

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/25/2016
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330
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W 0000 Bldg. 00	<p>This visit was for a predetermined full annual recertification and state licensure survey.</p> <p>Dates of Survey: July 12, 13, 14 and 25, 2016.</p> <p>Facility Number: 012633 Provider Number: 15G805 AIMS Number: 201072030</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 8/4/16.</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 2 of 2 sampled clients (#1 and #2) and 3 additional clients (#3, #4 and #5), the governing body failed to exercise general policy and operating direction over the facility: __To ensure sufficient direct care staff were provided to monitor and supervise all clients (#1, #2, #3 and #4) in the home</p>	W 0104	<p>CORRECTION:</p> <p><i>The Governing body must exercise general policy, budget and operating direction over the facility. Specifically:</i></p> <p><i>The facility must develop and</i></p>	08/24/2016

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

TITLE

(X6) DATE

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

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	<p>and to be able to effectively implement client #1's BSP (Behavior Support Plan) to prevent client #1's recurring elopement and ensure client #1's safety.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse were thoroughly investigated for clients #3 and #5.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure sufficient direct care staff were provided to monitor and supervise all clients (#1, #2, #3 and #4) in the home and to be able to effectively implement client #1's BSP to prevent client #1's recurring elopement and ensure client #1's safety. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of client to client abuse were thoroughly investigated for clients #3 and #5. Please see W149. 2. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of client to client abuse were thoroughly investigated for clients #3 and 		<p><i>implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</i> Specifically, the governing body has facilitated the following:</p> <p>The facility has hired and completed initial training for three additional direct support staff and the staffing matrix has been modified to assure no less than four direct support staff will be on duty during waking hours and no less than two staff will be on duty during the overnight shift.</p> <p>All staff have been retrained towards proper implementation of Client #1's Behavior Support Plan including but not limited to prevention of elopement and the facility has hired and completed initial training for three additional direct support staff and the staffing matrix has been modified to assure no less than four direct support staff will be on duty during waking hours and no less than two staff will be on duty during the overnight shift.</p> <p>The Operations Team, including the Program Manager and QIDP,</p>		

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	<p>#5. Please see W154.</p> <p>4. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure sufficient direct care staff were provided to monitor and supervise all clients (#1, #2, #3 and #4) in the home and to be able to effectively implement client #1's BSP to prevent client #1's recurring elopement and ensure client #1's safety. Please see W186.</p> <p>9-3-1(a)</p>		<p>will directly oversee all investigations. All agency investigators will be retrained regarding the need to investigate mistreatment and exploitation of clients that allegedly occurs in the community away from the facility including but not limited to theft of personal possessions. The Program Manager will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next 90 days. Additionally administrative staff, including the Program Managers, Quality Assurance Manager and Quality Assurance Coordinator will attend the next Indiana State Department of Health Investigation Training session to re-familiarize themselves with investigation expectations. The QIDP will be retrained regarding components of a thorough investigation including but not limited to interviewing and collecting statements from all potential witnesses.</p> <p>PREVENTION:</p> <p>The Residential Manager will submit schedule revisions to the QIDP and Program Manager for approval prior to implementation.</p>	

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			<p>The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to proper implementation of behavior supports. Members of the Operations Team, comprised of the Program Managers, Nurse Manager and Executive Director, Quality Assurance Manager, Training Coordinator and Quality Assurance Coordinator, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than twice weekly for the next 30 days, and no less than weekly until all staff demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic</p>	

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			<p>skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making</p>	

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			<p>recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to proper implementation of behavior supports as well as assuring adequate staff are on duty at all times. Monitoring will also include spot checks facility staff schedules and electronic attendance records as well as on-site verification.</p> <p>The Quality Assurance Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of the Program Managers, Nurse Manager and Executive Director, Quality Assurance Manager, Training Coordinator and Quality Assurance Coordinator. The Program Manger (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all</p>	

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			<p>investigations that are open for their homes. QIDPs will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Program Managers will provide weekly updates to the Executive Director and Quality Assurance Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members. Additionally the Quality Assurance Manager will maintain receive and maintain electronic copies of all completed investigations, checking them for thoroughness and providing follow-up as</p>	

