

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G752	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
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NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 9104 STRATHMORE LN FORT WAYNE, IN 46818
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	<p>This visit was for a full recertification and state licensure survey. This visit included the investigation of Complaint #IN00182726.</p> <p>Complaint #IN00182726: Unsubstantiated, due to lack of evidence.</p> <p>Dates of Survey: 10/26, 10/29, 10/30 and 11/2/15.</p> <p>Facility number: 011871 Provider number: 15G752 AIM number: 200921870</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/14/15.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 3 of 3 sampled clients (A, B and C) and for 3 additional clients (D, E and F), the facility's governing body failed to exercise general policy, budget and operating direction over the</p>	W 0104	<p>The loosecarpet by the exit in client E's bedroom has been repaired.</p> <p>PersonResponsible: Maintenance Supervisor DateCompleted: 12/28/15</p>	12/28/2015

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

TITLE

(X6) DATE

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

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W 0149 Bldg. 00	<p>facility to ensure the facility maintained and/or kept the group home in good repair.</p> <p>Findings include:</p> <p>During the 10/29/15 observation period between 6:17 AM and 7:52 AM, at the group home, the following was observed:</p> <p>-Client E's bedroom had loose carpet at the exit door. Client E had stained tile/carpet laying by the closet.</p> <p>-The bathroom toilet was loose from the floor/jiggled. The ceiling light/fan made a loud noise and had bugs/debris in the light bulb. The wall vent was rusty where clients A, B, C, D, E and F utilized the bathroom.</p> <p>-The large bathroom had a 2 inch piece of wall trim/wood missing by the shower.</p> <p>Interview with the Director of Residential Services (DRS) on 11/2/15 stated "They should be fixed."</p> <p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit</p>		<p>The bathroomtoilet has been fixed. The light/fan has been fixed and cleaned. The vent hasbeen replaced</p> <p>PersonResponsible: Maintenance Supervisor DateCompleted: 12/28/15</p> <p>The wood trimin the large bathroom will be replaced</p> <p>PersonResponsible: Maintenance Supervisor DateCompleted: 12/28/15</p> <p>The stainedcarpet by the closet in client E's bedroom will be cleaned</p> <p>PersonResponsible: House Supervisor DateCompleted: 12/28/15</p> <p>The QIDP willdo an observation three times a week for 1 month and then once a month ongoingchecking for cleanliness of the home and maintenance issues. The observationswill be documented and any issues noted will be corrected.</p> <p>PersonResponsible: QIDP DateCompleted: 12/28/15</p>		

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	<p>mistreatment, neglect or abuse of the client. Based on interview and record review for 3 of 3 sampled clients (A, B and C), and for 2 additional clients (D and E) the facility failed to implement its policy and procedures to prevent neglect/abuse of clients, and to ensure all allegations of abuse and/or neglect were immediately reported to the administrator and/or to state authorities.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 10/26/15 at 2:37 PM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>-7/6/15 "...On 7/6/15 [client A] reported to her behavior consultant that staff member [staff #2] is 'mean to me.' She also reported on 7/16/15 [staff #2] pushed the group home door towards her and it hit her upper right arm. Staff checked [client A's] arm and there was a scratch approximately 2.5 inches long... [Staff #2] is suspended pending an investigation."</p> <p>-7/6/15 "...On 7/6/15 it was reported by behavioral consultant, [name of consultant], that staff member [staff #2]</p>	W 0149	<p>Staff andhouse supervisor will be trained on avoiding abuse, neglect, and exploitation, following behavior plans and on proper reporting procedures</p> <p>PersonResponsible: QIDP DateCompleted: 12/28/15</p> <p>- The QIDP willdo an observation three times a week for 1 month and then once a month ongoingchecking for adherence to behavior plans. The observations will be documentedand any issues noted will be corrected.</p> <p>PersonResponsible: QIDP DateCompleted: 12/28/15</p>	12/28/2015

