

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/25/2013
NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1703 LAUREL DR MARION, IN 46953		
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: November 18, 19, 20, 21, 22 and 25, 2013.</p> <p>Provider Number : 15G581 AIM Number: 100245560 Facility Number: 001095</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed November 27, 2013 by Dotty Walton, QIDP.</p>	W000000	W 0000 No comments necessary		

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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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 neglected to implement policy and procedures for 6 of 53 incidents reviewed, to protect 1 of 4 sampled clients (client #1) and 1 additional client (client #7) from neglect/abuse of inappropriate use of physical redirection, and failed to document a thorough investigation in regards to injuries of unknown origin for 1 sampled client (client #1). The facility failed to develop and implement effective correction to prevent falls with injury involving 1 additional client (client #6) and failed to protect 1 of 4 sampled clients (client #1) from injury by failing to use seatbelts per company procedure.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 11/18/113 2:20 PM and included the following:</p> <p>1. A BDDS report dated 6/23/13 regarding client #1 indicated "during a behavior on the part of a consumer, a staff did not follow the behavior plan as written for the client. In addition, another</p>	W000149	<p>W149 Staff Treatment of Clients This item outlines that the agency failed to document a thorough investigation in regards to injuries of unknown origin. The plan of correction for this tag is as follows: The facility will ensure that all investigations are thorough. Specifically, the manager of this home will receive training by 12/25/2013 on the Components of a Thorough Investigation (presentation authored by ISDH)The Director of Group Homes will assure that all investigations are completed in a thorough manner completed by reviewing completed investigations. If necessary Corporate Compliance Officer will be involved as appropriate for review, oversight or completion of the investigatory process. The Survey noted that Behavior Support Plans were not followed as they are written. All staff will receive training on BSPs before 12/25/2013 noting that the expectation is that all staff follows the plans as written. The Survey noted that Client #6 did not have an OT/PT Evaluation after a series of falls. At this time, this consumer is receiving OT/PT services through a qualified provider, Angels of Mercy. No other consumers have had a</p>	12/25/2013	

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	<p>staff reported on 6/24/13 that the staff in question was abusive in manner toward the client. While showering the consumer three small bruises were found which were of no known origin." The report indicated an investigation was being completed, and staff #13 had quit before a statement was obtained from him.</p> <p>An undated follow up (to the 6/23/13 incident) description indicated "The three bruises are believed to be caused by [client #1] falling as she attempted to get up from the floor after being placed there by staff. The first bruise is along the bra line, there is an inch long bruise of no real width along the right shoulder blade, and a round dime size bruise above her right elbow...The incident started with a behavior from [client #1] where she was taking food from another consumer and when she was redirected by [staff #13] she yelled and hit at him. [Staff #8] states that [staff #13] picked her up under the arms and placed her in the wheelchair and took her back to her room. [Staff #13] then placed [client #1] on the floor in the middle of the room and moved her wheelchair out of her reach. This was in a previous behavior support plan for [client #1], but had been removed from her plan and staff had been trained on this no longer being appropriate...According to the investigative report, the bruising</p>		<p>series of falls such as Client #6. The Survey noted that the agency failed to assure proper vehicle safety measures resulting in a consumer not having a seat belt used during transport. The staff will have training on proper vehicle safety including ensuring all consumers have a seat belt engaged prior to putting the vehicle in gear prior to 12/25/2013. The manager will complete routine oversight through monitoring the staff to assure this is completed. The manager will assure that checking the vehicle for safety occurs daily initially. The Manager will be able to fade the frequency once there is 2 weeks of consistent use of safety mechanisms used but will maintain monitoring at least weekly to assure that this is consistently applied.</p>				

