner as it pertains to C1: all Third Street Direct Care staff will review the agency Abuse, Neglect and Exploitation Policy at their next house meeting on 12/16/14. 2. Additionally, all staff working with Third Street consumers will complete a competency test indicating their understanding of the policy and the requirement for reporting violations immediately. 3. Further information regarding the timely reporting of allegations of mistreatment, abuse or neglect can be found under the W153 tag. 4. In relation to the injury of unknown origin for C1: all staff working with C1 will be retrained on completing the I/I with indication that communication has been started on possibilities for the origin of the injury/how injury occurred so that prevention measures can be put into place. Retraining will occur at their next house meeting on 12/16/14. 5. Further information regarding the investigation of Injuries of Unknown Origin can be found</p>				

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	<p>easily accessible.... Also of great concern was the lack of follow-through on reporting mistreatment immediately when observed by 3 different staff during the morning classroom and leaving [client #1] in a situation for potential further mistreatment with any consumer as OK & not reportable. That they did not step in to intervene, did not assist & did not report came as a big surprise to the investigative team during the investigation process." A statement dated 10/30/14 by staff #11 indicated the DS Team Leader stated "I am going to tie him to a chair," and "then when sitting him on the floor she said'...twist your fingers....'" The investigation indicated the allegation of verbal abuse was substantiated and Day Services (DS) Team Leader was suspended without pay.</p> <p>The Program Director was interviewed on 11/13/14 at 3:50 PM and indicated all staff had been retrained on reporting allegations immediately and received monthly training regarding policy and procedures to prevent abuse and neglect. She indicated the day services manager monitored staff to client interactions on a daily basis to prevent future occurrence, and her office was across the hall from the room where client #1 attended day services.</p>		<p>under the W154 tag. Persons responsible: Third Street RMT, Program Director (PD), Residential Administrator(RA), and Administrative Assistant for Quality Assurance (AAQA). Target Completion Date: 12/18/14</p> <p>D. Corrective Action as it relates to BCS practices Agency Wide: 1. All RMT's, Administrative staff, medical department and supervisors working with residential consumers across all settings will be retrained on items C.1, C.2 and C.4 listed above. Retraining will occur on 12/15/14. 2. All staff working with residential consumers across all settings will receive training on items C.1, C.2 and C.4 listed above from RMT members by 12/18/14. All Supported Living DCS will be retrained at the next scheduled house/staff meetings by the SLMT members. Persons responsible: Administrative Team; RMT's, DS Coordinator, Bluffton Workshop (BWS) Manager and SLMT's. Target Completion Date: 12/18/14</p>		

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	<p>3. An Injury/Illness Report dated 7/18/14 was reviewed on 11/13/14 at 1:21 PM and indicated client #1 "has a bruise on his left upper arm closer to his arm pit." The bruise measured 3 inches by 1 and 1/2 inches. There was no indication in the report the cause of client #1's bruising was known. There was no evidence the incident of client #1's bruising was investigated.</p> <p>The Program Director was interviewed on 11/13/14 at 1:16 PM and indicated the incident of bruising for client #1 had not been investigated.</p> <p>4. A BDDS report dated 8/24/14 indicated client #4 "was reported missing for approximately 20 minutes." The report indicated staff were assisting other clients and client #4 was "found two blocks away. He was unharmed and returned to the group home without further incident." On 8/25/14 client #4 "was again reported missing for approximately 20 minutes." Staff were administering medications and the second staff did not arrive until 6:10 AM. Client #4 was last seen at 6:05 AM and found at 6:30 AM. The report indicated client #4 was found a half a block away and returned without further incident or injury.</p>			

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	<p>Interim Safety Guidelines for client #4 were reviewed on 11/13/14 at 12:58 PM and indicated client #4 "is at risk due to elopement, significant hearing loss, poor use of pedestrian safety practices, a high level of curiosity about people, places and things going on around him, being very outgoing and friendly even with strangers and children. In October of 2013, and March of 2014, [client #4] had incidents involving trying to say 'hi' to children in public restrooms. [Client #4] has a male staff with him at all times in the community, the male staff with him at the time of the incident in March, 2014 was able to intervene before and (sic) conversation/contact was made with the child." The guidelines indicated a line of sight staffing level had been established for client #4, and male staff were to be with him at all times in the community and when he used public restrooms.</p> <p>The Program Director was interviewed on 11/13/14 at 12:58 PM. She indicated client #4's plan had been revised since the elopement incidents and indicated staff were otherwise occupied with assisting other clients and had not noticed client #4 was missing. She indicated client #4 had previous incidents of talking to children in the community while using the restroom and under the supervision by staff which had alarmed the children and</p>				

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	<p>their parents.</p> <p>The facility's Abuse and Neglect, Exploitation and Violation of Individual Rights revised 11/13 was reviewed on 11/13/14 at 11:28 AM and indicated "Employees of Bi-County Services have the responsibility to ensure the protection of all consumers. This means that our consumers are free of mistreatment from abuse, neglect, exploitation or a violation of individual rights...NEGLECT is a failure to provide necessary supports needed to avoid physical harm and/or mental suffering." The policy indicated any incidents of abuse, neglect or exploitation should be reported to supervisory staff immediately and investigated.</p> <p>9-3-2(a)</p>			

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based upon observation, record review and interview for 1 of 3 sampled clients (client #1), the facility failed to ensure staff reported 1 of 1 allegation of abuse immediately to the administrator in accordance to state law.</p> <p>Findings include:</p> <p>The facility's reports to the BDDS (Bureau of Developmental Disabilities Services) were reviewed on 11/13/14 at 11:30 AM and indicated an incident on 10/30/14 involving alleged verbal abuse by staff #9 while at day services. An investigation attached into the incident dated 10/31/14 indicated "On 10/30/14, [staff #11] notified her supervisor that she had witnessed an instance of verbal abuse/mistreatment by [Day Services</p>	W000153	<p>W153 – Staff Treatment of Clients The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. BCS failed to ensure that allegations were immediately reported in accordance with State Law due to a substantiated abuse allegation occurring on 10/30/14, in which three staff neglected to report whatthey had witnessed in a timely manner. As stated under the W149 tag, BCS, through implementation of our written Abuse, Neglect and Exploitation Policy, has setup a structure which is intended to protect all consumers from mistreatment, neglect, or abuse of any kind. We believe that our Policies and</p>	12/18/2014	

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	<p>(DS) Team Leader] toward [client #1]....This information was not reported as per agency Abuse/Neglect policy immediately, but rather 3 hours after the incident had been observed. Two other DS staff members had also observed verbal mistreatment of [client #1] throughout the morning and did not report it to their supervisory who was easily accessible.... Also of great concern was the lack of follow-through on reporting mistreatment immediately when observed by 3 different staff during the morning classroom and leaving [client #1] in a situation for potential further mistreatment with any consumer as OK & not reportable. That they did not step in to intervene, did not assist & did not report came as a big surprise to the investigative team during the investigation process." A statement dated 10/30/14 by staff #11 indicated the DS Team Leader stated "I am going to tie him to a chair," and "then when sitting him on the floor she said'...twist your fingers....'" The investigation indicated the allegation of verbal abuse was substantiated and Day Services (DS) Team Leader was suspended without pay.</p> <p>The Program Director was interviewed on 11/13/14 at 3:50 PM and indicated all staff had been retrained on reporting allegations immediately and received</p>		<p>Procedures have been successful in their intended purpose under most circumstances, as evidenced by an increased level of transparency/reporting of concerns in a timely manner by direct care staff. However, the above cited incidents do indicate a need for additional retraining/supports to be put in place to act as further preventative measures. A. Corrective Action Specific to C1: 1. Upon receiving the report that verbal abuse had been alleged against C1 on 10/30/14, BCS assured that his safety was protected to the best of our ability from that point forward by removing the accused staff member from his classroom immediately. A thorough investigation was completed at that point, which did lead to substantiation of the allegations and a 12-hour unpaid suspension for the staff member (over the course of 3 days). 2. Prior to returning to work on 11/3/14, the responsible staff member was required to undergo competency testing to verify she understood the allegations against her, and the agency's policy against Abuse/Neglect and Exploitation. 3. The three staff members who failed to report the allegations in a timely manner received verbal warnings, outlining the agency's expectations according to our policies and procedures. The Personnel Action Forms were</p>				