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W 0149 Bldg. 00	<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 observation, record review and interview for 1 of 2 sampled clients (#1 and #2) and 3 additional clients (#3, #4 and #5), the facility failed to provide sufficient direct care staff to monitor and supervise all clients in the home (clients #1, #2, #3 and #4) and to be able to effectively implement client #1's BSP (Behavior Support Plan) to ensure client #1's safety due to continued behaviors of elopement.</p> <p>The facility failed to ensure all allegations of client to client abuse were thoroughly investigated for clients #3 and #5.</p> <p>Findings include:</p> <p>The facility's policies and procedures were reviewed on 7/13/16 at 2 PM. The 9/14/07 facility policy entitled "Abuse,</p>	W 0149	<p>needed.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p><i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically, the governing body has facilitated the following:</i></p> <p>The facility has hired and completed initial training for three additional direct support staff and the staffing matrix has been modified to assure no less than four direct support staff will be on duty during waking hours and no less than two staff will be on duty during the overnight shift.</p> <p>All staff have been retrained</p>	08/24/2016

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	<p>Neglect, Exploitation" indicated:</p> <p>___ "Adept employees actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect and exploitation shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of Adept, Rescare, and local, state and federal guidelines."</p> <p>___ "Intimidation/emotional abuse: the act of failure to act that results or could result in emotional injury to an individual. The act of insulting or coarse language or gestures directed toward an individual that subject him/her to humiliation or degradation. Discouraging or inhibiting behavior by threatening both actual or implied. Attitude or acts that interfere with the psychological and social well being of an individual."</p> <p>___ "Emotional/physical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment."</p> <p>1. The facility failed to implement its policy and procedures to ensure all allegations of abuse/neglect and client to</p>		<p>towards proper implementation of Client #1's Behavior Support Plan including but not limited to prevention of elopement and the facility has hired and completed initial training for three additional direct support staff and the staffing matrix has been modified to assure no less than four direct support staff will be on duty during waking hours and no less than two staff will be on duty during the overnight shift.</p> <p>The Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. All agency investigators will be retrained regarding the need to investigate mistreatment and exploitation of clients that allegedly occurs in the community away from the facility including but not limited to theft of personal possessions. The Program Manager will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next 90 days. Additionally administrative staff, including the Program Managers, Quality Assurance Manager and Quality Assurance Coordinator will attend the next Indiana State Department of Health Investigation Training session to re-familiarize themselves with</p>	

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	<p>client altercations were thoroughly investigated for clients #3 and #5. Please see W154.</p> <p>2. The facility failed to implement its policy and procedures to ensure the facility provided sufficient direct care staff to monitor and supervise all clients in the home (clients #1, #2, #3 and #4) and to be able to effectively implement client #1's BSP to ensure client #1's safety due to continued behaviors of elopement. Please see W186.</p> <p>9-3-2(a)</p>		<p>investigation expectations. The QIDP will be retrained regarding components of a thorough investigation including but not limited to interviewing and collecting statements from all potential witnesses.</p> <p>PREVENTION:</p> <p>The Residential Manager will submit schedule revisions to the QIDP and Program Manager for approval prior to implementation.</p> <p>The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to proper implementation of behavior supports. Members of the Operations Team, comprised of the Program Managers, Nurse Manager and Executive Director, Quality Assurance Manager, Training Coordinator and Quality Assurance Coordinator, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than twice weekly for the next 30 days, and no less than weekly until all staff demonstrate</p>	

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			<p>competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p>	

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			<p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to proper implementation of behavior supports as well as assuring adequate staff are on duty at all times. Monitoring will also include spot checks facility staff schedules and electronic attendance records as well as on-site verification.</p> <p>The Quality Assurance Manager</p>	

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			will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of the Program Managers, Nurse Manager and Executive Director, Quality Assurance Manager, Training Coordinator and Quality Assurance Coordinator. The Program Manger (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. QIDPs will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could	

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W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 1 of 7 allegations of abuse/neglect and/or client to client abuse reviewed, the facility failed to conduct a thorough investigation for clients #3 and #5.	W 0154	potentially have occurred as a result of staff negligence. The Program Managers will provide weekly updates to the Executive Director and Quality Assurance Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members. Additionally the Quality Assurance Manager will maintain receive and maintain electronic copies of all completed investigations, checking them for thoroughness and providing follow-up as needed. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director CORRECTION: <i>The facility must have evidence that all alleged violations are thoroughly investigated.</i> Specifically: the Operations Team, including the Program	08/24/2016