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	<p>found on [client #1] does not appear to have been caused by physical abuse, but rather from her fall attempting to get into her bed." The summary and recommendations included "It does not appear that there was any physical abuse and it is difficult to substantiate intimidation or verbal abuse based on one statement. However, placing [client #1] on the floor and removing access to her wheelchair (against the behavior plan) and then leaving her unattended during a behavior while allowing her to fall while attempting to get up from the floor, is very clearly willful neglect...." The report indicated staff were retrained on client #1's behavior support plan. There was no additional information indicating a fall involving client #1 or an explanation or evidence provided that explained why client #1's bruising was thought to be the result of a fall.</p> <p>An Accident/Incident Report dated 6/24/13 indicated three bruises were found on client #1 while showering and indicated "a bruise along bra line looks like where bra may have rubbed her. There is an inch long bruise no real width along right shoulder blade. There is also a round dime sized bruise above her right elbow."</p> <p>An investigation dated 6/24/13 attached</p>						

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	<p>to the report included a statement by staff #8 which indicated she had left the group home after the incident involving client #1 and when she returned 45 minutes later, staff #13 stated client #1 "had [urinated on] herself twice," and indicated client #1 had fallen after trying to get on her bed. Staff #8 indicated client #1's urine soaked clothing was still on the bathroom floor. A statement by client #1 indicated she had received her bruises as a result of falling.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 11/18/13 at 3:10 PM. She indicated client #1's bruising to her arm was determined to be a result of her sitting in her chair. She indicated the investigation should include more specific explanations of how the bruising was thought to have occurred.</p> <p>2. A BDDS report dated 2/26/13 indicated staff #14 told the group home manager while staff #15 was working she "drug" client #7 down the hall. The report indicated staff #15 had been suspended and the incident was being investigated. A follow up report dated 2/26/13 indicated "It was not substantiated that [staff #15] was physically abusive towards [client #7]. However, it was determined that [staff #15] did not follow the behavior</p>				

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	<p>support plan for [client #7] nor did she follow agency training for behaviors." Corrective action indicated staff #15 was being retrained on behavior management training and client #7's behavior support plan.</p> <p>An attached investigation dated 2/27/13 indicated client #7 was making verbalizations and staff #15 intervened by lifting client #7 and walking her to her room after she fell to the floor and "kept hooting and hollering." A statement by staff #15 indicated she had not dragged client #7, but when she lifted client #7 her heels "may have slid back a little bit," and when asked if client #7 walked to her room on her own, she stated "not quite," but indicated she did not drag client #7. Staff #15 was "uncertain" when asked what client #7's behavior plan calls for "during such a behavior." A summary of critical information indicated "It was determined that [staff #15] did not follow the behavior plan or the safe lifting plan in her interaction with [client #7]. [Client #7] should have been allowed to remain on the floor unless she became a danger to herself or to others and if it was determined she be lifted up off the floor [staff #15] should have asked [client #7] to help her with the lift. The allegation of physical abuse however was not substantiated." Staff #13 indicated "he has</p>				

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	<p>seen her do something similar (although not dragging her).</p> <p>3. a) A BDDS report dated 5/27/13 indicated client #6 had tripped on the curb and fell while walking down the driveway. Client #6 hit his face on the pavement which resulted in a bloody nose that was stopped with first aid. The report indicated client #6 had a fall risk plan and staff were present when he fell, but were unable to prevent the fall. Corrective action indicated because of the downward slope of the driveway, client #6 would be assisted by staff when walking down the driveway.</p> <p>b) A BDDS report dated 6/3/13 indicated client #6 was leaving the garage and "was not watching his step. He tripped over the garage step and fell to the porch where he received a small scrape on his left knee. The scrape was smaller than a dime." The report indicated maintenance had fixed the step so there was not an "abrupt" distance between garage step and porch, and a team meeting was scheduled on 6/4/13 to discuss client #6's increase in falls and "solutions to the problem." An undated follow up indicated during the team meeting on 6/5/13 it was decided to contact client #6's doctor and schedule an appointment to see if his eyesight was affecting his falls, and in addition, staff</p>						