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	<p>monthly training regarding policy and procedures to prevent abuse and neglect. She indicated the day services manager monitored staff to client interactions on a daily basis to prevent future occurrence.</p> <p>9-3-2(a)</p>		<p>received on 11/12/14. 4. An ongoing schedule of training for all Day Services staff was implemented following the incident on 10/30/14, in which the agency Abuse, Neglect and Exploitation (ANE) policy is reviewed weekly. This continues to be an ongoing procedure that is put in place as a preventative measure. 5. To effectively address the lack of reporting allegations of abuse, neglect or exploitation in a timely manner as it pertains to C1: all Third Street Direct Care Staff as well as Day Services staff will review the agency ANE Policy by 12/18/14. 6. Additionally, all Third Street/Day Service staff will complete a competency test indicating their understanding of the policy and the requirement for reporting violations immediately. Persons responsible: Third Street RMT, Day Services (DS) Coordinator, Program Director (PD), Residential Administrator (RA), and Administrative Assistant for Quality Assurance (AAQA). Target Completion Date: 12/18/14 B. Corrective Action specific to BCS practices Agency Wide: 1. All RMT's, Administrative staff, medical department and supervisors working with residential consumers across all settings will be retrained on items A.5 and A.6 listed above. Retraining will occur on 12/15/14. 2. All staff working with</p>		

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based upon observation, record review and interview for 1 of 3 sampled clients (client #1) the facility neglected to document a thorough investigation into 1 of 1 incident of injury of unknown origin.</p> <p>Findings include:</p> <p>An Injury/Illness Report dated 7/18/14 was reviewed on 11/13/14 at 1:21 PM and indicated client #1 "has a bruise on his left upper arm closer to his arm pit." The bruise measured 3 inches by 1 and 1/2 inches. There was no indication in the report the cause of client #1's bruising was known. There was no evidence the incident of client #1's bruising was investigated.</p>	W000154	<p>residential consumers across all settings will receive training/testing on items A.5 and A.6 listed above from RMT members by 12/18/14. All Supported Living DCS will be retrained at the next scheduled house/staff meetings by the SLMT members. Persons responsible: Administrative Team; RMT's, DS Coordinator, Bluffton Workshop (BWS) Manager and SLMT's. Target Completion Date: 12/18/14</p> <p>W154 – Staff Treatment of Clients The facility must have evidence that all alleged violations are thoroughly investigated. BCS failed to ensure all Injuries of Unknown Origin were investigated, due to an Injury/Illness report dated 7/18/14 concerning a 3x1 1/2" bruise for C1. Appropriate procedures for follow-up reported/investigation were not completed in accordance with agency standards. BCS has a system in place for any IUO to be investigated and a format for such. All Injury/Illness (I/I) reports are reviewed by the Medical Department and recommendations made for follow-up (F/U) or closure. The I/I is then routed through a series of</p>	12/18/2014	

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	The Program Director was interviewed on 11/13/14 at 4:1:16 PM and indicated the incident of bruising for client #1 had not been investigated. 9-3-2(a)		staff pertinent to the consumer including, but not limited to administrative team, residential management team, Day Services (DS) Coordinator &/or Workshop Manager. A. Corrective Action pertaining to C1: 1. The bruise on C1's left upper arm was reported via Injury/Illness report to RMT and Medical staff on 7/18/14. A subsequent Incident Report was submitted by the QIDP at that time on 7/22/14. Within the incident report, it states that a "subsequent investigation has not revealed a direct, likely cause for the injury." As noted within the W159 tag, the management team at that time had become isolated from other pertinent team members within the agency as it related to effective communication. In this specific instance, an emailed request was sent by the AAQA for an Injury of Unknown Origin Investigation to be completed/turned in for review following the submission of the I/I and IR. The investigation form was never received at that time. 2. C1's bruise was monitored by direct care staff (DCS) through bruise tracking & following the bruise protocol. Additionally, RN monitored the bruise for healing until 7/30/14, at which time they noted that the bruise had healed. No pain &/or swelling was noted as a result of this injury. The I/I was closed on 7/30/14. It is the opinion of staff working closely		

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			<p>with C1 that the bruising could have potentially been caused by bumping into an object in his home, as this has occurred in the past with C1. 3. To assist in preventing Injuries of Unknown Origin Specific to C1, the Third Street Program Manager developed a "Staff Assignment Protocol." This protocol will be utilized to assure that a specific scheduled staff is present with C1 at all times, and able to provide him with active treatment that ensures his Risk Plans are being adequately followed consistently. All staff working with C1 began training on the Protocol, and it will be fully implemented by 12/16/14. 4. For C1's protection and that of all our group home residents, all staff working with C1 & all group home residents will be retrained on completing the I/I with indication that communication has been started on possibilities for the origin of the injury/how injury occurred so that prevention measures can be put into place. Retraining will occur across all settings by 12/18/14. Persons responsible: Third Street RMT, Day Services (DS) Coordinator, Program Director (PD), Residential Administrator (RA), and Administrative Assistant for Quality Assurance (AAQA). Target Completion Date: 12/18/14</p> <p>B. Corrective Action specific to BCS practices Agency Wide:</p> <p>1. All RMT's, Administrative staff, medical department and</p>		

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W000159	<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. Based upon record review and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2 and #3) to ensure the QIDP (Qualified Intellectual Disabilities Professional) reviewed client objectives to determine progress, failed to ensure clients' comprehensive functional assessments (CFAs) were completed, failed to ensure clients' vocational assessments were completed, failed to ensure updated ISPs (Individual Support Plans) were provided for staff to use, and failed to ensure recommendations for</p>	W000159	<p>supervisors working with residential consumers across all settings will be retrained on item A.4 listed above, as well as completing IJO investigations as they occur. Retraining will occur on 12/15/14. 2. All staff working with residential consumers across all settings will receive training/testing on item A.4 listed above from RMT members by 12/18/14. All Supported Living DCS will be retrained at the next scheduled house/staff meetings by the SLMT members. Persons responsible: Administrative Team; RMT's, DS Coordinator, and SLMT's. Target Completion Date: 12/18/14</p> <p>W159 – Qualified Mental Retardation Professional Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. BCS failed to ensure that Third Street's QIDP was adequately completing all required job duties, including many aspects of program implementation (ISPs, CFAs, Vocational Assessments, objectives, etc.) for C1, C2, and C3. During internal audits of the Third Street group home in mid-2014, it became apparent the</p>	12/18/2014	

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	<p>communication were implemented for clients #1 and #2.</p> <p>Findings include:</p> <p>1. During observation at the workshop on 11/13/14 from 11:40 AM until 12:10 PM, client #2 sat without activity until prompted to sort colored pegs by color and shape. Client #2 completed the task within 2 minutes. Client #1 was not present during the observation.</p> <p>Staff #9 was interviewed on 11/13/14 at 12:05 PM and indicated client #2 was not offered opportunity for paid work, and stated, "I don't know why." She indicated client #2 did not have an objective for day services and indicated there had been turnover in the QIDP position and she was uncertain why client #2 did not have an objective. Staff #9 indicated client #1 left at 12:00 PM.</p> <p>Client #1's record was reviewed on 11/13/14 at 9:00 AM. Client #1's ISP dated 11/20/13 did not include evidence of an objective to address communication. Client #1's records were reviewed at the facility office on 11/13/14 at 2:10 PM. An ISP objective dated 2/1/14 in the office records indicated an objective to improve his communication skills by using his</p>		<p>ISP's, RP's and many other pertinent assessments had not been completed in a timely manner, reviewed &/or revised with input from the IST's and that some plans had just date changes with no data review. The RMT at the time had become increasingly isolated from other key members of the BCS team, including Administration as well as the Medical department. As a result the previous RMT is no longer working for BCS effective late September 2014. The Program Director and AAQA have since begun reviewing ISP's for individualized services, accurate data and plan revisions for several of the Third Street consumers. A new residential manager and QIDP are now in place and the administrative team has been working closely with them to assure that they have the training and support they need to do their jobs effectively, assure that consumers are receiving the training, services & supports consistent with their ISP's, and that active treatment is occurring across all settings in a consistent manner. In addition, the RMT will assure staff interactions with consumers are functional in nature, as well as respectful. The new RMT is at an advantage as both of the individuals have worked with the consumers at the Third Street group home in the past and they both have strong knowledge of the consumers &</p>				

