

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G620	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/06/2013
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NAME OF PROVIDER OR SUPPLIER  PEAK COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1625 HIGH ST LOGANSPORT, IN 46947
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 11/18, 11/19, 11/20, 11/27 and 12/6/13</p> <p>Facility Number: 001168 Provider Number: 15G620 AIMS Number: 100235360</p> <p>Surveyors: Amber Bloss, QIDP-TC Susan Eakright, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/16/13 by Ruth Shackelford, QIDP.</p>	W000000		

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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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review for 2 of 3 sampled clients (#2, #3) and 1 additional client (#6), the governing body failed to exercise general policy and operating direction over the facility to ensure the clients' money was not used for programming costs.</p> <p>Findings include:</p> <p>1) Observations and interviews were completed on 11/19/13 from 5:35 AM until 7:35 AM, at the group home. At 5:40 AM, GHS (Group Home Staff) #11 indicated clients #2, #3, and #6 rode the city community bus independently and paid for their own individual bus passes each month with their personal funds. GHS #11 indicated the facility reimbursed the clients at a later date each month after clients #2, #3, and #6 purchased a bus pass to ride the bus home from workshop. At 5:50 AM, client #6 obtained her personal bus pass which was kept inside the medication office. At 5:50 AM, client #6 stated she enjoyed riding the community bus independently "but I don't always have my money to buy things I want after I buy my bus ticket." At 7:25 AM, client #2 stated she didn't mind</p>	W000104	<p>W104Peak Community Services through the IDT ensures that it exercises general policy, budget, and operating direction over the High Street Supervised Group Living facility. Clients #2, 3 and 6 have always been reimbursed for the money they spent on community transportation bus passes. Clients #2, 3 and 6 have always been reimbursed for the money they spent on community transportation bus passes. They would turn in their receipt and would be reimbursed by Peak Community Services. It was part of their training program to budget their money and purchase items in the community. To remediate this issue Peak Community Services has changed the protocol to the clients in an SGL residence not have to purchase a community transportation bus pass. They will access the community transportation system, Cass Area Transit, and they will in turn bill Peak Community Services for any transportation provided to its Supervised Group Living clients. To monitor this situation the Residential Manager will monitor the requisitions from the SGL residence for the time period of January 1, 2014 to June 30, 2014. Persons Responsible: Martha Tristan,</p>	01/05/2014	

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	<p>buying her own bus pass "but my money is tight."</p> <p>A) During record review on 11/20/13 at 11:32 AM, Client #2's finances were reviewed and indicated Client #2 signed the following checks for bus passes:</p> <p>-5/20/13 for \$30.00 -7/24/13 for \$30.00 -8/6/13 for \$30.00 -9/15/13 for \$30.00 -10/2/13 for \$30.00</p> <p>B) During record review on 11/20/13 at 11:45 AM, Client #3's finances were reviewed and indicated Client #3 signed the following checks for bus passes:</p> <p>-5/20/13 for \$30.00 -6/18/13 for \$30.00 -7/23/13 for \$30.00 -9/20/13 for \$30.00</p> <p>C) During record review on 11/20/13 at 12:05 PM, Client #6's finances were reviewed and indicated Client #6 purchased a bus pass on 10/2/13 for \$30.00.</p> <p>During an interview on 11/20/13 at 11:40 AM, the Director of Residential Services (DRS) indicated clients had been reimbursed for their bus passes when the</p>		Residential Coordinator Jan Adair, Residential Manager				

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	<p>receipts had been turned into finance. The DRS indicated clients #2, #3, and #6 should not have been spending their personal money on program costs.</p> <p>9-3-1(a)</p>			

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W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (Client #3) to ensure Client #3 had an advocate to assist her with her medical and financial needs.</p> <p>Findings include:</p> <p>On 11/20/13 at 10:30 AM, a record review for Client #3 was conducted. Client #3's 4/10/13 "Informed Consent/Self Advocacy Assessment" and 4/10/13 Individual Support Plan (ISP) both indicated Client #3 was not independent with her finances and/or medical care. Client #3's Informed Consent Assessment and ISP indicated the following areas were reviewed: personal finances, housing, personal safety, medical, behavioral, civil rights, and communication. The assessment and ISP indicated Client #3 required twenty-four hour supervision and assistance to understand to be able to give informed consent in each area. Client #3's record indicated she did not have an advocate and did not have a contact</p>	W000125	W125Peak Community Services through the IDT ensures that clients enrolled in the Supervised Group Living program are allowed and encouraged to exercise their rights as clients of the facility, and as citizens of the United States, including the rights to file complaints, and the right to due process. Client # 3 has an outside advocate to assist her with understanding her rights, medications and money. This advocate is listed in the contacts area of client # 3's Individual Support Plan and Supervised Group Living Staff are aware of the this person and no how to contact them as necessary. Systemically the Supervised Group Living clients in the Peak Community Services system will be evaluated as their annual Individual Support Plan meeting is held to ascertain the need for an advocate to assist them in exercising their rights as clients of the facility, and as citizens of the United States, including the rights to file complaints, and the right to due process. Monitoring: To monitor this situation the Residential	01/05/2014			

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	<p>person outside the agency to assist client #3 to understand her rights. Client #3's record indicated she had been a victim of abuse in the past and had a no contact order in place against the perpetrators.</p> <p>On 12/6/13 at 1:55 PM, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated Client #3's Informed Consent Assessment and ISP did indicate she needed an advocate to assist her with her medications and with her finances. The DRS indicated Client #3 had been the victim of abuse in the past and a no contact order was in place against the perpetrators. The DRS indicated Client #3 did not have an outside advocate at this time. The DRS indicated Client #3 did not understand her rights, medications, or money and needed an advocate to assist to explain these to Client #3.</p> <p>9-3-2(a)</p>		<p>Manager will document the advocates of the SGL clients in a data base for easy retrieval of contact information as necessary for internal and external usage. Persons Responsible: Martha Tristan, Residential Coordinator Jan Adair, Residential Manager Stacey Platt, QDDP</p>		

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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. Based on record review and interview, the facility failed to implement written policies and procedures to thoroughly investigate an allegation of abuse for 3 of 3 investigations reviewed for allegation of abuse for 1 of 3 sampled clients (Client #1).</p> <p>Findings include:</p> <p>1) On 11/18/13 at 12:52 PM, the facility BDDS (Bureau of Developmental Disabilities Services) reports and the facility's internal "Incident/Accident" reports from 11/18/12 to 11/18/13 were reviewed. A BDDS report dated 5/31/13 indicated at 7:45 AM, while at the facility owned day program, a male client "told [Client #1] was upset about something and needed to talk. They went into a small meeting room area. [Male Client] told [Client #1] he needed a hug. He then kissed her and ran his hand under her shirt and touched her breast." The report indicated the male client "admitted to kissing [Client #1] and touching her." The report indicated the male client "agreed to stay in the break room where staff can observe him in the future and not to ask people to go with him to a private area. He indicated understanding of appropriate personal space and that he is not to kiss, hug or touch others at Peak." The report indicated Client #1 "was instructed to use appropriate assertiveness and personal safety measures." The report indicated Client</p>	W000149	<p>W149- STAFF TREATMENT OF CLIENTS Peak Community Services through the IDT will ensure that written policies and procedures that prohibit mistreatment, neglect and abuse of clients are implemented and monitored for implementation as written. Peak Community Services has developed and implemented policies and procedures that prohibit the mistreatment, neglect or abuse of the client. These policies and procedures can be found on page 31 - 36 of the Supervised Group Living procedure manual. Systemic Changes: The Peak Community Services investigation form has been revised to state that all investigations must be initiated and completed, and the results presented to the administrator or designated representative or other officials within five calendar days of the reporting of the incident. Peak Community Services SGL coordinator and Residential Manager will be in-serviced on this requirement through the use of on-line training. This systemic change will be monitored on an on-going basis by the Director of Quality Assurance and Support . Human Resources office will reorganize how they store HR</p>	01/05/2014			