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	<p>will assist him when navigating the driveway or other uneven terrain.</p> <p>Meeting minutes attached to the report dated 6/5/13 indicated an appointment was being scheduled to evaluate client #6's eyesight and "Will evaluate other alternatives if this is not the problem."</p> <p>c) A BDDS report dated 7/22/13 indicated client #6 did not pick his foot up high enough to get on the sidewalk and he tripped over the curb and skinned a small part of his left knee. Corrective action indicated client #6 would now use handicapped entrances on all future trips or if a handicapped entrance was not available, two staff were to assist him.</p> <p>d) A BDDS report dated 9/7/13 indicated staff found a half-dollar sized bruise across the top of client #6's left foot. Client #6 reported he fell outside. Corrective action indicated "Staff will be instructed to closely monitor [client #6] when he is outside."</p> <p>Client #6's Fall Risk Management plan dated 6/13/13 indicated client #6 was to be encouraged to stand up straight while walking, staff were to accompany him when walking on uneven terrain or navigating the driveway, and clear the environment of trip hazards.</p>						

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	<p>The QIDP was interviewed on 11/18/13 at 3:46 PM. She indicated the safety committee reviewed falls as well as the QIDP, nurse and house manager to determine corrective action.</p> <p>Client #6's record was reviewed on 11/19/13 at 9:15 AM. Client #6's record did not include an evaluation of his sensory motor skills by occupational health (OT) or physical therapy (PT). An eye visit form dated 6/7/13 indicated client #6's falls were not a result of his vision.</p> <p>The House Manager was interviewed on 11/19/13 at 9:20 AM and indicated there had not been an evaluation by OT or PT of client #6's mobility.</p> <p>The QIDP was interviewed on 11/22/13 at 4:30 PM and indicated staff had been retrained after client #6 fell on 7/21/13. She indicated client #6's doctor had been contacted regarding an evaluation of client #6's mobility after the fall in July, 2013, but client #6's doctor did not think it was necessary.</p> <p>Client #6's annual physical dated 6/17/13 was reviewed on 11/22/13 at 4:55 PM. There was no indication in the form of an evaluation or discussion of client #6's</p>						

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	<p>falls.</p> <p>There was no additional corrective action provided to address client #6's history of falls.</p> <p>4. A BDDS report dated 1/23/13 indicated client #1 refused to wear her seat belt in the van. "Staff although van trained was new and did not follow company policy to make sure that all clients were secure and left the parking lot without buckling the seat belt. The van went around a curve and the client fell to the floor of the van." Client #1 was assessed and no injuries were found, however on 1/24/13 client #1 was found with a bruise on her side 1 inch wide and 4 inches long. "It is believed that this bruise is from the accident on 1/23/12 (sic)." The report indicated staff had received a "coaching/counseling" regarding the matter. "All staff has been reminded that client choice does not supercede client safety and company policy."</p> <p>The report indicated staff had been concerned client #1's rights would have been violated if they had not honored her refusal to wear the seat belt. The report indicated all staff had been retrained on transporting procedures.</p> <p>The QIDP was interviewed on 11/18/13 at</p>				

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	<p>3:46 PM. She indicated "Staff are to make sure seatbelts are fastened before starting the vehicle. It's their responsibility as a driver."</p> <p>The facility's Abuse, Neglect and Exploitation Policy and Procedures for Reporting Abuse and Neglect and other Reportable or Unusual Incidents both dated 6/15/11 were reviewed on 11/18/13 at 2:30 PM. The Abuse, Neglect and Exploitation Policy indicated "It is the policy of Carey Services to respect the rights of consumers served and protect them from possible abusive treatment, negligence, or exploitation on the part of staff, volunteers, or other consumers. Abusive treatment and/or negligence of responsibilities with respect to the welfare and safety of consumers are incompatible with the purpose of the agency. Failure of a staff member to immediately report abuse/neglect/exploitation of a client to agency administration also constitutes 'neglect' and is subject to disciplinary action up to and including termination...."</p> <p>The Procedures for Reporting Abuse and Neglect and other Reportable or Unusual Incidents indicated "The Corporate Compliance officer will be responsible for gathering all of the relative information from any staff whom the consumer may have spoken about the incident. A written report is completed by the CCO and is to</p>						