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	<p>physically opened [client C's] mouth during a medication pass. It was reported that [staff #2] did this to make sure that [client C] had swallowed his medication...[staff #2] has been suspended pending an investigation."</p> <p>-7/6/15 "...On 7/6/15 it was reported by [client D's] roommate that staff member [staff #2] 'picks on [client D] and tells him to shut up.' [Staff #2] has been suspended until completion of an investigation...."</p> <p>The facility's 7/9/15 investigation indicated the behavior consultant (BC) was interviewed on 7/8/15. The BC's 7/8/15 witness statement indicated "According to [BC], on July 2, [staff #2] approached [administrative staff #1], Director of Group Homes, to inform her that they had had (sic) a rough morning, and she (staff #2) felt that [client A] may report [staff #2]. [Administrative staff #1] then spoke with [BC], letting her know the situation. [BC] was then stopped by [client A], who asked to speak to [BC] privately. [BC] said [client A] was 'obviously distressed' and cried during their discussion. [Client A] told [BC] that she 'had not been treated fairly' by [staff #2]. According to [client A], when they arrived at the workshop that morning and [client A] was attempting to</p>			

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	<p>exit the van, she began to be afraid she was going to fall. [Client A] said [staff #2] did not attempt to assist her in exiting the van...During their discussion July 2, according to [BC] [client A] made a comment about how [staff #2] 'doesn't treat them right.' [BC] pointed out that [client A] said 'them.' [Client A] specifically mentioned [client D], and that [staff #2] had told [client D] to 'shut up.'...."</p> <p>The facility's 7/9/15 investigation indicated client A was interviewed on 7/6/15. Client A's witness statement indicated client A wanted to talk about the scratch on her arm. Client A's witness statement indicated at the day program on Thursday, "...[Client D] was in the front seat and she (client A) was sitting in the back. She then asked me to stand up, and showed me (Quality Improvement Coordinator) where the door was in relation to her, and how the door had been pushed against her arm. She told me that [staff #2] had pushed the door against her arm, causing the scratch, and that [staff #2] had smiled and laughed at her...." Client A's witness statement indicated staff #2 had entered the client's bedroom without knocking and came in and closed the client's bedroom door. Client A's witness statement indicated client A became</p>			

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	<p>upset with staff #2 and client A "cussed at" and told staff #2 to get out of her room. Client A's 7/8/15 witness statement indicated "...According to [client A], also on Thursday [staff #2] threatened to call [client A's] guardian, [name of guardian]. [Staff #2] handed [client A] her phone, telling [client A] that she had a phone call. [Client A] asked if was [name of guardian], and said hello, but no one was there. [Client A] said that [staff #2] then laughed at her...She also mentioned [staff #2] forcing [client D] and [client C's] mouths open to check for their pills, but she was starting to get little upset and did not continue...[Client A] said she, and the other clients do not want [staff #2] to work there again...."</p> <p>The facility's 7/9/15 investigation indicated client D was interviewed on 7/8/15. Client D's witness statement indicated staff #2 did tell him to "...shut up...a couple of times...." Client D's witness statement indicated staff #2 was "...always 'telling us what to do'...."</p> <p>The facility's 7/9/15 investigation indicated staff #3 was interviewed on 7/8/15. Staff #3's witness statement indicated "I watched [staff #2] give [client D] his meds and after she gave it to him, I watched her tell him to open his</p>			

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	<p>mouth so she can check to see if he had swallowed it. I talked to [BC] and told her what happened. This happened on Tues (Tuesday) and I spoke with [BC] on Saturday (7/4/15). Also I have heard [staff #2] say shut up in the past to clients."</p> <p>The facility's 7/9/15 investigation indicated staff #4 was interviewed on 7/7/15. Staff #4's witness statement indicated "I cannot be specific w/ (with) dates but I have heard [staff #2] tell [client D] to shut up and go do something. Also I have seen her at med time make him open his mouth and show he doest (sic) have any pills left in his mouth."</p> <p>The facility's 7/9/15 investigation indicated staff #5 was interviewed on 7/7/15. Staff #5's witness statement indicated "...I asked if she (staff #5) was aware of any issues between [client A] and [staff #2]. She replied yes. She said [client A] is a 'harder to deal with client.' She says that [staff #2] yells, and '[client A] doesn't take too well to that...Last Wednesday, July 1, [staff #5] said [client A] was crying. When asked why she was crying, [client A] told [staff #5] that she doesn't want [staff #2] working there anymore. On Thursday when [staff #2] worked, [staff #5] noticed that [client A]</p>			