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	<p>#1 "knows it is 'OK' to say 'No' and tell people to respect her personal space, scream for help, and not to go to private areas. [Client #1] has difficulty being assertive with men and does attend counseling. [Client #1] did not appear to have any emotional trauma from this event."</p> <p>The follow up BDDS report dated 6/5/13 indicated Client #1's "level of supervision is closely followed and she and [male client] now sit in different areas at break time. Staff monitor [Client #1] regularly." The report indicated "staff have discussed maintaining assertive conversation with [Client #1] to say 'No' to unwanted advances."</p> <p>On 11/20/13 at 10:34 AM, the facility abuse investigations were reviewed. The investigation of incident on 5/31/13 was dated 5/31/13. The investigation report indicated the Work Services Manager conducted the investigation. The report indicated Client #1 "reported [male client] requested that she meet him in a private room. While in the room she said that he asked for a hug, kissed her and put his hand under her shirt, touching her breast." The report indicated [Client #1] reported the incident to workshop staff who was "monitoring the breakroom." The report indicated no documented statements of staff or clients. The report indicated the allegation was substantiated. The report indicated "policies and regulations were followed. Rights were not violated. Both clients returned to work." The investigation report</p>		<p>Investigation Reports. They will be clearly organized by date and event and will be accessible to Director of Residential Services and Director of Quality Assurance and Support. The Director of Residential Services and Director of Quality Assurance and Support will monitor monthly that all HR Investigations are complete and in the file; that they include the questions asked of all participants; and that they clearly state the outcome. The investigations will be reopened if recommended to assure. There will be a spreadsheet of all investigations documenting the 5 day completion time frame to these are being met. Investigation Training was presented by Steve Corya, Indiana State Department of Health. This training was held on 12.10.13 at Peak Community Services. This training will assist Peak Community Services staff on how to conduct a thorough investigation of allegations of abuse, neglect, and mistreatment of clients residing in the six SGL residences of Peak Community Services. Mr. Corya's information will be used to train other appropriate staff on the completion of thorough investigations of allegations of abuse, neglect, and mistreatment of clients of Peak Community Services. To monitor the thoroughness of an investigation and the completion of the</p>				

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	<p>recommended "further counseling by residential staff and with [mental health provider] counselor in assertiveness training." The investigation report recommended "Peak might consider offering training on sexuality issues."</p> <p>During an interview on 11/27/13 at 12:34 PM, the Director of Residential Services (DRS) indicated there was no further investigation documentation. The DRS indicated no written statements for the investigation were available for review. The DRS indicated the investigation was not thorough.</p> <p>2) On 11/18/13 at 12:52 PM, the facility BDDS (Bureau of Developmental Disabilities Services) reports and the facility's internal "Incident/Accident" reports from 11/18/12 to 11/18/13 were reviewed. A BDDS report dated 2/10/13 indicated staff wrote a note "reporting that one of the other staff had been verbally abusive to [Client #1]." The report indicated three Direct Support Professionals (DSP #5, DSP #6, DSP #7) were suspended pending an investigation. BDDS follow up reports dated 3/8/13 indicated all allegations of abuse were unsubstantiated because "[Client #1] stated that staff did not yell at her in the staff office area. When asked about staff slamming the door, [Client #1] replied that another client shut the door for privacy. [Client #1] said that she slammed her door shut because she was upset, not staff."</p>		<p>investigation within five (5) working days the Director of Quality Assurance and Support will review the investigations for quality and thoroughness based upon the material gained during the investigation training held on 12.10.13 presented by Steve Corya, Indiana State Department of Health. If the initial investigation is found to be substandard the investigation report will be returned with recommendations to the original investigators. Persons Responsible:Martha Tristan, Residential CoordinatorJan Adair Residential ManagerRick Phelps, Director of Residential ServicesStacey Platt, QDDPCornie English, Director of Quality Assurance and Support Stephanie Hoffman, Director of Human Resources</p>	

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	<p>On 11/20/13 at 10:34 AM, the facility abuse investigations were reviewed. The investigation contained an undated, written statement from DSP #5. DSP #5's written statement indicated "while in office [DSP #7] slammed office door at least twice, laughing about [Client #1] yelling back and not making since (sic)."I walked out office door. [Client #1] was still in kitchen, crying about her mother." DSP #5 indicated she tried to calm Client #1 by telling her "she missed her mom too." DSP #5 indicated when things were calm, she went outside for a break leaving the door open. DSP #5 indicated she was out on the porch and "heard a door slam, it was so loud it shook the house." DSP #5 indicated she heard Client #1 say in a low voice something like "gee whiz." DSP #5 stated "I went right into the house, office door was closed. I opened it and look (sic) straight at [DSP #7] and ask (sic) what was that." DSP #5 indicated DSP #7 "said to me she slammed the door." DSP #5 indicated the rest of the evening Client #1 stayed in her room while she helped her hang up her blouses. DSP #5 stated Client #1 "was being intimidated, I saw it, I know."</p> <p>The investigation packet included handwritten notes and interview responses but the handwritten notes were not labeled clearly who was being interviewed and the notes were not dated. In an email dated 3/7/13, the Director of Human Resources (DHR) indicated Client #1 "stated staff did not yell at her in the new office. When asked about staff slamming the door she replied that</p>			

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	<p>another client shut the door for privacy. [Client #1] said that she slammed her door shut because she was upset but not staff." The DHR indicated the environment was made safe because Client #1 "denied any issues except when she gets mad and yells staff will ask her if she needs space. She stated that they (staff) do not like to hear me yell." The DHR indicated "a full house training on Communication, Learning Styles and different ways to approach [Client #1] when she is having an outburst. Staff were receptive and have implemented some new strategies that seem to be positive. This was also discussed with [Client #1] by Site Coordinator. [Client #1] was also on board with trying something different to help her change her attitude."</p> <p>During an interview on 11/27/13 at 12:34 PM, the Director of Residential Services (DRS) indicated there was no further investigation documentation. The DRS indicated statements by staff and clients should be clearly identified and dated. The DRS indicated the investigation was not thorough.</p> <p>3) On 11/18/13 at 12:52 PM, the facility BDDS (Bureau of Developmental Disabilities Services) reports and the facility's internal "Incident/Accident" reports from 11/18/12 to 11/18/13 were reviewed. A BDDS report dated 9/3/13 indicated Direct Support Professional (DSP) #8 wrote a behavior incident report "that [Client #1] had a behavior and did not come out to eat her meal</p>			

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	<p>when it was ready. She stated in the report that she told [Client #1] that it was not sanitary to leave her plate on the table for a long period of time and so [DSP #8] proceeded to pack it for [Client #1]'s lunch the next day." The report indicated Client #1 "was upset and apparently staff did not provide anything else for her telling her supper was over. [Client #1] states that staff would not let her eat anything else. Staff states she offered her some fruit." The report indicated staff was suspended pending investigation.</p> <p>On 11/20/13 at 10:34 AM, the facility abuse investigations were reviewed. The behavior incident report dated 8/29/13 indicated "two hours after dinner [Client #1] came out and started to yell at staff saying that (sic) there I'm done so you can stop timing me." The report indicated "staff told [Client #1] that she was not being timed that it is her choice to stay in the shower that long but she missed dinner." The report indicated "staff told [Client #1] that she took to (sic) long in the shower and that it was not sanitary to leave her plate on the table any longer so staff packed it for her lunch the next day." The report indicated Client #1 "continued to yell at staff for hours."</p> <p>The investigation (dated 9/04/13) "summary of findings and recommendations" indicated Client #1 "stated she asked staff if she could have something else to eat. She stated the staff had told her no." The summary indicated DSP #8 denied the allegation and</p>			