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	<p>communication skills by using his communication device. Client #1's record did not include evidence of a review by the QIDP of client #1's progress for his objectives.</p> <p>Client #2's record was reviewed on 11/13/14 at 8:35 AM. Client #2's ISP dated 11/20/13 did not include evidence of an objective to address communication. Client #2's records were reviewed at the facility office on 11/13/14 at 2:10 PM. An ISP objective dated 2/1/14 in the office records indicated an objective to improve his communication skills by using his communication device and day services objectives dated 10/1/14 to "participate in scheduled activities and participate in community activities." Client #2's record did not include evidence of a review by the QIDP of client #2's progress for his objectives.</p> <p>Client #3's records were reviewed on 11/13/14 at 7:55 AM. Client #3's record did not include evidence of a review by the QIDP of client #3's progress for his objectives.</p> <p>The Program Director was interviewed on 11/13/14 at 12:35 PM. She indicated there were no QIDP reviews available to review of the clients' progress.</p>		<p>their needs as well as the consumers are genuinely fond of them. We feel that this Plan of Correction (POC) is timely and will assist in moving forward in better meeting the consumer's needs & wants/desires. A. Corrective Action Specific to C1:</p> <p>1. The current ISP for C1 was reviewed by a member of his IST on 12/13/14 to ensure that the plan meets all of his present needs. The plan will be forwarded to all locations serving C1 by 12/18/14 to ensure adequate program implementation. 2. Following the Third Street survey, a comprehensive Functional Assessment was completed for C1 on 11/20/14. 3. Additionally, a Vocational Assessment (Job Readiness Assessment) was completed for C1 on 11/26/14. 4. The current ISP for C1 contains a pertinent communication goal for his needs in relation to his limited knowledge and use of sign language, stating that he "will improve his communication skills by learning the sign for 'bathroom'." However, the QIDP will closely monitor the progress of the goal to ensure its appropriateness. Revisions will be made if it is found to be insufficient in meeting his needs. Persons responsible: Third Street RMT, Day Services (DS) Coordinator, Program Director (PD), Residential Administrator</p>		

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	<p>The Program Director was interviewed again on 11/17/14 at 4:52 PM and indicated the QIDP was responsible for ensuring objectives were available for staff to implement, to ensure assessments were completed and to ensure assessment recommendations were addressed.</p> <p>2. The QIDP failed to ensure for 3 of 3 sampled clients (clients #1, #2 and #3), comprehensive functional assessments were completed. Please see W210.</p> <p>3. The QIDP failed to ensure vocational skills and interests were assessed for 3 of 3 sampled clients (clients #1, #2 and #3). Please see W225.</p> <p>4. The QIDP failed to ensure for 2 of 3 sampled clients (clients #1 and #2), their Individual Support Plans (ISP) addressed their specific needs in the area of communication skills. Please see W227.</p> <p>5. The QIDP failed to ensure for 1 of 3 sampled clients (client #3), the ISP (Individualized Support Plan) was updated to correctly indicate when he was to use a walker. Please see W240.</p> <p>6. The QIDP failed to ensure the IDT (interdisciplinary team) addressed the use of recommended adaptive equipment</p>		<p>(RA), and Administrative Assistant for Quality Assurance (AAQA). Targeted Completion Date: 12/18/14 B. Corrective Action Specific to C2: 1. An updated ISP was developed for C2 effective 12/9/14, and was forwarded to all locations to ensure accurate implementation across all settings. 2. Following the Third Street survey, a comprehensive Functional Assessment was completed for C1 on 11/20/14. 3. Additionally, a Vocational Assessment (Job Readiness Assessment) was completed for C1 on 11/26/14. In assessing C2's job skills, it was determined that a workshop evaluation would be appropriate to determine a possible placement. This evaluation will take place no later than 12/17/14. 4. An ISP goal was added for C2 to address improving vocational skills when available with assistance, effective 12/9/14. 5. The updated ISP for C2 also includes a goal and objectives specific to his needs for communication in relation to his adaptive equipment/communication device. The Third Street QIDP has made contact with an AAC Specialist to receive further training on the device for all staff in the home and assistance with programming the device to best meet C2's needs. Further information regarding this can be found under the W436 tag.</p>				

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	(communication device) for 1 of 3 sampled clients (client #2). Please see W436. 9-3-3(a)		Persons responsible: Third Street RMT, BlufftonWorkshop (BWS) Supervisor, Day Services (DS) Coordinator, Program Director(PD), Residential Administrator (RA), and Administrative Assistant for Quality Assurance (AAQA). Targeted Completion Date: 12/18/14 C. Corrective Action Specific to C3: 1. The ISP for C3 was evaluated on 12/12/14 for appropriateness relative to his needs, and changes were made to his Risk Plan. The plan will be forwarded to all locations serving C1 by 12/18/14 to ensure adequate program implementation. 2. Following the Third Street survey, a comprehensive Functional Assessment was completed for C3 on 11/20/14. 3. Additionally, a Vocational Assessment (Job Readiness Assessment) was completed for C3 on 11/26/14. Persons responsible: Third Street RMT, Day Services (DS) Coordinator, Program Director (PD), Residential Administrator (RA), and Administrative Assistant for Quality Assurance (AAQA). Targeted Completion Date: 12/18/14 D. Corrective Action specific to staff working with all Third Street Consumers: 1. In November 2014, the new QIDP for the Third Street Group Home began receiving training from seasoned Program Managers within the agency on addressing specific		

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			needs within ISP's, reviewing data and progress, and assuring service design and delivery which provides consumers with an appropriate active treatment program. 2. On 11/26/14, the Third Street QIDP trained on Annual ISP documentation including completing accurate Assessments including Comprehensive Functional Assessments, Vocational Assessments, and all other pertinent information needed to develop an adequate treatment program. 3. A training schedule for incoming QIDP's was developed, effective 12/12/2014, to assist in ensuring that all Program Managers are trained and equipped with pertinent knowledge regarding the expectations needed to complete their job duties pertaining to the W159 tag including but not limited to: developing an effective ISP/active treatment program, observing for progress/reviewing data, revising based on individual need or performance, ensuring consistency, promoting independence, completing all assessments, etc. 4. The training schedule will include regular review of progress as it pertains to program implementation by the Residential Administrator (RA) and/or Administrative Assistant for Quality Assurance (AAQA). 5. Training for all RMT's and SLMT's covering items D.2 and	

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on interview and record review for 3 of 3 sampled clients (clients #1, #2 and #3), the facility failed to ensure comprehensive functional assessments were completed.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 11/13/14 at 9:00 AM. Client #1's record did not include evidence of a comprehensive functional assessment.</p> <p>Client #2's record was reviewed on 11/13/14 at 8:35 AM. Client #2's record did not include evidence of a comprehensive functional assessment.</p> <p>Client #3's records were reviewed on 11/13/14 at 7:55 AM. Client #3's record</p>	W000210	<p>D.3 listed above will occur on 12/15/14. Persons Responsible: Program Director (PD), Residential Administrator (RA), and Administrative Assistant for Quality Assurance (AAQA). Targeted Completion Date: 12/15/14</p> <p>W210 – Individual Program Plan Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to the admission. BSC failed to ensure that Clients #1, #2, and #3 had a Comprehensive Functional Assessment completed. As noted in the W159 tag, we feel that the change in management team has already been a positive step forward in improving the quality of the programming, care, supports and encouragement of growth, development and independence for all of the consumers living at the Third Street group home. Additionally, the training outlined for all QIDP's referenced within the W159 tag items D.2 and D.3 will provide pertinent resources to ensure that each individual</p>	12/18/2014	