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	<p>was avoiding [staff #2]. According to [staff #5], [staff #2] came into the room where [staff #5] was preparing meds and asked 'what's with [client A's] attitude?' "</p> <p>The facility's 7/9/15 investigation indicated staff #6 was interviewed on 7/9/15. Staff #6's witness statement indicated staff #6 had heard staff #2 arguing with client A when client D said something to staff #2. Staff #6 indicated staff #2 yelled at client D to "shut up." Staff #6's witness statement indicated client A went and told staff #1 what happened. Staff #6 indicated staff #6 went into the office and told staff #1 (group home supervisor) client A was "...telling the truth and that I (staff #6) had heard [staff #2] tell [client D] to shut up." Staff #6's witness statement indicated this had happened several weeks ago. Staff #6's witness statement indicated while in the van, staff #2 started arguing with client A as client A was told she had her seat belt on wrong. Staff #6 indicated he was driving the van. Staff #6 indicated staff #2 left the front seat of the van (sic) went to the back of the van where client A was. Staff #6's witness statement indicated staff #2 "...began readjusting the seat belt. [Client A] began to scream at the top of her voice that [staff #2] was hurting her but [staff #2] persisted. I could not pull over on</p>			

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	<p>[name of road] and the incident continued. Finally [staff #2] gave up and got back in front seat...by the time we got home everything was ok. I checked [client A] but there were no physical marks on her...." The facility's investigation indicated staff #2 was terminated for abuse and staff #1 received a written warning for not reporting previous incidents. The facility's 7/9/15 investigation indicated facility staff would be retrained in regard to "reportable events." The facility failed to ensure facility staff immediately reported the mistreatment of clients to the administrator when the incidents occurred.</p> <p>Interview with the Director of Residential Services (DRS) on 11/2/15 indicated the facility staff did not immediately report the allegations of abuse/mistreatment when they occurred. The DRS stated it was "against policy."</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 10/26/15 at 2:37 PM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>-8/8/15 "...During the course of an investigation for verbal abuse (8/10/15)</p>			
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	<p>an allegation of neglect emerged. The allegation was that [staff #7] was sleeping while working. The date of the incident is 8-8-15..." The reportable incident reports indicated clients A, B and E were present at the group home. The 8/8/15 reportable incident report indicated the facility was not aware of the allegation of neglect until 8/17/15.</p> <p>The facility's 8/24/15 follow-up report to the 8/8/15 reportable incident report indicated "The allegation of neglect of sleeping was substantiated. [Staff #7] will be given a written warning and a 90 day probation. He will be retrained on neglect prior to returning to work."</p> <p>-8/10/15 "...On 8/10/15 [client A] reported to her house supervisor, [staff #1] that [staff #7] said, 'Do you want to go to timeout and stay in your room?' He also told [client A] that she got him in trouble for sleeping. [Client A] said that she went to her room and didn't argue with him...."</p> <p>The facility's 8/21/15 investigation indicated staff #1 was interviewed on 8/13/15. Staff #1's witness statement summary indicated "According to [staff #1], [staff #7] sleeping or being on his phone has been an 'ongoing problem.' She said staff and even some parents</p>			

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	<p>have seen him sleeping. She said [staff #7] is sub (substitute) staff who used to work at one of the other group homes. She said she emailed the QIDP (Qualified Intellectual Disabilities Professional) and supervisor of that group home, [QIDP #2] and [staff #8] respectively, as well as [staff #7's] new QIDP (QIDP #3), about the issues. [Staff #1] had also emailed the other group home QIDP, [QIDP #1], as well as the residential (sic) Director, [name of director], and this email generated the incident report. [Staff #1] said she spoke to [client A] on 8/10/15. According to [staff #1], [client A] told her that [staff #7] was sleeping and [client A] woke him up. He mentioned a time-out because [client A] was "bugging him."</p> <p>The 8/21/15 investigation indicated staff #4 was interviewed on 8/14/15. Staff #4's witness statement summary indicated client A had told staff #4 staff #7 had been asleep while staff #4 had taken another client on a van ride on 8/8/15. Staff #4's witness summary indicated staff #4 had observed staff #7 being asleep at the group home as well. Staff #4's witness statement indicated staff #4 reported the allegation of neglect (sleeping) to staff #1.</p> <p>An attached 8/8/15 email written by staff</p>			