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	<p>indicated "she did offer [Client #1] to go to the refrigerator and get herself something to eat. [DSP #8] stated she was the only one working and was getting ready to pass meds." The summary report indicated the allegation was unsubstantiated. The summary report did not address why DSP #8 did not assist Client #1 with making a replacement meal.</p> <p>During an interview on 11/27/13 at 12:34 PM, the Director of Residential Services (DRS) indicated there was no further investigation documentation. The DRS indicated she could understand how the investigation may not be thorough enough to indicate the allegation was unsubstantiated. The DRS indicated the investigation was not thorough.</p> <p>On 11/20/13 at 10:09 AM, the facility policy of "Abuse/Neglect/Exploitation/Mistreatment of an Individual/Violation of an Individual's Rights Investigation Procedure" dated 12/14/09 was reviewed and indicated "the investigator must thoroughly investigate...".</p> <p>9-3-2(a)</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 on record review and interview, the facility failed to thoroughly investigate an allegation of abuse for 3 of 3 investigations reviewed for allegation of abuse for 1 of 3 sampled clients (Client #1).</p> <p>Findings include:</p> <p>1) On 11/18/13 at 12:52 PM, the facility BDDS (Bureau of Developmental Disabilities Services) reports and the facility's internal "Incident/Accident" reports from 11/18/12 to 11/18/13 were reviewed. A BDDS report dated 5/31/13 indicated at 7:45 AM, while at the facility owned day program, a male client "told [Client #1] was upset about something and needed to talk. They went into a small meeting room area. [Male Client] told [Client #1] he needed a hug. He then kissed her and ran his hand under her shirt and touched her breast." The report indicated the male client "admitted to kissing [Client #1] and touching her." The report indicated the male client "agreed to stay in the break room where staff can observe him in the future and not to ask people to go with him to a private area. He indicated understanding of</p>	W000154	<p>W154 - STAFF TREATMENT OF CLIENTS Peak Community Services through the IDT will ensure that written policies and procedures that prohibit mistreatment, neglect and abuse of clients are implemented and monitored for implementation as written. Peak Community Services has developed and implemented policies and procedures that prohibit the mistreatment, neglect or abuse of the client. These policies and procedures can be found on page 31 - 36 of the Supervised Group Living procedure manual.</p> <p>Systemic Changes: The Peak Community Services investigation form has been revised to state that all investigations must be initiated and completed, and the results presented to the administrator or designated representative or other officials within five calendar days of the reporting of the incident. Peak Community Services SGL coordinator and Residential Manager will be in-serviced on this requirement through the use of on-line training. This systemic change will be monitored on an on-going basis by the Director of Quality Assurance and Support . Human Resources office will reorganize how they store HR</p>	01/05/2014

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	<p>appropriate personal space and that he is not to kiss, hug or touch others at Peak." The report indicated Client #1 "was instructed to use appropriate assertiveness and personal safety measures." The report indicated Client #1 "knows it is 'OK' to say 'No' and tell people to respect her personal space, scream for help, and not to go to private areas. [Client #1] has difficulty being assertive with men and does attend counseling. [Client #1] did not appear to have any emotional trauma from this event."</p> <p>The follow up BDDS report dated 6/5/13 indicated Client #1's "level of supervision is closely followed and she and [male client] now sit in different areas at break time. Staff monitor [Client #1] regularly." The report indicated "staff have discussed maintaining assertive conversation with [Client #1] to say 'No' to unwanted advances."</p> <p>On 11/20/13 at 10:34 AM, the facility abuse investigations were reviewed. The investigation of incident on 5/31/13 was dated 5/31/13. The investigation report indicated the Work Services Manager conducted the investigation. The report indicated Client #1 "reported [male client] requested that she meet him in a private room. While in the room she said that he asked for a hug, kissed her and put his</p>		<p>Investigation Reports. They will be clearly organized by date and event and will be accessible to Director of Residential Services and Director of Quality Assurance and Support . The Director of Residential Services and Director of Quality Assurance and Support will monitor monthly that all HR Investigations are complete and in the file; that they include the questions asked of all participants; and that they clearly state the outcome. The investigations will be reopened if recommended to assure. There will be a spreadsheet of all investigations documenting the 5 day completion time frame to these are being met. Investigation Training was presented by Steve Corya, Indiana State Department of Health. This training was held on 12.10.13 at Peak Community Services. This training will assist Peak Community Services staff on how to conduct a thorough investigation of allegations of abuse, neglect, and mistreatment of clients residing in the six SGL residences of Peak Community Services. Mr. Corya's information will be used to train other appropriate staff on the completion of thorough investigations of allegations of abuse, neglect, and mistreatment of clients of Peak Community Services. To monitor the thoroughness of an investigation and the completion of the</p>		

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	<p>hand under her shirt, touching her breast." The report indicated [Client #1] reported the incident to workshop staff who was "monitoring the breakroom." The report indicated no documented statements of staff or clients. The report indicated the allegation was substantiated. The report indicated "policies and regulations were followed. Rights were not violated. Both clients returned to work." The investigation report recommended "further counseling by residential staff and with [mental health provider] counselor in assertiveness training." The investigation report recommended "Peak might consider offering training on sexuality issues."</p> <p>During an interview on 11/27/13 at 12:34 PM, the Director of Residential Services (DRS) indicated there was no further investigation documentation. The DRS indicated no written statements for the investigation were available for review. The DRS indicated the investigation was not thorough.</p> <p>2) On 11/18/13 at 12:52 PM, the facility BDDS (Bureau of Developmental Disabilities Services) reports and the facility's internal "Incident/Accident" reports from 11/18/12 to 11/18/13 were reviewed. A BDDS report dated 2/10/13 indicated staff wrote a note "reporting that</p>		<p>investigation within five (5) working days the Director of Quality Assurance and Support will review the investigations for quality and thoroughness based upon the material gained during the investigation training held on 12.10.13 presented by Steve Corya, Indiana State Department of Health. If the initial investigation is found to be substandard the investigation report will be returned with recommendations to the original investigators. Persons Responsible: Martha Tristan, Residential Coordinator Jan Adair Residential Manager Rick Phelps, Director of Residential Services Stacey Platt, QDDP Connie English, Director of Quality Assurance and Support Stephanie Hoffman, Director of Human Resources</p>				

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	<p>one of the other staff had been verbally abusive to [Client #1]." The report indicated three Direct Support Professionals (DSP #5, DSP #6, DSP #7) were suspended pending an investigation. BDDS follow up reports dated 3/8/13 indicated all allegations of abuse were unsubstantiated because "[Client #1] stated that staff did not yell at her in the staff office area. When asked about staff slamming the door, [Client #1] replied that another client shut the door for privacy. [Client #1] said that she slammed her door shut because she was upset, not staff."</p> <p>On 11/20/13 at 10:34 AM, the facility abuse investigations were reviewed. The investigation contained an undated, written statement from DSP #5. DSP #5's written statement indicated "while in office [DSP #7] slammed office door at least twice, laughing about [Client #1] yelling back and not making since (sic)."I walked out office door. [Client #1] was still in kitchen, crying about her mother." DSP #5 indicated she tried to calm Client #1 by telling her "she missed her mom too." DSP #5 indicated when things were calm, she went outside for a break leaving the door open. DSP #5 indicated she was out on the porch and "heard a door slam, it was so loud it shook the house." DSP #5 indicated she heard Client #1 say in a</p>			

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	<p>low voice something like "gee whiz." DSP #5 stated "I went right into the house, office door was closed. I opened it and look (sic) straight at [DSP #7] and ask (sic) what was that." DSP #5 indicated DSP #7 "said to me she slammed the door." DSP #5 indicated the rest of the evening Client #1 stayed in her room while she helped her hang up her blouses. DSP #5 stated Client #1 "was being intimidated, I saw it, I know."</p> <p>The investigation packet included handwritten notes and interview responses but the handwritten notes were not labeled clearly who was being interviewed and the notes were not dated. In an email dated 3/7/13, the Director of Human Resources (DHR) indicated Client #1 "stated staff did not yell at her in the new office. When asked about staff slamming the door she replied that another client shut the door for privacy. [Client #1] said that she slammed her door shut because she was upset but not staff." The DHR indicated the environment was made safe because Client #1 "denied any issues except when she gets mad and yells staff will ask her if she needs space. She stated that they (staff) do not like to hear me yell." The DHR indicated "a full house training on Communication, Learning Styles and different ways to approach [Client #1]</p>			