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	include...a discussion with the consumer and staff or volunteer involved, as well as involve any other individual including staff, consumers and possible witnesses in both investigating the situation and determining an appropriate remedy." 9-3-2(a)				

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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 document a thorough investigation in regards to injuries of unknown origin for 1 sampled client (client #1).</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 11/18/13 2:20 PM and included the following:</p> <p>1. A BDDS report dated 6/23/13 (regarding client #1) indicated "during a behavior on the part of a consumer, a staff did not follow the behavior plan as written for the client. In addition, another staff reported on 6/24/13 that the staff in question was abusive in manner toward the client. While showering the consumer three small bruises were found which were of no known origin." The report indicated an investigation was being completed, and staff #13 had quit before a statement was obtained from him.</p> <p>An undated follow up description indicated "The three bruises are believed</p>	W000154	<p>W154 Staff Treatment of Clients This item outlines that the agency failed to document a thorough investigation regarding injuries of unknown origin. The plan of correction for this tag is as follows: The facility will ensure that all investigations are thorough. Specifically, the manager of this home will receive training by 12/25/2013 on the Components of a Thorough Investigation (presentation authored by ISDH)The Director of Group Homes will assure that all investigations are completed in a thorough manner completed by reviewing completed investigations. If necessary Corporate Compliance Officer will be involved as appropriate for review, oversight or completion of the investigatory process. The Survey noted that Behavior Support Plans were not followed as they are written. All staff will receive training on BSPs before 12/25/2013 noting that the expectation is that all staff follows the plans as written.</p>	12/25/2013			

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	<p>to be caused by [client #1] falling as she attempted to get up from the floor after being placed there by staff. The first bruise is along the bra line, there is an inch long bruise of no real width along the right shoulder blade, and a round dime size bruise above her right elbow...The incident started with a behavior from [client #1] where she was taking food from another consumer and when she was redirected by [staff #13] she yelled and hit at him. [Staff #8] states that [staff #13] picked her up under the arms and placed her in the wheelchair and took her back to her room. [Staff #13] then placed [client #1] on the floor in the middle of the room and moved her wheelchair out of her reach. This was in a previous behavior support plan for [client #1], but had been removed from her plan and staff had been trained on this no longer being appropriate...According to the investigative report, the bruising found on [client #1] does not appear to have been caused by physical abuse, but rather from her fall attempting to get into her bed." The summary and recommendations included "It does not appear that there was any physical abuse and it is difficult to substantiate intimidation or verbal abuse based on one statement. However, placing [client #1] on the floor and removing access to her wheelchair (against the behavior plan) and then</p>			

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	<p>leaving her unattended during a behavior while allowing her to fall while attempting to get up from the floor, is very clearly willful neglect...." The report indicated staff were retrained on client #1's behavior support plan. There was no additional information indicating a fall involving client #1 or an explanation or evidence provided that explained why client #1's bruising was thought to be the result of a fall.</p> <p>An Accident/Incident Report dated 6/24/13 indicated three bruises were found on client #1 while showering and indicated "a bruise along bra line looks like where bra may have rubbed her. There is an inch long bruise no real width along right shoulder blade. There is also a round dime sized bruise above her right elbow."</p> <p>An investigation dated 6/24/13 attached to the report included a statement by client #1 which indicated she had received her bruises as a result of falling.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 11/18/13 at 3:10 PM. She indicated client #1's bruising to her arm was determined to be a result of her sitting in her chair. She indicated the investigation should include more specific explanations</p>						

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	of how the bruising was thought to have occurred. 9-3-2(a)				