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	<p>#1 to QIDP #1 (call center) indicated "Well the last three times that [staff #7] has worked staff has complained that he won't do any tasks even if staff asked him. All he does is play with his phone, or sleep. A parent came in and he was sleeping, the parent stated to staff they should made (sic) him do something. Even the clients have commented on him sleeping...."</p> <p>The facility's 8/21/15 investigation indicated staff #7 was interviewed on 8/17/15. Staff #7's witness statement indicated staff #7 indicated he was on some medication which had the side effects of "drowsiness & (and) sleepiness and HR (Human resources) do (sic) have a record on file when I was off FMLA (Family Medical Leave Absence)...."</p> <p>The facility's 8/21/15 investigation indicated the allegation of sleeping/neglect was substantiated.</p> <p>Interview with the DRS and QIDP #1 on 11/2/15 indicated the allegation of neglect of staff sleeping was substantiated. The DRS stated it was "against policy."</p> <p>The facility's policy and procedures were reviewed on 10/26/15 at 3:00 PM. The facility's 3/23/11 policy entitled Health and Safety indicated the facility staff</p>			

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W 0153 Bldg. 00	<p>should report allegations of abuse and/or neglect immediately to their supervisor and the supervisor would report to the QIDP, and the QIDP would report to the administrator. The facility's policy and procedure indicated a Bureau of Developmental Disabilities Services (BDDS) report would be filed within 24 hours of the incident.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>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 on interview and record review for 5 of 9 allegations of neglect and/or abuse reviewed, the facility failed to ensure allegations of abuse/neglect were reported to the administrator immediately and/or failed to ensure all allegations of abuse/neglect were reported timely to state officials for clients A, B, C, D and E.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 10/26/15 at 2:37 PM. The</p>	W 0153	<p>The QIDP will be retrained on reporting procedures for allegations of abuse, neglect and exploitation</p> <p>Person Responsible: Department Director Date Completed: 12/28/15 Staff and house supervisor will be trained on avoiding abuse, neglect, and exploitation, following behavior plans and on proper reporting procedures</p> <p>Person Responsible: QIDP Date Completed: 12/28/15</p> <p>The QIDP will do an observation three times a week for 1 month and then once a month ongoing checking for adherence to behavior plans. The observations will be</p>	12/28/2015

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	<p>facility's reportable incident reports and/or investigations indicated the following:</p> <p>-7/6/15 "...On 7/6/15 [client A] reported to her behavior consultant that staff member [staff #2] is 'mean to me.' She also reported on 7/16/15 [staff #2] pushed the group home door towards her and it hit her upper right arm. Staff checked [client A's] arm and there was a scratch approximately 2.5 inches long...."</p> <p>-7/6/15 "...On 7/6/15 it was reported by behavioral consultant, [name of consultant], that staff member [staff #2] physically opened [client C's] mouth during a medication pass. It was reported that [staff #2] did this to make sure that [client C] had swallowed his medication...."</p> <p>-7/6/15 "...On 7/6/15 it was reported by [client D's] roommate that staff member [staff #2] 'picks on [client D] and tells him to shut up.' [Staff #2] has been suspended until completion of an investigation...."</p> <p>The facility's 7/9/15 investigation indicated the behavior consultant (BC) was interviewed on 7/8/15. The BC's 7/8/15 witness statement indicated "According to [BC], on July 2, [staff #2]</p>		<p>documented and any issues noted will be corrected. Person Responsible: QIDP Date Completed: 12/28/15 Addendum: The QIDP will do an observation three times a week for 1 month and then once a month ongoing checking for adherence to behavior plans and reporting issues regarding abuse, neglect, mistreatment, exploitations, and injury of unknown source. The observations will be documented and any issues noted will be corrected. Person Responsible: QIDP Date Completed: 12/28/15 The Residential Director will complete an observation of the group home once a month for 3 months checking for reporting issues regarding abuse, neglect, mistreatment, exploitations, and injury of unknown source. The observations will be documented and any issues noted will be corrected. Person Responsible: Residential Director Completion Date: 12/28/15</p>	