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W000225	<p>did not include evidence of a comprehensive functional assessment.</p> <p>The Program Director was interviewed on 11/13/14 at 2:30 PM and indicated the QIDP had failed to complete the clients' comprehensive functional assessments.</p> <p>9-3-4(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills.</p> <p>Based on observation, record review and interview, the facility failed to assess vocational skills and interests for 3 of 3 sampled clients (clients #1, #2 and #3).</p> <p>Findings include:</p> <p>During observation at the workshop on 11/13/14 from 11:40 AM until 12:10 PM, client #2 sat without activity until prompted to sort colored pegs by color and shape. Client #2 completed the task</p>	W000225	<p>servicing in that role understands their pivotal nature to the adequacy of the program each consumer receives in relation to Functional Assessments as well as other evaluations. Persons Responsible: Program Director (PD), Residential Administrator (RA), and Administrative Assistant for Quality Assurance (AAQA). Targeted Completion Date: 12/15/14</p> <p>W225 – Individual Program Plan The comprehensive functional assessment must include, as applicable, vocational skills. BSC failed to ensure that Clients #1, #2, and #3 had a current Vocational Assessment completed. As noted in the W159 tag, we feel that the change in management team has already been a positive step forward in improving the quality of the programming, care, supports and encouragement of growth, development and independence for all of the consumers living at</p>	12/18/2014

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	<p>within 2 minutes.</p> <p>Staff #9 was interviewed on 11/13/14 at 12:05 PM and indicated client #2 was not offered opportunity for work, and stated, "I don't know why." She indicated client #1 had left at noon and client #3 did not attend the workshop on that day of the week.</p> <p>Client #1's record was reviewed on 11/13/14 at 9:00 AM. Client #1's record did not include evidence of a vocational assessment.</p> <p>Client #2's record was reviewed on 11/13/14 at 8:35 AM. Client #2's record did not include evidence of a vocational assessment.</p> <p>Client #3's records were reviewed on 11/13/14 at 7:55 AM. Client #3's record did not include evidence of a vocational assessment.</p> <p>The Program Director was interviewed on 11/13/14 at 2:30 PM and indicated the clients' vocational skills should have been assessed.</p> <p>9-3-4(a)</p>		<p>the Third Street group home. Additionally, the training outlined for all QIDP's referenced within the W159 tag item D.3 will provide pertinent resources to ensure that each individual serving in that role understands their pivotal nature to the adequacy of the program each consumer receives in relation to Vocational Assessments. Persons Responsible: Program Director (PD), Residential Administrator (RA), and Administrative Assistant for Quality Assurance (AAQA). Targeted Completion Date: 12/15/14</p>		

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, interview and record review for 2 of 3 sampled clients (clients #1 and #2), the facility failed to ensure the Individual Support Plan (ISP) addressed their needs in the area of communication skills.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 11/12/14 from 6:24 PM until 7:40 PM. Clients #1 and #2 did not communicate using speech and did not use a communication system during the observation. Client #1 attempted to drink</p>	W000227	<p>W227 – Individual Program Plan The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive functional assessment. BCS failed to ensure that Clients #1 and #2 had an Individual Support Plan which addressed identifiable needs in the area of Communication. As noted in the W159 tag, we feel that the change in management team has already been a positive step forward in improving the quality of the programming, care, supports and encouragement of growth, development and independence for all of the consumers living at the Third</p>	12/18/2014

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	<p>beverages during the observation and was redirected by staff. Client #2 sat on the sofa in the living room and watched TV.</p> <p>Observations were completed on 11/13/14 from 6:35 AM until 7:45 AM. Clients #1 and #2 did not communicate using speech and did not use a communication system during the observation. Client #1 grabbed bread and ate it and assisted with making his breakfast meal. Client #2 prepared his lunch with the assistance of staff.</p> <p>Client #1's record at the group home was reviewed on 11/13/14 at 9:00 AM. There was no evidence of an objective to address client #1's communication skills at the group home. A Behavior Support Plan (BSP) dated 3/1/14 indicated target behaviors of self injurious behavior, physical aggression and eating unsafe foods. The plan indicated the goal of the program was "to assist [client #1] in improving his methods of appropriately communicating his wants and needs, likes and dislikes and in dealing with situations that cause him anxiety or agitation." The plan indicated client #1 "is non-verbal and has very limited knowledge and use of sign language communication. [Client #1's] main form of communication is to lead another person by the hand to the item of location he wants." The plan indicated client #1 engaged in self injurious behavior to</p>		<p>Street group home. Additionally, the training outlined for all QIDP's referenced within the W159 tag item D.3 will provide pertinent resources to ensure that each individual serving in that role understands their pivotal nature to the adequacy of the program each consumer receives in relation to ISP development, including appropriate goal development and data review. Persons Responsible: Program Director (PD), Residential Administrator (RA), and Administrative Assistant for Quality Assurance (AAQA). Targeted Completion Date: 12/15/14</p>				

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	<p>communicate "dislike of a particular task or request to complete a specific task." Client #1's records at the facility's office were reviewed on 11/13/14 at 1:32 PM. Client #1's ISP dated 4/1/14 indicated an objective to learn the sign for bathroom. An OT (Occupational Therapy) consultation for communication dated 5/7/12 indicated a speech evaluation was completed with recommendations of "presents only 1 step directions, allow choices from only 2 items. Can use pictures." There was no evidence of an objective to address the evaluation's recommendations in client #1's ISP, in client #1's record or evidence of an IDT (interdisciplinary team) discussion of the status of the recommendations made in the evaluation.</p> <p>Client #2's record at the group home was reviewed on 11/13/14 at 8:35 AM. Client #2's ISP dated 11/20/13 did not include evidence of an objective to address communication. Client #2's records were reviewed at the facility office on 11/13/14 at 2:10 PM. An ISP objective dated 2/1/14 in the office records indicated an objective to improve his communication skills by using his communication skills by using his communication device. A speech discharge summary dated 10/15/13 indicated "Patient is essentially</p>			

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	<p>non-verbal. Uses gestures for social greetings. Increase in vocal output. Improved attention to task. Making choices from an array of 8. Patient initiating choices. Continues to require hand over hand to make functional communication choices such as yes/no and basic wants and needs. Recognizes some written words such as has (sic) name. Diagnostic Recommendations: Speech therapy for improved expressive communication for basic wants/needs and for participation in programming at Bi-County...Additional Comments: Discussed with nurse the status of the augmentative device. The Dynavox has some icons but appear to be higher level than what patient is capable of using. Will add and modify current icons and speech board to make them more functional for the patient for daily activities."</p> <p>Additional records for client #2 were reviewed on 11/17/14 at 9:35 AM. A speech re-evaluation dated 2/14/14 indicated client #2 "was using a gesture which appeared to be an approximation of a 'yes' ASL (American Sign Language) sign. He continues to struggle with initiation if held up to him he will take and place with the matching word or picture. Patient appears to be able to match words and picture with verbal</p>			

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	<p>prompt. He responds to 'no' if incorrect and does utilize 'high five' when he is correct....Diagnostic Recommendations: Speech therapy for improved expressive communication for basic wants/needs and for participation in programming at Bi-County" once weekly for 12 weeks.</p> <p>A note dated 11/14/14 written by the QIDP (Qualified Intellectual Disabilities Professional) was reviewed on 11/17/14 at 9:35 AM and indicated client #2 worked with a Dynavox (augmentative communication device) from May, 2013 until July, 2014 when client #2 "lost interest and refused to use it." There was no evidence of an evaluation as to why client #2 lost interest or an intervention to encourage client #2's use of the device provided.</p> <p>The Program Director was interviewed on 11/18/14 at 4:52 PM and indicated the staff implemented the clients' ISPs available at the group home and day services and the communication objectives should have been provided to staff for implementation and indicated the communication objectives found at the facility office were located on the facility's computer data base.</p> <p>9-3-4(a)</p>			