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to develop and implement effective correction to prevent falls with injury involving 1 additional client (client #6).</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 11/18/13 2:20 PM and included the following:</p> <p>1. a) A BDDS report dated 5/27/13 indicated client #6 had tripped on the curb and fell while walking down the driveway. Client #6 hit his face on the pavement which resulted in a bloody nose that was stopped with first aid. The report indicated client #6 had a fall risk plan and staff were present when he fell, but were unable to prevent the fall. Corrective action indicated because of the downward slope of the driveway, client #6 would be assisted by staff when walking down the driveway.</p> <p>b) A BDDS report dated 6/3/13 indicated client #6 was leaving the garage and "was</p>	W000157	<p>W157 Staff Treatment of Clients This item outlines that the agency failed to develop and implement effective correction to prevent falls with injury for one client. The plan of correction for this tag is as follows: The Survey noted that Client #6 did not have an OT/PT Evaluation after a series of falls. At this time, this consumer is receiving OT/PT services through a qualified provider, Angels of Mercy. No other consumers have had a series of falls such as Client #6. The agency's plan of correction to prevent Client #6 from falling includes the following 1) following all OT/PT recommendations and continue with the OT/PT sessions that are underway 2) Staff following High Risk Plan (Falling) to assure the consumer is safe 3) follow physician recommendations if deterioration or concerns are noted. The consumer's safety is the main priority.</p>	12/25/2013	

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	<p>not watching his step. He tripped over the garage step and fell to the porch where he received a small scrape on his left knee. The scrape was smaller than a dime." The report indicated maintenance had fixed the step so there was not an "abrupt" distance between garage step and porch, and a team meeting was scheduled on 6/4/13 to discuss client #6's increase in falls and "solutions to the problem." An undated follow up indicated during the team meeting on 6/5/13 it was decided to contact client #6's doctor and schedule an appointment to see if his eyesight was affecting his falls, and in addition, staff will assist him when navigating the driveway or other uneven terrain.</p> <p>Meeting minutes attached to the report dated 6/5/13 indicated an appointment was being scheduled to evaluate client #6's eyesight and "Will evaluate other alternatives if this is not the problem."</p> <p>c) A BDDS report dated 7/22/13 indicated client #6 did not pick his foot up high enough to get on the sidewalk and he tripped over the curb and skinned a small part of his left knee. Corrective action indicated client #6 would now use handicapped entrances on all future trips or if a handicapped entrance was not available, two staff were to assist him.</p>						

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	<p>d) A BDDS report dated 9/7/13 indicated staff found a half-dollar sized bruise across the top of client #6's left foot. Client #6 reported he fell outside. Corrective action indicated "Staff will be instructed to closely monitor [client #6] when he is outside."</p> <p>Client #6's Fall Risk Management plan dated 6/13/13 was reviewed on 11/22/13 at 10:00 AM and indicated client #6 was to be encouraged to stand up straight while walking, staff were to accompany him when walking on uneven terrain or navigating the driveway, clear the environment of trip hazards.</p> <p>The QIDP was interviewed on 11/18/13 at 3:46 PM. She indicated the safety committee reviewed falls as well as the QIDP, nurse and house manager to determine corrective action.</p> <p>Client #6's record was reviewed on 11/19/13 at 9:15 AM. Client #6's record did not include an evaluation of his sensory motor skills by occupational health (OT) or physical therapy (PT). An eye visit form dated 6/7/13 indicated client #6's falls were not a result of his vision.</p> <p>The House Manager was interviewed on 11/19/13 at 9:20 AM and indicated there</p>						

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	<p>had not been an evaluation by OT or PT of client #6's mobility.</p> <p>The QIDP was interviewed on 11/22/13 at 4:30 PM and indicated staff had been retrained after client #6 fell on 7/21/13. She indicated client #6's doctor had been contacted regarding an evaluation of client #6's mobility after the fall in July, 2013, but client #6's doctor did not think it was necessary.</p> <p>Client #6's annual physical dated 6/17/13 was reviewed on 11/22/13 at 4:55 PM. There was no indication in the form of an evaluation or discussion of client #6's falls.</p> <p>The corrective action provided to address client #6's history of falls was not effective as he continued to receive falls with injury.</p> <p>9-3-2(a)</p>						