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	<p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 7/12/16 at 1 PM. The 10/13/15 Bureau of Developmental Disabilities Services (BDDS) report indicated on 10/14/15 at 6 AM client #3 slapped client #5. The facility records indicated an incomplete investigative form. The investigative final report of the 10/13/15 incident indicated no interviews and/or statements from the staff and/or the clients.</p> <p>During interview with the Residential Manager (RM) on 7/13/16 at 1 PM, the RM indicated all allegations of abuse/neglect were to be thoroughly investigated.</p> <p>9-3-2(a)</p>		<p>Manager and QIDP, will directly oversee all investigations. All agency investigators will be retrained regarding the need to investigate mistreatment and exploitation of clients that allegedly occurs in the community away from the facility including but not limited to theft of personal possessions. The Program Manager will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next 90 days. Additionally administrative staff, including the Program Managers, Quality Assurance Manager and Quality Assurance Coordinator will attend the next Indiana State Department of Health Investigation Training session to re-familiarize themselves with investigation expectations. The QIDP will be retrained regarding components of a thorough investigation including but not limited to interviewing and collecting statements from all potential witnesses.</p> <p>PREVENTION:</p> <p>The Quality Assurance Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective</p>		

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			measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of the Program Managers, Nurse Manager and Executive Director, Quality Assurance Manager, Training Coordinator and Quality Assurance Coordinator. The Program Manger (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. QIDPs will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Program Managers will provide weekly updates to the Executive	

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W 0186 Bldg. 00	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to provide sufficient direct care staff to monitor and supervise all</p>	W 0186	<p>Director and Quality Assurance Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members. Additionally the Quality Assurance Manager will maintain receive and maintain electronic copies of all completed investigations, checking them for thoroughness and providing follow-up as needed.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team</p> <p>CORRECTION: <i>The facility must provide sufficient direct care staff to manage and supervise clients in</i></p>	08/24/2016

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	<p>clients in the home and to be able to effectively implement client #1's Behavior Support Plan (BSP) to prevent client #1's recurring elopement and to ensure client #1's safety.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/12/16 between 3:15 PM and 5:45 PM.</p> <p>__ There were three direct care staff and four male clients (#1, #2, #3 and #4).</p> <p>__ The group home was a single level brick home with four bedrooms, a dining room, two living/entertainment rooms and an attached garage.</p> <p>__ The home was located 0.2 miles (352 yards) from a major highway and the local police station.</p> <p>__ The back door opened onto a small patio/area with a tall privacy fence and a gate.</p> <p>__ There were alarmed egress doors in the dining room (the front door), the small living room (the side door), the large living room (the back door) and the garage door.</p> <p>__ There were alarms on all the windows in both living rooms, the dining room and in client #1 and #3's bedrooms. The alarms on both windows in the main living room and the alarm on the window near the back egress door in the smaller</p>		<p><i>accordance with their individual program plans.</i> Specifically, the facility has hired and completed initial training for three additional direct support staff and the staffing matrix has been modified to assure no less than four direct support staff will be on duty during waking hours and no less than two staff will be on duty during the overnight shift.</p> <p>PREVENTION:</p> <p>The Residential Manager will submit schedule revisions to the QIDP and Program Manager for approval prior to implementation.</p> <p>Members of the Operations Team (comprised of the Program Managers, Quality Assurance Manager, Quality Assurance Coordinator, Training Coordinator and Nurse Manger) will conduct administrative monitoring at the facility no less than twice weekly for the next 30 days, and after 30 days, will conduct administrative observations no less than weekly until supervisory staff demonstrate competence in staffing providing sufficient staff at all times. At the conclusion of this period of enhanced administrative monitoring and</p>	

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	<p>living room were turned off.</p> <p>__ Client #1 was a young male who was loud, in constant motion, fast on his feet and invasive of his peers' and the staffs' personal space.</p> <p>__ Client #2 was a tall active young male.</p> <p>__ Client #3 was an older male who had a slight forward lean and ambulated at a moderate pace.</p> <p>__ Client #4 was an older male who kept mostly to himself, sitting outside on the patio or the front porch, in the dining room, in the living room or in his bedroom. Client #4 did not participate in any leisure activities and required constant staff prompting to participate in any activity.</p> <p>__ Clients #1, #2, #3 and #4 required staff direction and assistance with leisure skills.</p> <p>__ One staff supervised client #1 and one staff supervised client #4.</p> <p>__ A staff did not remain within arm's reach of client #1 at all times.</p> <p>__ The staff did not position themselves between client #1 and the egress doors each time client #1 was having behaviors and/or running through the home.</p> <p>The facility's reportable and investigative records were reviewed on 7/12/16 at 1 PM.</p> <p>The 7/12/16 Incident/Accident report</p>		<p>support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Monitoring will include spot checks facility staff schedules and electronic attendance records as well as on-site verification.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p>				