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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (client #3), the facility failed to ensure the client's ISP (Individualized Support Plan) correctly indicated when he was to use a walker.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 11/12/14 from 6:24 PM</p>	W000240	<p>W240 – Individual Program Plan The individual program plan must describe relevant interventions to support the individual toward independence. BCS failed to ensure that Consumer #3 had an Individual Support Plan which adequately outlined when he was to utilize his walker based upon physical therapy recommendations. As noted in the W159 tag, we feel that the change in management team has already been a positive</p>	12/18/2014

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	<p>until 7:40 PM and again on 11/13/14 from 6:35 AM until 7:45 AM. Client #3 had a walker in his room, but did not use the walker during the observation.</p> <p>Client #3's record was reviewed on 11/13/14 at 7:55 AM. A Health/Risk Plan dated 7/22/14 indicated a fall risk "Staff will continue to encourage [client #3] to use his walker at all times when he is in the community and at Day Services. [Client #3] is to use his walker at home at all times until further notice or change (improvement) in his status...."</p> <p>The Program Director was interviewed on 11/13/14 at 3:02 PM and indicated she didn't think client #3 was to use his walker at all times any more as he was no longer frail and had improved in his ability to walk unaided. She indicated she would look for additional documentation of client #3's mobility status.</p> <p>A physical therapy clinic note dated 10/24/12 was reviewed on 11/17/14 at 9:40 AM and indicated "allow [client #3] to choose to use walker or not use walker when walking in his home. When at workshop or in the community it is recommended [client #3] continue to use his walker."</p> <p>9-3-4(a)</p>		<p>step forward in improving the quality of the programming, care, supports and encouragement of growth, development and independence for all of the consumers living at the Third Street group home. Additionally, the training outlined for all QIDP'sreferenced within the W159 tag item D.3 will provide pertinent resources to ensure that each individual serving in that role understands their pivotal nature to the adequacy of the program each consumer receives in relation to utilizing adaptive equipment/generating current plans that promote independence. Persons Responsible: Program Director (PD), Residential Administrator (RA), and Administrative Assistant for Quality Assurance (AAQA). Targeted Completion Date: 12/15/14 A. Corrective Action specific to Consumer#3:</p> <ol style="list-style-type: none"> 1. Effective 12/12/14, C3's Consumer Specific Training and Fall Risk Plan were revised to reflect current Physical Therapy recommendations for walker use. Current information indicates that C3 is to utilize his walker at all times when at Day Services or in the community, but that he had "demonstrated safe walking without the use of a walker when in a quiet,non-cluttered environment" effective 10/24/12. 2. The updated Risk Plan and CST will be forwarded for use in all locations by 12/18/14. 				

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W000248	<p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on observation, record review, and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2 and #3) by not ensuring current communication objectives for clients #1 and #2, updated day services objectives for client #2 and an updated fall risk plan for client #3 were available for staff to implement.</p> <p>Findings include:</p> <p>1. Client #1's record at the group home was reviewed on 11/13/14 at 9:00 AM. There was no evidence of an objective to address client #1's communication skills at the group home. Client #1's records at the facility's office were reviewed on 11/13/14 at 1:32 PM. Client #1's ISP (Individual Support Plan) dated 4/1/14</p>	W000248	<p>Persons Responsible: Third Street RMT, Program Director (PD), Residential Administrator (RA), and Administrative Assistant for Quality Assurance (AAQA). Targeted Completion Date: 12/18/14</p> <p>W248 – Individual Program Plan A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents or legal guardian. BCS failed to ensure relevant staff was equipped with pertinent information pertaining to client ISP's including Consumer #1 and #2 communication goals, updated Day Services goals for Consumer #2 and an updated Fall Risk Plan for Consumer #3. As noted in the W159 tag, we feel that the change in management team has already been a positive step forward in improving the quality of the programming, care, supports and encouragement of growth, development and independence for all of the</p>	12/18/2014	

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	<p>indicated an objective to learn the sign for bathroom.</p> <p>2. During observation at the workshop on 11/13/14 from 11:40 AM until 12:10 PM, client #2 sat without activity until prompted to sort colored pegs by color and shape. Client #2 completed the task within 2 minutes.</p> <p>Day services staff #5 was interviewed on 11/13/14 at 12:05 PM and indicated client #2 did not have an objective for day services. She reviewed the computerized record for client #2 and indicated there was no objective for client #2 available.</p> <p>Client #2's record at the group home was reviewed on 11/13/14 at 8:35 AM. Client #2's ISP dated 11/20/13 did not include evidence of an objective to address communication. Client #2's records were reviewed at the facility office on 11/13/14 at 2:10 PM. An ISP objective dated 2/1/14 in the office records indicated an objective to improve his communication skills by using his communication device and day services objectives dated 10/1/14 to "participate in scheduled activities and participate in community activities."</p> <p>The Program Director was interviewed</p>		<p>consumers living at the Third Street group home. Additionally, the training outlined for all QIDP's referenced within the W159 tag items D.2 and D.3 will provide pertinent resources to ensure that each individual serving in that role understands their pivotal nature to the adequacy of the program each consumer receives in relation to assuring consistent program implementation across all settings. Additional information regarding communication goals for C1 and C2 can be located under the W159 tag, and information regarding an updated Risk Plan for C3 can be found under the W240 tag. Persons Responsible: Program Director (PD), Residential Administrator (RA), and Administrative Assistant for Quality Assurance (AAQA). Targeted Completion Date: 12/18/14</p>				

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	<p>on 11/18/14 at 4:52 PM and indicated the staff implemented the clients' ISPs available at the group home and day services and the communication objectives should have been provided to staff for implementation and indicated the communication objectives found at the facility office were located on the facility's computer data base.</p> <p>9-3-4(a)</p>						
W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based upon record review and interview for 1 of 3 sampled clients (client #1) the facility failed to implement his plan to address unsafe eating.</p> <p>Findings include:</p>	W000249	<p>W249 – Program Implementation As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and</p>	12/18/2014			

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	<p>Observations were completed at the group home on 11/12/14 from 6:24 PM until 7:40 PM. During the observation, client #1 picked up a can of soda and drank 2 drops of liquid until it was empty.</p> <p>Staff #2 was interviewed on 11/12/14 at 6:30 PM and indicated the can of soda was probably client #6's.</p> <p>Observations were completed at the group home on 11/13/14 from 6:35 AM until 7:45 AM. Client #1 grabbed a piece of toast from the counter and took a bite out of the toast folded in two. Staff #8 removed the toast from his hand and threw it away.</p> <p>Client #1's record was reviewed on 11/13/14 at 1:32 PM. A Behavior Support Plan (BSP) dated 3/1/14 indicated target behaviors of self injurious behavior, physical aggression and eating unsafe foods. The plan indicated client #1 "is directed to follow a pureed diet by his physician due to severe dysphagia resulting from an esophageal stricture...[client #1] frequently attempts to eat food that is not pureed, posing a choking risk due to the unmodified texture. Verbal redirection to deter this behavior is not typically successful with</p>		<p>services insufficient number and frequency to support the achievement of the objective identified in the individual program plan. BCS failed to effectively implement needed interventions to address the issue of unsafe eating for Client #1. As noted in the W159 tag, we feel that the change in management team has been a positive step forward in improving the quality of the programming, care, supports and encouragement of growth, development and independence for all of the consumers living at the Third Street group home. Additionally, the training outlined for all QIDP's referenced within the W159 tag items D.2 and D.3 will provide pertinent resources to ensure that each individual serving in that role understands their pivotal nature to the adequacy of the program each consumer receives in relation to ensuring needed interventions are in place to support identified objectives. A. Corrective Action and Follow-Up Specific to C1 1. On 12/9/14, the Third Street Program Manager developed a "Staff Assignment Protocol" specific to C1. This protocol will be utilized to assure that a specific scheduled staff is present with C1 at all times, and able to provide him with active treatment that ensures his Risk Plans are being adequately followed consistently. All staff working with C1 began training on</p>				