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	<p>approached [administrative staff #1], Director of Group Homes, to inform her that they had had (sic) a rough morning, and she (staff #2) felt that [client A] may report [staff #2]. [Administrative staff #1] then spoke with [BC], letting her know the situation. [BC] was then stopped by [client A], who asked to speak to [BC] privately. [BC] said [client A] was 'obviously distressed' and cried during their discussion. [Client A] told [BC] that she 'had not been treated fairly' by [staff #2]. According to [client A], when they arrived at the workshop that morning and [client A] was attempting to exit the van, she began to be afraid she was going to fall. [Client A] said [staff #2] did not attempt to assist her in exiting the van...During their discussion July 2, according to [BC] [client A] made a comment about how [staff #2] 'doesn't treat them right.' [BC] pointed out that [client A] said 'them.' [Client A] specifically mentioned [client D], and that [staff #2] had told [client D] to 'shut up.'...."</p> <p>The facility's 7/9/15 investigation indicated client A was interviewed on 7/6/15. Client A's witness statement indicated client A wanted to talk about the scratch on her arm. Client A's witness statement indicated at the day program on Thursday, "...[Client D] was</p>			
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	<p>in the front seat and she (client A) was sitting in the back. She then asked me to stand up, and showed me (Quality Improvement Coordinator) where the door was in relation to her, and how the door had been pushed against her arm. She told me that [staff #2] had pushed the door against her arm, causing the scratch, and that [staff #2] had smiled and laughed at her...." Client A's witness statement indicated staff #2 had entered the client's bedroom without knocking and came in and closed the client's bedroom door. Client A's witness statement indicated client A became upset with staff #2 and client A "cussed at" and told staff #2 to get out of her room. Client A's 7/8/15 witness statement indicated "...According to [client A], also on Thursday [staff #2] threatened to call [client A's] guardian, [name of guardian]. [Staff #2] handed [client A] her phone, telling [client A] that she had a phone call. [Client A] asked if was [name of guardian], and said hello, but no one was there. [Client A] said that [staff #2] then laughed at her...She also mentioned [staff #2] forcing [client D] and [client C's] mouths open to check for their pills, but she was starting to get little upset and did not continue...[Client A] said she, and the other clients do not want [staff #2] to work there again...."</p>			
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	<p>The facility's 7/9/15 investigation indicated client D was interviewed on 7/8/15. Client D's witness statement indicated staff #2 did tell him to "...shut up...a couple of times...." Client D's witness statement indicated staff #2 was "...always 'telling us what to do'...."</p> <p>The facility's 7/9/15 investigation indicated staff #3 was interviewed on 7/8/15. Staff #3's witness statement indicated "I watched [staff #2] give [client D] his meds and after she gave it to him, I watched her tell him to open his mouth so she can check to see if he had swallowed it. I talked to [BC] and told her what happened. This happened on Tues (Tuesday) and I spoke with [BC] on Saturday (7/4/15). Also I have hear [staff #2] say shut up in the past to clients."</p> <p>The facility's 7/9/15 investigation indicated staff #4 was interviewed on 7/7/15. Staff #4's witness statement indicated "I cannot be specific w/ (with) dates but I have heard [staff #2] tell [client D] to shut up and go do something. Also I have seen her at med time make him open his mouth and show he doest (sic) have any pills left in his mouth."</p> <p>The facility's 7/9/15 investigation</p>			

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	<p>indicated staff #5 was interviewed on 7/7/15. Staff #5's witness statement indicated "...I asked if she (staff #5) was aware of any issues between [client A] and [staff #2]. She replied yes. She said [client A] is a 'harder to deal with client.' She says that [staff #2] yells, and '[client A] doesn't take too well to that...Last Wednesday, July 1, [staff #5] said [client A] was crying. When asked why she was crying, [client A] told [staff #5] that she doesn't want [staff #2] working there anymore. On Thursday when [staff #2] worked, [staff #5] noticed that [client A] was avoiding [staff #2]. According to [staff #5], [staff #2] came into the room where [staff #5] was preparing meds and asked 'what's with [client A's] attitude?' "</p> <p>The facility's 7/9/15 investigation indicated staff #6 was interviewed on 7/9/15. Staff #6's witness statement indicated staff #6 had heard staff #2 arguing with client A when client D said something to staff #2. Staff #6 indicated staff #2 yelled at client D to "shut up." Staff #6's witness statement indicated client A went and told staff #1 what happened. Staff #6 indicated staff #6 went into the office and told staff #1 (group home supervisor) client A was "...telling the truth and that I (staff #6) had heard [staff #2] tell [client D] to shut up." Staff #6's witness statement</p>			