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	<p>when she is having an outburst. Staff were receptive and have implemented some new strategies that seem to be positive. This was also discussed with [Client #1] by Site Coordinator. [Client #1] was also on board with trying something different to help her change her attitude."</p> <p>During an interview on 11/27/13 at 12:34 PM, the Director of Residential Services (DRS) indicated there was no further investigation documentation. The DRS indicated statements by staff and clients should be clearly identified and dated. The DRS indicated the investigation was not thorough.</p> <p>3) On 11/18/13 at 12:52 PM, the facility BDDS (Bureau of Developmental Disabilities Services) reports and the facility's internal "Incident/Accident" reports from 11/18/12 to 11/18/13 were reviewed. A BDDS report dated 9/3/13 indicated Direct Support Professional (DSP) #8 wrote a behavior incident report "that [Client #1] had a behavior and did not come out to eat her meal when it was ready. She stated in the report that she told [Client #1] that it was not sanitary to leave her plate on the table for a long period of time and so [DSP #8] proceeded to pack it for [Client #1]'s lunch the next day." The report indicated Client #1 "was</p>			

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	<p>upset and apparently staff did not provide anything else for her telling her supper was over. [Client #1] states that staff would not let her eat anything else. Staff states she offered her some fruit." The report indicated staff was suspended pending investigation.</p> <p>On 11/20/13 at 10:34 AM, the facility abuse investigations were reviewed. The behavior incident report dated 8/29/13 indicated "two hours after dinner [Client #1] came out and started to yell at staff saying that (sic) there I'm done so you can stop timing me." The report indicated "staff told [Client #1] that she was not being timed that it is her choice to stay in the shower that long but she missed dinner." The report indicated "staff told [Client #1] that she took to (sic) long in the shower and that it was not sanitary to leave her plate on the table any longer so staff packed it for her lunch the next day." The report indicated Client #1 "continued to yell at staff for hours."</p> <p>The investigation (dated 9/04/13) "summary of findings and recommendations" indicated Client #1 "stated she asked staff if she could have something else to eat. She stated the staff had told her no." The summary indicated DSP #8 denied the allegation and indicated "she did offer [Client #1] to go</p>						

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	<p>to the refrigerator and get herself something to eat. [DSP #8] stated she was the only one working and was getting ready to pass meds." The summary report indicated the allegation was unsubstantiated. The summary report did not address why DSP #8 did not assist Client #1 with making a replacement meal.</p> <p>During an interview on 11/27/13 at 12:34 PM, the Director of Residential Services (DRS) indicated there was no further investigation documentation. The DRS indicated she could understand how the investigation may not be thorough enough to indicate the allegation was unsubstantiated. The DRS indicated the investigation was not thorough.</p> <p>9-3-2(a)</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 on observation, interview, and record review for 1 additional client (#5), the Qualified Intellectual Disabilities Professional (QIDP) failed to coordinate communication between the group home and the facility owned day program in regards to use of PRN (given as needed) pain medications.</p> <p>Findings include:</p> <p>On 11/19/13 at 7:00 AM, medication observations and interviews were completed with GHS (Group Home Staff) #11 and Client #5. At 7:00 AM, Client #5 verbally stated to GHS #11 she wanted something for her "bad" leg pain. At 7:00 AM, GHS #11 checked Client #5's MAR (Medication Administration Record) and indicated to Client #5 that she could not have her "Hydrocodone" for pain because Client #5 was receiving her Gabapentin for pain "this morning." At 7:00 AM, GHS #11 selected the unlabeled "Gabapentin 100mg (for pain) (and) Acetaminophen 325mg 2 tabs (tablets) every 4 hrs (hours) as needed for pain." When asked how the group home staff determine Client #5's pain, GHS #11</p>	W000159	<p>W159 – Qualified Mental Retardation Professional Peak Community Services ensures that each client's active treatment program is integrated, coordinated, and monitored by a qualified mental retardation professional. Communication between the SGL residence and the Day program is facilitated through the use of a daily communication log. The QDDP will monitor the daily log and ensure that the Day Program is aware of events that have transpired in the evening before and the morning of each day. The daily communication log between the Day Program and the SGL residence contains information on when the PRN medication has last been given. This communication log travels between the Day program and the SGL residence. SGL staff writes the time that the hydrocodone had been given to avoid the Day Program staff giving client # 5's medication before the next time allowed. Client # 5's physician has stated that client # 5's pain management protocol is in place. The pain management protocol calls for Hydrocodone/Tylenol 500 - 325 mg one (1) tablet as</p>	01/05/2014			

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	<p>indicated Client #5 was verbal and the staff will give her the medication. When asked if the staff have contacted the agency nurse when Client #5 continued to have pain and/or breakthrough pain, GHS #11 stated "no."</p> <p>On 11/19/13 from 9:20 AM until 10:18 AM, observations and interviews were completed at the facility owned Workshop with Client #5. From 9:20 AM until 9:50 AM, Client #5 sat at her workstation without working, had her eyes closed, her head on the table, expressed that she was in pain, and wrinkled her face when she moved her legs. At 9:45 AM, WKS (Workshop Staff) #1 stated Client #5 was "always in pain." WKS #1 indicated Client #5's pain had been increasing and the workshop staff had pain medication Client #5 could request. When asked if WKS #1 knew if Client #5 had her pain medication today, WKS #1 pulled out Client #5's communication book and provided a review of Client #5's group home communication to the workshop staff which did not include the administration of Client #5's as needed pain medications and did not include Client #5's expression of pain at 7:00 AM. When asked how the WKS staff determine Client #5's pain, WKS #1 indicated Client #5 was verbal and stated "we watch her."</p>		<p>needed. It also calls for Gabapentin 300mg 3 x daily. Peak Community Services High Street SGL staff has been trained on the use of the Wong-Baker FACES Pain Rating Scale to be used with clients that have the cognitive ability to utilize such a scale. When client #5 indicates that she is in pain the staff are to utilize the pain rating scale and document the level next to the prn medication record. Breakthrough pain and pain of extraordinary amount is communicated to the SGL program nurse for consultation and recommendations. Systematically during the quarterly nursing assessment the nurse will discuss with the staff what method they use to gauge an individual clients pain. This information will be placed on the quarterly assessment as well as placed in the client's file for staff to refer to when needed. Person Responsible: Martha Tristan, SGL Coordinator, Jan Adair, Manager of SGL, Stacey Platt, QDDP, Alison Harris, SGL Program Nurse</p>		

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	<p>On 11/20/13 at 12:30 PM, Client #5's record review indicated Client #5's diagnoses included, but were not limited to, intellectual disabilities, history of pulmonary embolism, schizophrenia, and urinary incontinence. Client #5's 1/4/13 ISP (Individual Support Plan) did not indicate Client #5 had routine and/or breakthrough pain. Client #5's 7/7/13, 4/28/13, 1/29/13, and 10/31/12 Nursing Quarterly reviews did not indicate Client #5 had routine and/or breakthrough pain due to a past automobile accident which injured her leg.</p> <p>On 11/20/13 at 9:20 AM, an interview with the DRS (Director of Residential Services) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. Both the DRS and QIDP indicated Client #5 had pain daily and required routine and as needed pain medication. The DRS indicated Client #5 had been in a car accident several years ago and Client #5's pain had been increasing. The DRS stated "We've noticed she is going downhill."</p> <p>On 12/6/13 at 12:48 PM, the nurse who was contracted by the facility was interviewed and indicated the residential staff need to coordinate communication with the workshop staff regarding when</p>			

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	Client #5 takes a PRN pain medication because one is a controlled substance.  9-3-3(a)			