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	<p>[client #1]. Strategies for changing the meal preparation routine in his group home are available to limit his risk for eating these unsafe foods..." An ISP (Individual Support Plan) dated 4/1/14 indicated "I will remain safe by not eating foods of a regular texture." Strategies indicated "follow guidelines in [client #1's] BSP addressing eating unsafe foods. Assist [client #1] to avoid the kitchen and dining areas while food of a regular texture is being prepared..." The undated Swallow Recommendations indicated "Eliminate distractions during meals. If possible, sit with him 1:1 (one to one) in another area away from others. Eliminate potentials for choking (leaving food/drinks out after mealtimes). Monitor him closely knowing his risk from choking/aspiration..." A Dining plan dated 7/30/14 indicated client #1 was to eat a pureed diet and encouraged to eat 6 small meals daily "due to the modified, small size of his stomach," and client #1 was to use a slow flow cup when drinking fluids.</p> <p>The group home nurse was interviewed on 11/13/14 at 2:40 PM and indicated client #1 should be supervised closely to prevent him from getting food not prepared to pureed consistency and offered pureed food instead. The group home nurse indicated staff were to put</p>		<p>the Protocol, and it will be fully implemented by 12/16/14. 2. Additionally, all staff working with C1 will be retrained on Mandt Body Positioning techniques as a way to assist C1 in avoiding unsafe food/drink in a respectful, non-threatening manner. This training will occur at the Third Street House meeting on 12/16/14. Persons responsible: Third Street RMT, Program Director (PD), Residential Administrator (RA), and Administrative Assistant for Quality Assurance (AAQA). Targeted Completion Date: 12/18/14</p>		

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W000368	<p>themselves between food and client #1 to prevent his access.</p> <p>9-3-4(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based upon record review and interview, the facility failed for 2 of 3 sampled clients (clients #1 and #3) and for 2 additional clients (clients #4 and #5) to ensure medications were dispensed without error.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 11/13/14 at 11:30 AM and indicated the following:</p> <p>1. A BDDS report dated 6/17/14 indicated client #1 received a "double dose" of the prescribed medication Zyprexa (anti-psychotic). The report did not indicate the dose of medication client #1 received in error. The report indicated client #1 was monitored to ensure he didn't experience side</p>	W000368	<p>W368 – Drug Administration The system for drug administration must assure that all drugs are administered in compliance with physician's orders. BCS did not meet this standard as evidenced by failure to assure that five of six consumer's medications were administered according to their physicians' orders. Our agency RN's do an excellent job of teaching/training staff and take very seriously the responsibility for training all staff agency wide on the State mandated drug administration course "Living in the Community" Core A & B. The Medical Caseworker is actively involved with Direct Care Staff (DCS) working with residential consumers across all settings and provides open</p>	12/18/2014	

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	<p>effects of the medication error. The report indicated the staff responsible for the error would be retrained.</p> <p>A BDDS report dated 7/16/14 indicated client #1 did not receive his dose of Haldol (anti-psychotic) 1 mg (milligrams). The medication was discovered on the floor of the medication administration room on 7/17/14. The report indicated staff would be retrained on administration of medications.</p> <p>A BDDS report dated 8/24/14 indicated client #1 did not receive his Olanzapine (anti-psychotic) 5 mg when visiting family. The staff responsible for transporting his medication failed to ensure the medication was given to the family and the medication had fallen away from the medications given to client #1's family.</p> <p>Medication Error Review Team (MERT) Recommendations were reviewed on 11/13/14 at 12:15 PM. A MERT dated 8/26/14 indicated staff would be retrained on ensuring medications were given to the family and medications would be placed in zipped bags for transport.</p> <p>A BDDS report dated 9/23/14 indicated staff failed to give client #1 his Oxcarbazepine (mood stabilizer) 300 mg at 7:00 AM. The report indicated staff would be retrained and the MERT team would review the incident.</p> <p>A MERT Recommendation dated 9/30/14 regarding the error on 9/23/14 indicated disciplinary action and training for staff #4 as this was his 4th error and staff #6 would be trained on reviewing medication administration documentation for errors.</p> <p>A MERT Recommendation dated 6/20/14</p>		<p>communication and supports in providing pertinent information regarding changes to consumers' medications and other priority health related needs included in consumers MAR/TAR's & Risk Plans. Residential Management Teams (RMT) along with the Administrative Team will work closely with the nurses and Medical Caseworker to assist with monitoring of ensuring that staff administers medications/treatments per physician's orders. As noted in the W159 QMRP narrative, lack of supervision by the previous management team resulted with lack of communication & isolation with medical department. There was some question if disciplinary action &/or staff retraining actually took place as it related to medication errors and recommendations and if so not in a timely manner. New management team in place works well with the medical department & other staff working with the Third Street consumers across all settings. Although we have several safeguards in place for assuring that medications are administered per physician's orders: including but not limited to Medication Error Review Team (MERT), Medication Administration Guidelines, Medication Administration Mentors (MAM), Check List for Transcribing Orders, Buddy Check System, Proper Med Pass</p>				

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	<p>indicated client #2 did not receive Ketoconazole (anti-fungal) topical (dose not indicated) and staff #2 and #10 would be retrained on medication administration and review of medication administration procedures to prevent errors.</p> <p>A MERT Recommendation dated 7/16/14 indicated client #2 did not receive Haloperidol (anti-psychotic) 1 mg at 9:00 PM. Staff #2 was given disciplinary action and retrained on medication administration.</p> <p>2. A BDDS report dated 6/4/14 indicated client #3 was given 200 mg of Clozapine in error by staff #2 on 6/3/14 and 6/4/14. The report indicated staff #3 removed pills from a pack that was intended for future use in addition to the medication that was to be given at the time of the medication administration time. The poison control center was called to determine what adverse side effects client #3 could experience (increased sedation). Client #3's doctor was notified of the error. Staff #2 was removed from medication administration until retraining was completed to prevent future errors. The report indicated the MERT team would review the incident.</p> <p>A MERT Recommendation 6/6/14 regarding the errors dated 6/3/14 and 6/4/14 indicated staff #2 would be retrained and extra medications would be placed in a separate location to prevent future errors.</p> <p>3. A BDDS report dated 5/10/14 indicated client #4 did not receive his dose of Lamictal (seizures) and Paxil (anti-depressant) (dosage not indicated) on 5/9/14. The error occurred when the medication administrator overlooked the multi-dose pack containing these medications and did not triple check the MAR (medication</p>		<p>Observation by RN's, Group Home Medication Tracking Procedure, Medication Storage Protocol for DS & Sheltered Workshops and Medication Monitoring and Management Procedures for DS & Workshops it is apparent that we need to re-organize ourselves in such a manner as to assess and address concerns relating to the number of errors still occurring so as to assure that medications &/or treatments are administered in compliance with physician's orders. In conjunction with previous surveys, our protocols and other safeguards have been reviewed and revisions were identified for change(s)/additions. Additions include MERT Corrective Guidelines and a Quarterly &/or Semi-Annual Medication Error Report Card for all DCS working in residential group homes provided by agency RN's. Other supports, including Emar's will be identified in the Corrective Action & Follow-Up section below. The review emphasized the importance of our need to aggressively pursue and implement ongoing monitoring & implementing of safeguards with outcome focus on ending recurrence of medication errors.</p> <p>A. Corrective Action Specific to Consumers #1, 2, 3, 4 and 5 relating to medication administration: Consumer #1 (C1): C1 experienced 3</p>				