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	<p>indicated this had happened several weeks ago. Staff #6's witness statement indicated while in the van, staff #2 started arguing with client A as client A was told she had her seat belt on wrong. Staff #6 indicated he was driving the van. Staff #6 indicated staff #2 left the front seat of the van (sic) went to the back of the van where client A was. Staff #6's witness statement indicated staff #2 "...began readjusting the seat belt. [Client A] began to scream at the top of her voice that [staff #2] was hurting her but [staff #2] persisted. I could not pull over on [name of road] and the incident continued. Finally [staff #2] gave up and got back in front seat...by the time we got home everything was ok. I checked [client A] but there were no physical marks on her..." The facility's investigation indicated staff #2 was terminated for abuse and staff #1 received a written warning for not reporting previous incidents. The facility's 7/9/15 investigation indicated facility staff would be retrained in regard to "reportable events."</p> <p>Interview with the Director of Residential Services (DRS) on 11/2/15 indicated the facility staff did not immediately report the allegations of abuse/mistreatment when they occurred. The DRS stated it was "against policy."</p>			

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	<p>2. The facility's reportable incident reports and/or investigations were reviewed on 10/26/15 at 2:37 PM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>-8/8/15 "...During the course of an investigation for verbal abuse (8/10/15) an allegation of neglect emerged. The allegation was that [staff #7] was sleeping while working. The date of the incident is 8-8-15..." The reportable incident reports indicated clients A, B and E were present at the group home. The 8/8/15 reportable incident report indicated the facility was not aware of the allegation of neglect until 8/17/15.</p> <p>The facility's 8/24/15 follow-up report to the 8/8/15 reportable incident report indicated "The allegation of neglect of sleeping was substantiated. [Staff #7] will be given a written warning and a 90 day probation. He will be retrained on neglect prior to returning to work."</p> <p>-8/10/15 "...On 8/10/15 [client A] reported to her house supervisor, [staff #1] that [staff #7] said, 'Do you want to go to timeout and stay in your room?' He also told [client A] that she got him in trouble for sleeping. [Client A] said that</p>			
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	<p>she went to her room and didn't argue with him...."</p> <p>The facility's 8/21/15 investigation indicated staff #1 was interviewed on 8/13/15. Staff #1's witness statement summary indicated "According to [staff #1], [staff #7] sleeping or being on his phone has been an 'ongoing problem.' She said staff and even some parents have seen him sleeping. She said [staff #7] is sub (substitute) staff who used to work at one of the other group homes. She said she emailed the QIDP (Qualified Intellectual Disabilities Professional) and supervisor of that group home, [QIDP #2] and [staff #8] respectively, as well as [staff #7's] new QIDP (QIDP #3), about the issues. [Staff #1] had also emailed the other group home QIDP, [QIDP #1], as well as the residential (sic) Director, [name of director], and this email generated the incident report. [Staff #1] said she spoke to [client A] on 8/10/15. According to [staff #1], [client A] told her that [staff #7] was sleeping and [client A] woke him up. He mentioned a time-out because [client A] was 'bugging him.'"</p> <p>The 8/21/15 investigation indicated staff #4 was interviewed on 8/14/15. Staff #4's witness statement summary indicated client A had told staff #4 staff #7 had</p>			

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W 0312 Bldg. 00	<p>been asleep while staff #4 had taken another client on a van ride on 8/8/15. Staff #4's witness summary indicated staff #4 had observed staff #7 being asleep at the group home as well. Staff #4's witness statement indicated staff #4 reported the allegation of neglect (sleeping) to staff #1.</p> <p>An attached 8/8/15 email written by staff #1 to QIDP #1 (call center) indicated "Well the last three times that [staff #7] has worked staff has complained that he won't do any tasks even if staff asked him. All he does is play with his phone, or sleep. A parent came in and he was sleeping, the parent stated to staff they should made (sic) him do something. Even the clients have commented on him sleeping...."</p> <p>Interview with the DRS and QIDP #1 on 11/2/15 indicated the allegation of neglect of staff sleeping was substantiated. The DRS stated it was "against policy."</p> <p>9-3-2(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral</p>			