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W000312	<p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview, for 2 of 3 sampled clients (clients #2 and #3) who used psychotropic medications, the facility failed to include the use of Client #2 and Client #3's depression medications into a specific active treatment program.</p> <p>Findings include:</p> <p>1) On 11/19/13 at 11:10 AM, record review indicated Client #2's ISP (Individual Support Plan) dated 11/30/12 indicated Client #2 had an "Antipsychotic/Depression High Risk Meds" plan dated 12/4/12. The risk plan indicated the following "Proactive Strategies":</p> <p>"1. [Client #2] needs 24 staffing to monitor her and to help her with her needs and medication. 2. [Client #2] needs monitoring for any possible side effects of these medications. 3. [Client #2] will receive assistance as needed to various medical appointments. 4. [Client #2] will be encouraged to discuss any issues she may have with her</p>	W000312	<p>W312 – Drug UsagePeak Community Services ensures that drugs used for the control of inappropriate behavior are to be used only as an integral part of the client's individual program plan that is directed to the reduction of and eventual elimination of the behaviors for which drugs are employed. Client # 2 has her depression medications incorporated into a specific active treatment plan. Client # 2's depression medication is used for the symptoms of depression and not for elimination of behaviors. A risk plan that incorporates the use of the medication will be developed that allows for the tracking of depressive behaviors which will then be presented to the prescribing medical practitioner. The question of titration will be addressed specifically for depressive medications and if indicated by the prescribing medical practitioner a plan will be developed. Client # 3 has her depression medications incorporated into a specific active treatment plan. Client # 3's depression medication is used for the symptoms of depression and</p>	01/05/2014
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	<p>psychiatrist.</p> <p>5. [Client #2] will be encouraged in following doctor recommendations.</p> <p>6. Staff is to observe [Client #2] for any severe mood swings or changes in behavior and report them to her doctor immediately."</p> <p>Record review indicated Client #2 had a "Psychotropic Medication Review" on 9/26/13 with her psychiatrist. The medication review indicated Client #2 was taking Bupropion (Wellbutrin) 150mg daily and Cymbalta 90mg daily for "unstable mood." Client #2's ISP (dated 11/30/12) indicated Client #2 did not have a BSP (Behavior Support Plan) with a medication reduction plan to address the use of anti-depressants.</p> <p>During an interview on 11/20/13 at 3:10 PM, the group home manager (HM) indicated there was no tracking done of Client #2's mood or anxiety.</p> <p>During an interview on 11/27/13 at 12:34 PM, the Director of Residential Services (DRS) indicated Client #2 did not have a behavior support plan in place and no monitoring or tracking of the signs and symptoms of depression was being done. The DRS indicated she was unaware an anti-depressant medication required additional monitoring and needed to be a</p>		<p>not for elimination of behaviors. A risk plan that incorporates the use of the medication will be developed that allows for the tracking of depressive behaviors which will then be presented to the prescribing medical practitioner. The question of titration will be addressed specifically for depressive medications and if indicated by the prescribing medical practitioner a plan will be developed. Systemically the Psychotropic Medication Review form will be changed to specifically prompt the prescribing medical practitioner to address the need for continuation of the current medications and dosages or the titration of them. In the instructions for the form, there will be direction for the medical practitioner and also for Peak staff to address this with the medical practitioner. Once the form is completed the IDT will review the information from the medical practitioner and devise a plan accordingly if necessary. Monitoring: The Residential Manager will monitor the form to ensure that a titration plan is developed or the reason why it is not recommended is reviewed by the prescribing medical personnel. If it has not been addressed then the Residential Manager will notify the prescribing individual that the information is required. Person Responsible: Martha Tristan,</p>		

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	<p>integral part of Client #2's ISP (Individual Support Plan).</p> <p>2) Client #3's record was reviewed on 11/20/13 at 10:30am. Client #3's record indicated an 9/2013 "Physician's Order" for "Ativan (Lorazepam) 0.5mg (milligrams), take 1 tab (tablet) as needed daily" (for behaviors), "Bupropion XL (Wellbutrin XL) 300mg, give 1 tablet orally every morning" for depression, Mirtazapine (Remeron) 15mg, give 1 tablet orally every evening (to) keep focus," and Vistaril (Hydroxyzine Pam) 100mg, give 1 capsule orally 3 times a day (for) anxiety." Client #3's record did not include a Behavior Support Plan (BSP). Client #3's record did not indicate the use of Wellbutrin, Vistaril, Remeron, Ativan, and did not have a specific active treatment program available for review. Client #3's 4/10/13 ISP (Individual Support Plan) did not include a specific active treatment program to address the client's anxiety and/or depression.</p> <p>Client #3's record included 9/26/13, 7/8/13, 5/9/13, 3/17/13, 12/6/12, and 10/9/12 "Psychiatric Medication Reviews" for the use of "Ativan (Lorazepam) 0.5mg (milligrams), take 1 tab (tablet) as needed daily" (for behaviors), "Bupropion XL (Wellbutrin XL) 300mg, give 1 tablet orally every</p>		Residential CoordinatorJan Adair, Residential ManagerStacey Platt QDDP				

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	<p>morning" for depression, Mirtazapine (Remeron) 15mg, give 1 tablet orally every evening (to) keep focus," and Vistaril (Hydroxyzine Pam) 100mg, give 1 capsule orally 3 times a day (for) anxiety." Client #3's record did not include a specific active treatment program to address client #3's medications prescribed by her Psychiatrist.</p> <p>On 12/6/13 at 1:55pm, an interview with the DRS (Director of Residential Services) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The DRS and the QIDP both indicated Client #3 ISPs and record did not include a specific active treatment program to address the use of her "Ativan (Lorazepam) 0.5mg (milligrams), take 1 tab (tablet) as needed daily" (for behaviors), "Bupropion XL (Wellbutrin XL) 300mg, give 1 tablet orally every morning" for depression, Mirtazapine (Remeron) 15mg, give 1 tablet orally every evening (to) keep focus," and Vistaril (Hydroxyzine Pam) 100mg, give 1 capsule orally 3 times a day (for) anxiety." The DRS indicated Client #3 had depression and stated because Client #3 "had depression she did not need a plan" developed for the use of her medications. When asked how the Agency determines the effectiveness of</p>						

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	<p>each of the medications if there is no plan to measure the effectiveness and outcomes, the DRS indicated Client #3 had depression and stated "No one else ever asked about that before."</p> <p>9-3-5(a)</p>			

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility nursing staff failed to develop a Warfarin (an anticoagulant) care plan which included monitoring of bruising and monitoring for a diet low in Vitamin K and failed to develop/maintain a record keeping system to document medical information in the client's record in regards to lab results for 1 additional client (#5).</p> <p>Based on observation, record review, and interview, the facility nursing staff failed to develop a pain management plan which included pain assessment and monitoring the use of PRN (given as needed) pain medication for 1 additional client (#5).</p> <p>Based on record review and interview, the facility nurse failed to ensure the pharmacist recommendations for client medication regimen reviews were reported to the prescribing physician for 3 of 3 sampled clients (#1, #2, and #3).</p> <p>Findings include:</p> <p>1) On 11/20/13 at 12:30 PM, record review indicated Client #5's diagnoses included, but were not limited to,</p>	W000331	<p>W331 – Nursing Services Peak Community Services IDT system ensures that Peak Community Services provides clients with nursing services in accordance with their needs. Client # 5 has a developed an updated Warfarin care plan which included monitoring of bruising and monitoring for a diet low in Vitamin K. The plan contains forms for the staff to use in monitoring for the bruising and the diet low in Vitamin K. The SGL staff at High Street has been trained on the updated Warfarin plan and the usage of the subsequent documentation forms. Client # 5 has a pain management plan developed. Her physician has stated that client # 5's pain management protocol is in place. The pain management protocol calls for Hydrocodone/Tylenol 500 - 325 mg one (1) tablet as needed. It also calls for Gabapentin 300mg 3 x daily. The SGL program nurse has contacted pain specialist Dr. Kusumi and Client # 5 is actually on the review list. She is into the 3rd week of being on the list. Dr. Kusimi's office will contact Peak Community Services' SGL staff to schedule an appt for client # 5. This will get client # 5 established and then be placed on a schedule of future appointments. Peak</p>	01/05/2014			