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	<p>administration record) as directed by agency guidelines. The report indicated the MERT team would review the error. The report indicated staff #11 would receive disciplinary action as he "has had several medication errors in the past of similar circumstances...."</p> <p>4. A MERT Recommendation dated 7/17/14 indicated client #5 did not receive Clonazepam .25 mg. Recommendations indicated staff #2 would be retrained.</p> <p>The Program Director was interviewed on 11/13/14 at 12:58 PM and stated "We've done a lot in addressing errors." She indicated a new system to review errors had been developed to determine and address patterns of errors.</p> <p>9-3-6(a)</p>		<p>medication errors during May 1st through November 17th:</p> <ul style="list-style-type: none"> ·On 6/17/14, C1 received an extra dose of his 10 mg Zyprexa. C1 did not display adverse side effects due to the error when monitored. His physician was contacted at the time and noted no additional concerns. An Incident Report was submitted on 6/18/14 and closed at the time of submission. The staff member administering the extra dose was to receive a Verbal Warning per Medication Error Review Team (MERT) recommendations. Additionally, training took place regarding calling On-call for any questions prior to passing medications when clarification is needed. ·On 8/24/14, C1 did not receive his 5 mg dose of Zyprexa while home with his family due to an error during transport, allowing the Zyprexa to fall out of the bag containing all other medications. MERT recommendations included retraining for the responsible staff person on ensuring all medications are located in a secure container before transporting. ·On 9/23/14, C1 was not given his 7 am dose of Oxcarbazepine 300 mg. The error was not detected that day by the buddy checker, and was not reported to an RMT member for several days. Once discovered, it was noted that C1 had not experienced any adverse effects 		

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			<p>from the missed dose. An Incident Report was submitted on 9/29/14, with a Follow-Up Report being sent in on 10/1/14. The Incident was closed at that time. MERT evaluated the error and recommended a Written Warning to the responsible staff member, as well as training to include accurate documentation. The staff responsible for buddy checking the medication administration on that date was issued a Verbal Warning, and training to include Proper Buddy Check Procedures.</p> <p>Consumer #2 (C2): C2 experienced 2 medication errors during May 1st through November 17th:</p> <ul style="list-style-type: none"> ·On 6/20/14, C2 did not receive his topical dose of Ketoconazole. Following MERT evaluation, recommendations included retraining on offering support between staff, especially pertaining to medication administration (i.e. allowing for ample time to complete thorough processes/checks). The responsible staff member was given a 2-week period of additional monitoring/support. ·On 7/17/14, one of C2's Haldol 1 mg pills was discovered on the floor of the medication administration room. It was determined to be likely that he had missed his dose from the previous day – 7/16/14. No adverse effects were noted due to the missed dose. An incident 		

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			<p>report was submitted on 7/22/14, and was closed at the time of submission. Results of the MERT evaluation included a Written Warning for the staff responsible for medications on 7/16/14. The MERT Employee Med Error Record also noted a trend for the responsible staff member at that time, and as a result he was pulled from administering medications until a training/mentoring program could be completed.</p> <p>Consumer #3 (C3): C3 experienced 1 medication error during May 1st through November 17th:</p> <ul style="list-style-type: none"> On 6/3/14 and 6/4/14, C3 received two doses of his Clozapine 200 mg. The error occurred when the responsible staff administered regular medications, but also included an extra dose from a pack intended for future use (overflow). Poison Control was contacted, and indicated that C3 should be monitored for increased sedation, which was not noted when monitored. C3's physician was also contacted at that time. An Incident Report was submitted on 6/4/14 and was closed upon submission. MERT recommendations included the responsible staff being pulled from administration pending retraining including two medpass observations (one with the house Medication Administration Mentor and one with the House 		

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			<p>Manager), a Verbal Warning, and ensuring all overflow medications were placed in a separate location to prevent future confusion.</p> <p>Consumer#4 (C4): C4 experienced 1 medication error during May 1st through November 17th: ·On 5/9/14, C4 did not receive his morning doses of Lamictal and Paxil. The error was due to the medication administrator failing to accurately complete checks as outlined in the agency's Medication Administration Guidelines. No negative effects were noted as a result of the error. An Incident Report was submitted on 5/10/14 and was closed at the time of submission. MERT recommendations for the error included a 3-Day suspension for the administration due to pattern of errors within the Employee Medication Error Record. Notification was made at that time that a further error would result in termination. The staff member responsible for buddy checking was given a Verbal Warning.</p> <p>Consumer#5 (C5): C5 experienced 1 medication error during May 1st through November 17th: ·On 7/17/14, C5 did not receive his Clonazepam .25mg. No adverse effects were noted due to the error, and his physician was contacted. As a result of the error the responsible staff person</p>		

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			<p>received a Written Warning, and in conjunction with the 7/17/14 error for C2 noted above, was pulled from administering medications until atraining/mentoring program could be completed.</p> <p>B. Corrective Action and Follow-Up Specific to all Residential Staff working with Third Street Consumers:</p> <p>1. Bi-County Services' agency RN's are committed to providing quality training to the direct carestaff working for the agency. After the survey was completed on 11/17/14, a comprehensive Medication Administration Remediation Course (MARC) was held for all direct support staff at the Third Street. The curriculum was developed and training specific to needs of those attending MARC. Competency testing was individualized per individual need(s). The training was held on 11/18/14, with all staff members passing with a rate of 89% or higher. 2. The MERT revised their Medication Administration Guidelines to include very specific Corrective Action Guidelines for personnel action for medication errors. These guidelines address # of errors by individual staff, the reasoning for the corrective action and where an individual staff falls in the continuum. These guidelines apply to the individual administering medications, as well as the Buddy Checker, as</p>		

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			<p>their responsibilities are equal. All staff working with the Third Street consumers across all settings were provided with training on the Corrective Action Guidelines on in early November 2014. 3. The agency RN's have developed a Quarterly &/or Semi-Annual Medication Error Report Card which indicates by individual staff any errors, # of errors involved, running total of errors, corrective action and a tally of total house errors compared with the staff's total errors and their responsibility for the % of the Third Street errors. This provides a very visual reminder of concerns related to each staff and their role in being a part of the solution rather than part of the problem. We hope that this will be a motivator. The Report Cards go hand in hand with the MERT Corrective Action Guidelines. All Third Street staff met with the RN's to discuss their Report Card status on 11/18/14. 4. All staff working with the Third Street consumers & all residential consumers across all settings will be re-trained on medication administration expectations and guidelines, as well as the importance of better communication and documentation across all settings for med error prevention. Additional training agenda items will be added as recommended by RN's, MERT, supervisory &/or administrative staff. Training will be completed by 12/18/14. 5. All</p>		

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based upon observation, record review, and interview, the facility failed for 1 of 3 sampled clients (client #2) to encourage him to use a recommended adaptive equipment (communication device).</p> <p>Findings include:</p>	W000436	<p>RMT members will be trained on items A.2-4 on 12/15/14. Person's Responsible: PD, RA, AAQA, RN's, Medical Caseworker and RMT's. Target Completion Date: 12/18/14</p> <p>Corrective Action and Follow-Up specific to BCS practices agency wide to eliminate recurrence of medication error(s): 1. The Supported Living Management Team(SLMT) will be trained on items A.2-4 on 12/15/14. The SLMT's will then train their staff at the next staff &/or house meeting. Person's Responsible: PD; RA, AAQA, SLMT's & other supervisory staff. Target Completion Date: 12/18/2014</p> <p>W436 – Space and Equipment The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. BCS did not meet this standard</p>	12/18/2014	