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	<p>part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 1 of 2 sampled clients (C), the facility failed to ensure the client had an active treatment program/desensitization plan for the use of a pre-sedation medication prior to medical appointments.</p> <p>Findings include:</p> <p>Client C's record was reviewed on 10/30/15 at 2:28 PM. Client C's October 2015 physician's order indicated client C received Diazepam 10 milligrams 2 tablets 1 hour prior to appointments.</p> <p>Client C's 2/2/15 Individual Support Plan (ISP) did not indicate client C had an active treatment program and/or a desensitization plan for the use of Diazepam 10 milligrams prior to appointments. Client C's ISP and/or record did not indicate the specific behaviors client C demonstrated for the use of the pre-sedation medication.</p> <p>Interview with the Director of Residential Services (DRS), RN #1 and the Qualified Intellectual Disabilities Professional (QIDP) on 11/2/15 indicated client C received Diazepam for seizures and as a pre-medication for appointments. The</p>	W 0312	<p>Adesensitization plan will be added to Client C's ISP and include behaviors that Client C demonstrates for pre-medication prior to appointments PersonResponsible: QIDP DateCompleted: 12/28/15 The QIDP will be retrained on inclusion of desensitization plans in ISPs for sedation for appointments PersonResponsible: Department Director DateCompleted: 12/28/15 The department director will review medical records for the clients living at Strathmore to determine if other clients require a desensitization plan PersonResponsible: Department Director DateCompleted: 12/28/15</p>	12/28/2015

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W 0336 Bldg. 00	<p>QIDP and the DRS indicated client C did not have desensitization plan for the use of the Diazepam as a pre-medication prior to appointments.</p> <p>9-3-5(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on interview and record review for 3 of 3 sampled clients (A, B and C), the facility's nursing services failed to conduct quarterly nursing examinations from 10/14 to 10/15.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 10/30/15 at 1:20 PM. Client A's October 2015 physician's order indicated client A received routine medications. Client A's October 2015 physician's order indicated client A's diagnoses included, but were not limited to, Congestive Heart Failure, Pacemaker, Afibrillation, Hypertension, Hypothyroidism, Encephalopathy, Seizures, Gout and high cholesterol. Client A's record indicated the nurse did not conduct quarterly nursing</p>	W 0336	<p>The agencynurses will be retrained to conduct nursing assessments of each client at leastquarterly</p> <p>PersonResponsible: Nurse Supervisor CompletionDate: 12/28/15</p> <p>The Directorof Group Home Services will complete an audit of client records quarterly toensure that quarterly nursing assessments are being completed</p> <p>PersonResponsible: Department Director Completion Date: 12/28/15</p>	12/28/2015

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	<p>assessments as client A had quarterly nursing assessments dated 10/24/14 and 8/5/15 in the past year.</p> <p>Client B's record was reviewed on 10/30/15 at 2:02 PM. Client B's October 2015 physician's order indicated the client received routine medications. Client B's October 2015 physician's order indicated client B's diagnoses included but were not limited to Over active Bladder and hypothyroidism. Client B's record indicated the nurse did not conduct quarterly nursing assessments as client had quarterly nursing assessments dated 3/16/15 and 8/5/15 in the past year.</p> <p>Client C's record was reviewed on 10/30/15 at 2:28 PM. Client C's October 2015 physician's order indicated client C received routine medications. Client C's October 2015 physician's order indicated client C's diagnoses included, but were not limited to, Seizure Disorder and Gastroesophageal Disease. Client C's record indicated the nurse did not conduct quarterly nursing assessments as client had quarterly nursing assessments dated 3/16/15 and 8/27/15 in the past year.</p> <p>Interview with RN #1, Director of Residential Services (DRS) and the Qualified Intellectual Disabilities</p>			

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	Professional (QIDP) on 11/2/15 stated "Yes, they are missing nursing quarterlies." 9-3-6(a)				