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	<p>intellectual disabilities, history of pulmonary embolism, schizophrenia, and urinary incontinence. Client #5's 9/2013 physician order sheet indicated a prescription dated 11/12/12 for Warfarin Sodium (Coumadin) 11 mgs (milligrams) daily. Client #5's 1/4/13 ISP (Individual Support Plan) indicated a "Warfarin High Risk Medication" plan. Client #5's Warfarin risk plan (dated 1/4/13) indicated "[Client #5] had a blood clot in the past and takes Warfarin Sodium which is an anticoagulant (blood thinner) to prevent future clots. Warfarin is used to prevent heart attacks, strokes, and blood clots in veins and arteries and other purposes as prescribed. Warfarin may cause a person to bleed more easily." The Warfarin care plan indicated the following proactive strategies:</p> <ol style="list-style-type: none"> <li>"1. 24 hour staffing to monitor her with her needs and medication.</li> <li>2. [Client #5] has regular labs to monitor blood levels to adjust her Warfarin medication as needed.</li> <li>3. [Client #5] will receive assistance as needed to various medical appointments.</li> <li>4. [Client #5] will encouraged to discuss any issues she may have with her doctor.</li> <li>5. [Client #5] will be encouraged in following doctor recommendations.</li> <li>6. Staff is to observe [Client #5] for any bleeding issues and report to the doctor</li> </ol>		<p>Community Services High Street SGL staff has been trained on the use of the Wong-Baker FACES Pain Rating Scale to be used with clients that have the cognitive ability to utilize such a scale. When client #5 indicates that she is in pain the staff are to utilize the pain rating scale and document the level next to the prn medication record. Breakthrough pain and pain of extraordinary amount is communicated to the SGL program nurse for consultation and recommendations. This is to be done using the Peak Community Services e-mail system to track and document ongoing nursing involvement. Systemically during the quarterly nursing assessment the nurse will discuss with the staff what method they use to gauge an individual clients pain. This information will be placed on the quarterly assessment as well as placed in the client's file for staff to refer to when needed. Client's 1, 2, and 3's latest pharmacist recommendations for client medication reviews have been shared with their PCP or the prescribing physician Systemically the protocol has been put in place that calls for the Residential Manger to share the pharmacist recommendations with the clients PCP or prescribing medical professional and the SGL program nurse. Monitoring of this action will be by the use of an</p>		

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	<p>immediately."</p> <p>The Warfarin care plan indicated "other important information when taking Warfarin (diet)" which indicated Client #5 "should not eat large amounts of leafy green vegetables. Leafy green vegetables contain Vitamin K. Certain oils also contain large amounts of Vitamin K. Too much Vitamin K can lower the effect of Warfarin Sodium." Client #5's Warfarin care plan also indicated Client #5 should "avoid or drink only small amounts" of cranberry juice and alcohol.</p> <p>Record review indicated Client #5 had required blood work to ensure the therapeutic range of Warfarin on 5/20/13.</p> <p>Client #5's 7/7/13, 4/28/13, 1/29/13, and 10/31/12 Nursing Quarterly reviews did not include information that Warfarin monitoring labs had been completed.</p> <p>During an interview on 11/20/13 at 1:50 PM, Client #5's QIDP (Qualified Intellectual Disabilities Professional) indicated she was unsure where Client #5's labs in regards to monitoring Warfarin were kept.</p> <p>During an interview on 11/20/13 at 2:35 PM, the House Manager (HM) indicated Client #5 was taken for her labs</p>		<p>e-mail tracking system that allows for the tracking of the delivery of the pharmacist recommendations for client medication reviews to be sent to the PCP or other prescribing medical professional. The residential manager will copy the Director of Residential Services of such e-mails during the time frame of January1, 2013 through June 30, 2013. Person Responsible:Martha Tristan, SGL Coordinator,Jan Adair, Residential Manager Alison Harris, SGL Program NurseRick Phelps, Director of Residential Services</p>				

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	<p>approximately every month. The HM indicated she would have to call the doctor for a copy of the labs as they were not maintained in the client record.</p> <p>On 12/6/13 at 12:48 PM, the facility nurse was interviewed and indicated she does not develop client care plans. The nurse indicated she does not have access to many client lab results as they are not kept at the house where she assesses the clients for their Nurse Quarterly reviews. The nurse indicated nursing and pharmacy could better assess clients if lab results were maintained in each record.</p> <p>During an interview on 11/20/13 at 2:35 PM, the House Manager (HM) indicated Client #5 was on a mechanical soft diet. The HM indicated she knew of no other dietary considerations or monitoring for Client #5.</p> <p>During an interview on 12/6/13 at 12:48 PM, the facility nurse indicated staff call her if Client #5 "bumps something" and has a chance of injury. The facility nurse indicated monitoring of bruising should have been in Client #5's Warfarin care plan. The facility nurse indicated the QIDP (Qualified Intellectual Disabilities Professional) usually writes the care plans. The facility nurse indicated she did not develop Client #5's Warfarin care plan</p>						

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	<p>and was unsure whether Vitamin K should be monitored in Client #5's diet. The nurse indicated she wasn't sure whether Client #5's physician had addressed whether to monitor Vitamin K intake or not.</p> <p>2. On 11/19/13 at 7:00 AM, medication observations and interviews were completed with GHS (Group Home Staff) #11 and Client #5. At 7:00 AM, Client #5 verbally stated to GHS #11 she wanted something for her "bad" leg pain. At 7:00 AM, GHS #11 checked Client #5's MAR (Medication Administration Record) and indicated to Client #5 that she could not have her "Hydrocodone" for pain because Client #5 was receiving her Gabapentin for pain "this morning." At 7:00 AM, GHS #11 selected unlabeled "Gabapentin 100mg (for pain) (and) Acetaminophen 325mg 2 tabs (tablets) every 4 hrs (hours) as needed for pain." GHS #11 did not compare the three unlabeled medications to the 11/2013 MAR because no label was present on each of the three medications. At 7:00 AM, GHS #11 administered the unlabeled medications to Client #5 and she consumed them. When asked how the group home staff determine Client #5's pain, GHS #11 indicated Client #5 was verbal and the staff will give her the medication. When asked if the staff have contacted the</p>			

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	<p>agency nurse when Client #5 continued to have pain and/or breakthrough pain, GHS #11 stated "no."</p> <p>On 11/19/13 at 7:25 AM, Client #5's 9/2013 "Physician's Order" and Client #5's 11/2013 MAR (Medication Administration Record) were reviewed and indicated the following: "Hydrocodone (for pain) 5/500mg alternate one capsule every 8 hours with Gabapentin 100mg (for pain) (and) Acetaminophen 325mg 2 tabs every 4 hrs as needed for pain."</p> <p>On 11/19/13 from 9:20 AM until 10:18 AM, observations and interviews were completed at the facility owned Workshop with Client #5. From 9:20 AM until 9:50 AM, Client #5 sat at her workstation without working, had her eyes closed, her head on the table, expressed that she was in pain, and wrinkled her face when she moved her legs. At 9:45 AM, WKS (Workshop Staff) #1 stated Client #5 was "always in pain." WKS #1 indicated Client #5's pain had been increasing and the workshop staff had pain medication Client #5 could request. When asked if WKS #1 knew if Client #5 had her pain medication today, WKS #1 pulled out Client #5's communication book and provided a review of Client #5's group home</p>						

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	<p>communication to the workshop staff which did not include the administration of Client #5's as needed pain medications and did not include Client #5's expression of pain at 7:00 AM. When asked how the WKS staff determine Client #5's pain, WKS #1 indicated Client #5 was verbal and stated "we watch her."</p> <p>On 11/20/13 at 12:30pm, Client #5's record was reviewed. Client #5's 1/4/13 ISP (Individual Support Plan) did not indicate Client #5 had routine and/or breakthrough pain. Client #5's 7/7/13, 4/28/13, 1/29/13, and 10/31/12 Nursing Quarterly reviews did not indicate Client #5 had routine and/or breakthrough pain, and did not include a review of the use of her as needed pain medications. Client #5's record did not indicate an assessment of her pain and/or breakthrough pain.</p> <p>On 11/20/13 at 9:20 AM, an interview with the DRS (Director of Residential Services) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. Both the DRS and QIDP indicated Client #5 had pain daily and required routine and as needed pain medication. The DRS indicated Client #5 had been in a car accident several years ago and Client #5's pain had been increasing. The DRS stated "We've noticed she is going downhill." Both staff</p>			