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	<p>Observations were completed at the group home on 11/12/14 from 6:24 PM until 7:40 PM. Client #2 did not use a communication system during the observation. Client #2 sat on the sofa in the living room and watched TV.</p> <p>Observations were completed on 11/13/14 from 6:35 AM until 7:45 AM. Client #2 did not use a communication system during the observation. Client #2 prepared his lunch with the assistance of staff.</p> <p>During observation at the workshop on 11/13/14 from 11:40 AM until 12:10 PM, client #2 did not use a communication system. Client #2 sat without activity until prompted to sort colored pegs by color and shape. Client #2 completed the task within 2 minutes.</p> <p>Client #2's record at the group home was reviewed on 11/13/14 at 8:35 AM. Client #2's ISP dated 11/20/13 did not include evidence of an objective to address communication. Client #2's records were reviewed at the facility office on 11/13/14 at 2:10 PM. An ISP objective dated 2/1/14 in the office records indicated an objective to improve his communication skills by using his communication skills by using his communication device. A speech discharge summary dated 10/15/13</p>		<p>as evidenced by failing to ensure that Client #2 was encouraged to utilize his recommended adaptive equipment (communication device). It is the intention of BCS to ensure that all consumers are provided with adequate environmental supports and assistive devices needed to assist them in leading more independent lives. A. Corrective Action specific to C2: 1. Initial training for staff regarding the use of the Communication Device for C2 occurred in April 2014. However, further evaluation suggests there may have been inconsistency in the Follow-Up from previous RMT members regarding its implementation. 2. The current RMT is committed to assisting C2 in utilizing his communication device effectively to support a greater development of independence. Contact has been made with an AAC Specialist to conduct further training on the device. 3. Additionally, C2 has now been provided with an updated ISP, including effective Communication goals across all settings effective 12/9/14. The updated communication goal focuses on teaching/training C2 to utilize his adaptive equipment to the best of his ability. Person's Responsible: PD, RA, AAQA, and RMT's. Target Completion Date: 12/18/14 B. Corrective Action specific to BCS practices agency wide:</p>		

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	<p>indicated "Diagnostic Recommendations: Speech therapy for improved expressive communication for basic wants/needs and for participation in programming at Bi-County...Additional Comments: Discussed with nurse the status of the augmentative device. The Dynavox has some icons but appear to be higher level than what patient is capable of using. Will add and modify current icons and speech board to make them more functional for the patient for daily activities."</p> <p>A note dated 11/14/14 written by the QIDP (Qualified Intellectual Disabilities Professional) was reviewed on 11/17/14 at 9:35 AM and indicated client #2 worked with a Dynavox (augmentative communication device) from May, 2013 until July, 2014 when client #2 "lost interest and refused to use it." There was no evidence of an evaluation as to why client #2 lost interest or discussion/intervention by the IDT (interdisciplinary team) to encourage client #2's use of the device provided.</p> <p>The Program Director was interviewed on 11/13/14 at 4:52 PM. When asked if the IDT (interdisciplinary team) had addressed client #2's refusals to use his communication device, she indicated an appointment had been made to address</p>		<p>1. Training for all RMT's and SLMT's will occur on 12/15/14 covering the expectation outlined within the W436 tag as it relates to Sensorimotor, Physical and Environmental Needs Assessments, Functional Assessments, and general QIDP expectations. Person's Responsible: PD, RA, AAQA, RMT's and SLMT's. Target Completion Date: 12/18/14</p>		

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W000455	<p>client #2's use of the device. She indicated the facility had a responsibility to ensure client #2 had opportunity and encouragement to use the device.</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based upon record review and interview, the facility failed for 1 of 3 sampled clients (client #2) to ensure he washed his hands before food preparation and eating.</p> <p>Findings include:</p> <p>Observations were completed on 11/13/14 from 6:35 AM until 7:45 AM. Client #2 used the restroom and did not wash his hands. Client #2 was prompted by staff #8 to assist</p>	W000455	<p>W455 – Infection Control There must be an active program for the prevention, control, and investigation of infection and communicable diseases. BCS failed to ensure this standard was met by not requiring that Consumer #2 washed his hands prior to food preparation and consumption. As stated under the W368 tag, our agency RN's do an excellent job of teaching/training staff. They are also very committed to providing</p>	12/18/2014

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	<p>in preparing breakfast and ate breakfast without being asked to wash his hands first.</p> <p>The group home nurse was interviewed on 11/13/14 at 2:40 PM and indicated client #2 should have been prompted to wash his hands prior to engaging in food preparation or eating his breakfast.</p> <p>9-3-7(a)</p>		<p>excellent teaching and training to the consumers of BCS. A. Corrective Action Specific to C2: 1. Once per year, agency RN's train each consumer within the agency on "Consumer Wellness", which includes Proper Hand washing techniques. The date of the most recent training, including C2, was 9/12/14. 2. Additionally, Universal Precautions are covered once per year for all staff as part of the Mandatory In-service Training, most recently occurring on 4/24/14. 3. As a preventative measure to ensure the safety of C2, he will be retrained on Proper Hand washing Techniques, as well as each consumer residing at the Third Street Group Home. This training will take place on 12/16/14. 4. All DCS working at the Third Street Group Home will also be retrained on Proper Hand washing Techniques, also on 12/16/14. Person's Responsible: PD, RA, AAQA, RN's, Medical Caseworker and RMT's. Target Completion Date: 12/18/14 B. Corrective Action specific to BCS practices agency wide: 1. All RMT's, SLMT's, Administrative staff, and supervisors working with residential consumers across all settings will be retrained on item A.4 listed above. Retraining will occur on 12/15/14. 2. All staff working with residential consumers across all settings will receive training on item A.4 listed</p>		

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NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 503 N THIRD ST DECATUR, IN 46733		
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W009999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>460 IAC 9-3-2(c)(3) Resident Protections</p> <p>(c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: (3) conviction of a crime substantially related to a dependent population or any violent crime.</p> <p>The provider shall obtain, as a minimum, a bureau of motor vehicles record, a</p>	W009999	<p>above from RMT members by 12/18/14. All Supported Living DCS will be retrained at their next scheduled house/staff meetings by the SLMT members. 3. All Residential Consumers will receive retraining on item A.3 listed above by 12/18/14. SL Consumers will receive retraining on item A3 listed above following their next scheduled house meeting Person's Responsible: PD; RA, AAQA, RMT's, and SLMT's. Target Completion Date: 12/18/14</p> <p>W9999 – Resident Protections The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5, and three references. Mere verification of employment dates by previous employers shall not constitute a reference. BCS did not meet this standard by failing to ensure that Staff #8 had three proper references in place prior to employment, checking only employment dates. BCS has existing policies in place stating that a minimum of three <i>thorough</i></p>	12/18/2014	

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	<p>criminal history check as authorized in IC 5-2-5-5 [IC 5-2-5 was repealed by P.L.2-2003, SECTION 102, effective July 1, 2003. See IC 10-13-3-27.], and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>This State Rule is not met as evidenced by:</p> <p>Based on record review and interview, for 1 of 3 staff (staff #8) personnel files, the facility failed to ensure three references were obtained prior to employment.</p> <p>Findings include:</p> <p>The facility's personnel files were reviewed on 11/13/14 at 11:55 AM. Records for staff #8 indicated 2 complete references. The other reference confirmed dates of employment only.</p> <p>The Human Resource Manager was interviewed on 11/13/14 at 12:01 PM and indicated there were no other references available to review for staff #8.</p> <p>9-3-2(c)(3)</p>		<p>references must be in place prior to the hiring of any new employee. This policy is supported by the procedure of following a standard script of questions when checking a potential employee's references, including stating that the potential employee is being considered for employment "with vulnerable individuals" and verifying whether the reference has any concerns/reservations. If one or more of a potential employee's references is unable to be contacted and/or is unable to provide adequate answers to the background questions, the potential employee must provide additional references until three are obtained. In the case of the citation, this policy and procedure was not adequately followed by the Third Street RMT.</p> <p>Corrective Action and Follow-Up Specific to BCS Practices Agency Wide to prevent recurrence of inadequate reference checks:</p> <p>1. On 12/12/14, the policy and procedure for obtaining references was revised to clearly state that all outlined questions within the guidelines must be answered to qualify as a reference. 2. The HR Supervisor for BCS composed a memo, alerting all supervisory staff to the updated policy/procedure to ensure that each department was aware of the change, not to only include those directly involved</p>				

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			with Residential and Supported Living consumers. 3. Additionally, all RMT and SLMT will be trained on the updated policy/procedure on 12/15/14. Person's Responsible: HR Supervisor, PD; RA, AAQA, RMT's,SLMT's and all other supervisory staff. Target Completion Date: 12/18/14		