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based upon record review and interview for 1 of 4 sampled clients (client #1), the facility failed to ensure staff implemented client behavior plans as written.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 11/18/13 2:20 PM and included the following:</p> <p>A BDDS report dated 6/23/13 (regarding client #1) indicated "during a behavior on the part of a consumer, a staff did not follow the behavior plan as written for the client."</p> <p>An undated follow up description indicated "The incident started with a behavior from [client #1] where she was taking food from another consumer and when she was redirected by [staff #13] she yelled and hit at him. [Staff #8] states that [staff #13] picked her up under the</p>	W000249	<p>W249 Program Implementation</p> <p>This item outlines that the agency failed to ensure staff implemented client behavior plans as written. The plan of correction for this tag is as follows: The Survey noted that Behavior Support Plans were not followed as they are written. All staff will receive training on BSPs before 12/25/2013 noting that the expectation is that all staff follows the plans as written. Monitoring will occur routinely by manager, Director and Chief Program Officer. The Manager will discuss with staff weekly on aspects of each consumer's BSP. The manager will initially monitor each staff to assure that he/she is following the plan. This will concur with verbal quizzing of the staff to assure that they have a full understanding of the plan and what to do and what not to do.</p>	12/25/2013	

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	<p>arms and placed her in the wheelchair and took her back to her room. [Staff #13] then placed [client #1] on the floor in the middle of the room and moved her wheelchair out of her reach. This was in a previous behavior support plan for [client #1], but had been removed from her plan and staff had been trained on this no longer being appropriate...The summary and recommendations in the report indicated "It does not appear that there was any physical abuse and it is difficult to substantiate intimidation or verbal abuse based on one statement. However, placing [client #1] on the floor and removing access to her wheelchair (against the behavior plan) and then leaving her unattended during a behavior while allowing her to fall while attempting to get up from the floor, is very clearly willful neglect...." The report indicated staff were retrained on client #1's behavior support plan.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 11/18/13 at 2:55 PM. She indicated staff had failed to follow client #1's plan as written.</p> <p>Client #1's Behavior Support Plan dated 7/12 attached to the report was reviewed on 11/18/13 at 3:00 PM and indicated target behaviors of physical aggression,</p>						

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	<p>verbal aggression, verbal and physical non-compliance, and spitting. The plan did not include removing client #6's wheelchair from her use or the use of physical intervention including picking her up under the arms.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 11/18/13 at 2:55 PM. She indicated staff had failed to follow the client's behavior plan as written.</p> <p>9-3-4(a)</p>				

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W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 2 of 4 sampled clients (clients #1 and #3) and 2 additional clients (clients #5 and #8), the facility failed to encourage clients to assist in meal preparation.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 11/19/13 from 6:29 AM until 8:30 AM. Staff #4 prepared bowels of cereal for clients #1, #3, #5 and #8 without their assistance during the observation.</p> <p>Staff #4 and the House Manager were interviewed on 11/19/13 at 7:29 PM. Staff #4 indicated he prepared client #3, #5 and #8's food for them as they were altered in texture.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 11/21/13 at 4:05 PM. She stated, "Sometimes staff have to be reminded to encourage clients to prepare their food to their ability." She indicated the clients were capable of preparing food with assistance from staff.</p>	W000488	<p>W488 Dining Areas and Service This item outlines that the facility failed to encourage clients to assist in meal preparation. The plan of correction for this tag is as follows: All staff will complete training on meal preparation and service expectation highlighting that the consumers must all be engaged in this process at each meal to the maximum of their abilities. This training will occur on or before 12/25/2013. The Manager will discuss with staff weekly on aspects dining and meal prep assistance - that we are to help the consumer be independent as possible and not complete tasks for consumers if they are capable to do so. The manager will intially monitor each staff to assure that he/she is following the regulation. This will concur with verbal quizzing of the staff to assure that they have a full understanding of the regulation and what to do and what not to do.</p>	12/25/2013			

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