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	<p>indicated Client #5 did not have a pain assessment which addressed Client #5's routine pain and Client #5's breakthrough pain. Both staff indicated Client #5 used as needed pain medications daily for her breakthrough pain. Both staff indicated Client #5's pain had been increasing each month and had become more acute over the past six (6) months.</p> <p>On 12/6/13 at 12:48 PM, the facility nurse was interviewed and indicated she does not develop client care plans. The nurse indicated her quarterlies indicate how the client is doing on the day she physically assesses them. The nurse indicated if Client #5 did not indicate she was feeling pain on the day of the assessment, her pain management would not be addressed in the quarterly nurses review. The nurse indicated she was aware that Client #5's leg causes her ongoing pain. The nurse indicated she has no documentation to indicate staff have called her regarding Client #5's pain level. The nurse indicated the residential staff need to coordinate communication with the workshop staff regarding when Client #5 takes a PRN.</p> <p>3a) On 11/19/13 at 12:07 PM, record review indicated Client #1 had diagnoses which included, but were not limited to, moderate intellectual disabilities, brain</p>			

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	<p>injury, petite mal seizure disorder, irritable bowel syndrome, and attention deficit hyperactivity disorder.</p> <p>Record review indicated Client #1 had a pharmacy review of her medication regimen on 2/13/13 which indicated on 1/18/13 "Vyvanse 70mg D/ced (discontinued) on MAR (medication administration record) and Methylphenidate SR (sustained release) 40mg started." Client #1's medication regimen review indicated the pharmacist was "unable to locate documentation for same (ie) (for example) notes from an office visit or copy of Rx (prescription)."</p> <p>Record review indicated Client #1 had a pharmacy review of her medication regimen on 5/14/13 which indicated "Pg (page) 2 and Pg 3 of physician orders not signed (April). Therapeutic Q day (each day) - handwritten on April MAR (medication administration review) starting 4/2/13, unable to locate order for same, not added to April physician order sheet?" The review indicated "POS (physician order sheet) not dated as to when it was signed." Record review indicated no documentation Client #1's prescribing physician had been notified of the pharmacy recommendations.</p> <p>Record review indicated Client #1 had a</p>						

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	<p>pharmacy review dated 8/14/13 which indicated Client #1's "last dated P.O.S. (physician order sheet) dated April 2013. Please insure physician signs pg (page) 2 and pg 3." Record review indicated there was no documentation Client #1's prescribing physician had been notified of the 8/14/13 pharmacy recommendations.</p> <p>b) On 11/19/13 at 11:10 AM, record review indicated Client #2's diagnoses included, but was not limited to, mild intellectual disabilities, history of pneumonia, sinus infection, Parkinson's shaking, and depression.</p> <p>Record review indicated Client #2 had a pharmacy medication regimen review on 2/13/13. The pharmacist note indicated "Tramadol 50mg PRN (given as needed) order hand written on the Jan. (January 2013) MAR (medication administration review) - dose given on 1/9 (2013), unable to locate current order for same." No further documentation indicated the facility notified Client #2's prescribing physician of the pharmacy recommendations on 2/13/13.</p> <p>Record review indicated Client #2 had a pharmacy medication regimen review on 8/14/13. The pharmacist note indicated "last signed P.O.S. (physician order sheet) dated 4/4/13. No further documentation</p>			

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	<p>indicated the facility notified Client #2's prescribing physician of the pharmacy recommendations of 8/14/13.</p> <p>c) On 11/20/13 at 10:30 AM, record review indicated Client #3 had a pharmacy medication regimen review on 2/13/13. The pharmacist noted "resident has PRN (given as needed) order for Ibuprofen 200mg and Naprosyn 500mg. Recommend D/Cing (discontinuing) one of these, should not be used at same time." Record review indicated no documentation Client #3's prescribing physician was notified of the pharmacy recommendation.</p> <p>Record review indicated Client #3 had a pharmacy medication regimen review on 5/14/13. The pharmacist indicated "last documentation I could find for Depo (birth control) shot administration is 12/20/12. The pharmacist indicated Client #3's "Pg (page) 2 and pg 3 of physician orders not signed (April)." Record review indicated no documentation Client #3's prescribing physician was notified of the pharmacy recommendations of 5/14/13.</p> <p>Record review indicated Client #3 had a pharmacy medication regimen review on 8/14/13. The pharmacist indicated Client #3's "last signed P.O.S. (physician order</p>			

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	<p>sheet) dated April 2013. Please ensure physician signs pg (page) 2 and pg 3." No documentation indicated Client #3's prescribing physician was notified of pharmacy recommendations.</p> <p>During an interview on 11/20/13 at 1:13 PM, the pharmacist indicated she provides the facility with recommendations for each individual on separate forms which can be forwarded to the prescribing physician.</p> <p>During an interview on 11/20/13 at 10:34 AM, the facility's Director of Residential Services (DRS) indicated the facility had switched pharmacies in the fall of 2012. The DRS indicated the new pharmacy does not give the facility the physician notification forms they were accustomed to receiving from the prior pharmacy. The DRS indicated the facility had no documentation the prescribing physician was notified of pharmacy recommendations for clients #1, #2, and #3 during the 2013 pharmacy medication regimen reviews. The DRS indicated she understood the importance of physician notification of pharmacy recommendations.</p> <p>During an interview on 12/6/13 at 12:48 AM, the facility nurse indicated she is not responsible for reviewing pharmacy</p>			

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	<p>recommendations and was not the staff responsible in ensuring clients #1, #2, #3's prescribing physician was notified of pharmacy recommendations.</p> <p>9-3-6(a)</p>			

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W000381	<p>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. Based on observation, interview, and record review, for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6), the facility failed to ensure the controlled substances medications were doubled locked.</p> <p>Findings include:</p> <p>Observations and interview were completed on 11/19/13 from 5:35 AM until 7:35 AM, at the group home. The medication office door was opened and not locked. During the observation period clients #1, #2, #3, #4, #5, and #6 walked into and out of the open medication office and throughout the group home. From 6:30 AM, until 7:25 AM, medications were administered inside the office. From 6:30am, until 7:25am, GHS (Group Home Staff) #11 administered medications to clients #1, #2, #3, #4, #5, and #6 from the single locked medication cabinet. At 7:25 AM, GHS (Group Home Staff) #11 indicated the medication office door was the second lock for the controlled substance medications. At 7:25 AM, GHS #11 indicated clients #1, #3, #5, and #6's controlled medications were not double locked at the group home.</p> <p>On 11/19/13 at 7:25 AM, GHS #11</p>	W000381	<p>W381Peak Community Services through the IDT ensures that drugs are stored under proper conditions of security.Clients 1, 2,3,4,5 and six controlled medications are doubled locked as required by Peak Community Services procedures and state regulation.Monitoring: To monitor the corrective action Peak Community Services, Residential Coordinator, QMRP staff and the Residential Manager will monitor the use of proper conditions of medication security procedures in their routine residence observations that are conducted at random times during the month. This monitoring will continue on a permanent basis.Systematically all DSP's in the Peak Community Services SGL system are in-serviced on the need to follow the proper conditions of security with controlled substances. This protocol requires that all controlled medications be doubled locked. This training will be at the house meetings conducted monthly by the Residential Manager and the QDDP.Person Responsible:Martha Tristan, Residential CoordinatorJan Adair, Residential ManagerStacey Platt, QDDP</p>	01/05/2014			

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	<p>provided a review of client #1, #3, #5, and #6's records at the group home and indicated the medication office was not locked and the controlled substance medications were not double locked for clients #1, #3, #5, and #6.</p> <p>On 11/19/13 at 7:25 AM, Client #1's 9/2013 "Physician's Order" and Client #1's 11/2013 MAR (Medication Administration Record) was reviewed and indicated the following: "Vyvanse 70mg 1 cap (capsule) every AM (morning) (to keep focus."</p> <p>On 11/19/13 at 7:25 AM, Client #3's 9/2013 "Physician's Order" and Client #3's 11/2013 MAR (Medication Administration Record) was reviewed and indicated the following: "Lorazepam (Ativan) 0.5mg (milligrams) tablet take 1 tablet by mouth daily as needed."</p> <p>On 11/19/13 at 7:25 AM, Client #5's 9/2013 "Physician's Order" and Client #5's 11/2013 MAR (Medication Administration Record) was reviewed and indicated the following: "Hydrocodone (for pain) 5/500mg alternate one capsule every 8 hours with Gabapentin 100mg (for pain)."</p> <p>On 11/19/13 at 7:25 AM, Client #6's On 11/19/13 at 7:25am, Client #6's 9/2013</p>			

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	<p>"Physician's Order" and Client #6's 11/2013 MAR (Medication Administration Record) was reviewed and indicated the following: "Zolpiden Tartrate 10mg, give 1 tablet orally at bedtime for sleep."</p> <p>On 11/20/13 at 9:20 AM, an interview with the DRS (Director of Residential Services) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. Both the DRS and QIDP indicated controlled medications for clients #1, #3, #5, and #6 should have been double locked and were not on 11/19/13. Both staff indicated the facility followed Core A/Core B medication administration training for medication administration.</p> <p>On 11/20/13 at 9:40 AM, a review of the undated facility's "Medication" policy and procedure indicated "Medications will be maintained under lock except when being prepared for administration...." The policy and procedure did not include double locking controlled substance medications.</p> <p>During an interview on 12/6/13 at 12:48 PM, the facility nurse indicated staff had been trained in "Living in the Community: Core A/Core B" medication training. The nurse indicated controlled</p>			

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	medications should have been double locked.  9-3-6(a)			

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W000391	<p><b>483.460(m)(2)(ii) DRUG LABELING</b> The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation, interview, and record review, for 3 of 35 medications administered during the morning medication administration (Client #5), the facility failed to ensure each medication had a pharmacy label.</p> <p>Findings include:</p> <p>On 11/19/13 at 7:00am, medication observations and interview were completed with GHS (Group Home Staff) #11 and Client #5. At 7:00am, GHS #11 selected unlabeled "Olanzapine (Zyprexa) 15mg give 1 tablet orally 2 times a day in AM (morning) and 4pm (Anti Depressant), Saphris 10mg sublingual (melt under the tongue), give 1 tablet sublingually 2 times a day (Anti Psychotic), (and) Acetaminophen 325mg 2 tabs (tablets) every 4 hrs (hours) as needed for pain." GHS #11 did not compare the three unlabeled medications to the 11/2013 MAR because no label was present on each of the three medications. At 7:00am GHS #11 administered the unlabeled medications to Client #5 and she consumed them.</p> <p>On 11/19/13 at 7:25am, GHS #11 provided a review of Client #5's record at the group home and indicated Client #5's Olanzapine, Saphris, and Acetaminophen medications were not labeled.</p> <p>On 11/19/13 at 7:25am, Client #5's 9/2013 "Physician's Order" and Client #5's 11/2013 MAR (Medication Administration Record) was reviewed and indicated the following: "Olanzapine (Zyprexa) 15mg give 1 tablet orally 2 times a day in AM (morning) and 4pm (Anti Depressant),</p>	W000391	W391 – Drug LabelingPeak Community Services system for drug administration assures that all drugs, including those that are self-administered, are administered in compliance with the physician's orders and contain the proper drug label that is issued by the pharmacy per Peak Community Services procedures.Client # 5's medications are labeled appropriately in line with Peak Community Services procedures. GHS 11 who committed the errors mentioned in the Survey has been retrained in the appropriate administration of medications according to Med Core A and B. They have been observed passing medication by their direct supervisor.As part of Peak Community Service's continuous competency observation system the SGL staff working in the High Street home will have a medication pass as part of their observation. The continuous competency observation system calls for a minimum of three (3) staff observations within Fiscal Year 2014 which will run through June 2014.System wide Peak Community Services SGL will have a medication pass observation as part of their	01/05/2014			

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	<p>Saphris 10mg sublingual (melt under the tongue), give 1 tablet sublingually 2 times a day (Anti Psychotic), Acetaminophen 325mg 2 tabs every 4 hrs as needed for pain."</p> <p>On 11/20/13 at 9:20am, an interview with the DRS (Director of Residential Services) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. Both the DRS and QIDP indicated the agency staff followed the "Living in the Community: Core A/Core B" medication training. The DRS indicated medications should be labeled with a pharmacy label. The DRS indicated the facility staff should ensure that each medication label matched the clients' MAR and physician's order. The DRS indicated Client #5's medications were not labeled. The DRS indicated each medication should have client identification on each medication to signify it belonged to that client, a direction for the medication use, and open date if not replaced every thirty days.</p> <p>On 11/20/13 at 9:40am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be labeled. The training manual indicated each clients' medication should be dated when the medication was opened.</p> <p>On 11/20/13 at 9:40am, a review of the undated facility's "Medication" policy and procedure did not indicate a pharmacy label with the directions for each medications use and the name of the client.</p> <p>During an interview on 12/06/13 at 12:48 PM, the facility nurse indicated the facility staff should have been following the guidelines in their "Living in the Community: Core A/Core B" medication</p>		<p>Continuous Competency observation. System wide Peak Community Services SGL residences have been inspected for unlabeled medications. Person Responsible: Martha Tristan, SGL Coordinator Jan Adair, Residential Manager</p>				

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	<p>training. The facility nurse indicated all medications administered should have been appropriately labeled.</p> <p>9-3-6(a)</p>			

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W000454	<p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation, record review, and interview, for 1 of 3 sampled clients (Client #2), the facility failed to ensure infection control practices during medication administration.</p> <p>Findings include:</p> <p>On 11/19/13 at 7:10am, medication observations and interview were completed with GHS (Group Home Staff) #11 and Client #2. At 7:10am, GHS #11 selected Client #2's oral morning medications which included "Bupropion HCL XL 150mg (milligrams), give one tab orally once daily at 7AM" for behaviors. GHS #11 handed the medication cup with the oral medication inside the cup. Client #2 dropped the Bupropion medication on the medication office floor. GHS #11 verbally prompted Client #2 to pick up the dropped Bupropion medication and to consume the medication. At 7:25am, Client #2 picked up the medication and took the dropped tablet of Bupropion medication.</p> <p>On 11/20/13 at 9:20am, an interview with the DRS (Director of Residential Services) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. Both the DRS and QIDP indicated the agency staff followed the "Living in the Community: Core A/Core B" medication training. The DRS indicated client #2 should have had her Bupropion medication tablet replaced with a different tablet of the same medication. The DRS indicated staff should not have encouraged and prompted client #2 to consume medication that had been dropped on the floor.</p>	W000454	455 - INFECTION CONTROL Peak Community Services through the IDT system will ensure that it provides a sanitary environment to avoid sources and transmissions of infections and that there is an active program for the prevention, control, and investigation of infection and communicable diseases. GHS # 11 has been in-serviced on the need to follow the infection control protocol in dispensing medications. This protocol prohibits the dispensing of medications that have been dropped from the client's hand or medication cup. To monitor the corrective action Peak Community Services, Residential Coordinator, QMRP staff and the Residential Manager will monitor the use of proper sanitary procedures in their routine residence observations that are conducted at random times during the month. This monitoring will continue on a permanent basis. Systematically the need to maintain sanitary conditions while dispensing medications in the SGL residence will be addressed at SGL monthly staff meetings from 01.05.13 to 06.30.14 Systematically all DSP's in the Peak Community Services SGL system have been	01/05/2014			

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9-3-7(a)	On 11/20/13 at 9:40 AM, a record review of the undated facility's policy and procedure for infection control indicated the facility staff should encourage sanitary methods at the group home. The policy and procedure did not include during medication administration times.		in-serviced on the need to follow the infection control protocol in dispensing medications. This protocol prohibits the dispensing of medications that have been dropped from the client's hand or medication cup. Person Responsible: Martha Tristan, Residential Coordinator Jan Adair, Residential Manager Stacey Platt, QDDP	