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	<p>indicated on 7/12/16 at 7:50 AM client #1 ran out the front door, down the street and in front of a car. Staff followed client #1 and "brought (client #1) back to the house...."</p> <p>The 6/29/16 Bureau of Developmental Disabilities Services (BDDS) report indicated on 6/28/16 at 7:30 AM "[Client #1] was trying to run out the front door, when staff was blocking, [client #1] was able to break past staff and took off running down the road. Staff followed by keeping [client #1] in line of sight. [Client #1] saw a police officer and flagged them down. Staff then approached and the police officer offered to take [client #1] back to the group home. [Client #1] got in the police car and went back to group home."</p> <p>The 6/26/16 I/A report indicated at 6:30 PM client #1 ran out the front door. Client #1 got as far as the end of the driveway when the staff were able to talk client #1 back inside the house.</p> <p>The 6/19/16 BDDS report indicated on 6/18/16 at 8:30 PM the staff had asked client #1 if he wanted to go for a van ride to get a soda. "Staff didn't know that [client #1] had already had several pops that day." Staff offered client #1 other choices when client #1 became</p>			

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	<p>aggressive and "took off running and ran out the front door and down the road. Staff followed keeping him (client #1) in line of sight." Staff were able to verbally redirect client #1 back to the group home.</p> <p>The 5/27/16 BDDS report indicated on 5/26/16 at 7:10 AM client #1 ran to the back of the house and climbed out a window. Staff followed client #1 in a vehicle. When client #1 attempted to run across the main road, staff verbally redirected client #1 to get into the facility van. Client #1 got into the van and staff transported client #1 back to the group home.</p> <p>The 5/6/16 I/A report indicated on 5/6/16 at 6:07 PM client #1 ran out the back door and scratched his arm in the process. Client #1 was verbally prompted back into the house.</p> <p>The 4/21/16 BDDS report indicated on 4/20/16 at 7:55 PM client #1 became verbally and physically aggressive towards staff and was placed in a two person YSIS (You're Safe I'm Safe Hold). After being released from the hold client #1 calmed and began walking to the back door. The "staff followed remaining within an arm's length distance. [Client #1] then ran out the back door and gate. [Client #1] was verbally redirected back</p>			

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	<p>inside the house."</p> <p>The 3/24/16 BDDS report indicated on 3/23/16 at 6:36 PM client #1 was in his room when the staff heard the window alarm go off. The staff opened client #1's door to find client #1 was gone and had climbed out his window. One staff went out the front door and one staff went out the back door. The staff caught up with client #1 and redirected him back to the house.</p> <p>The 2/24/16 BDDS report indicated on 2/23/16 at 7 PM client #1 came out of the bathroom and ran out the back door to the road. Staff was able to verbally prompt client #1 back into the house.</p> <p>The 4/2/16 BDDS report indicated on 4/2/16 at 2:30 PM while staff were clocking out, client #3 went out the back door, out the back gate and toward a local general store. Client #3 got out of line of sight with the staff before the staff could catch up to him. The staff eventually caught up to him and talked client #3 into going back to the house.</p> <p>Review of the facility staff schedules for May, June and July 2016 on 7/13/16 at 2 PM indicated: __ Two staff were scheduled to work the first shift (6 AM to 2 PM) on June 5, 6,</p>			

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	<p>20, 21, 22, and 23, 2016.</p> <p>__ Two staff were scheduled to work the second shift (2 PM to 11 PM) on May 23, 25, 26, June 1, 27, 29, July 4, and 13, 2016.</p> <p>Client #1's record was reviewed on 7/13/16 at 1 PM.</p> <p>Client #1's revised 5/4/16 Behavior Support Plan (BSP) indicated client #1 had targeted behaviors of physical aggression, verbal aggression, property disruption/destruction, leaving his assigned area (elopement), false allegations or mistreatment, stealing and socially inappropriate behaviors.</p> <p>The BSP indicated "[Client #1] has a difficult time focusing for even short amounts of time and difficulty remaining still. He is almost always in motion in some way. [Client #1] has a history of self-injurious behaviors, physical aggression, verbal aggression, property disruption/destruction, threats to harm others, elopement, false allegations and socially offensive behavior which he will demonstrate at home or in the community. As a result of these behavioral issues, [client #1] has been relatively isolated from others and has not learned positive socialization and relationship skills. These behaviors</p>				

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	include: yelling, crying, cursing, throwing objects [(rocks, hammers, etc.)], hitting, kicking, hitting his head or hand on objects [(walls, floors, doors, windows)], intentional incontinence, refusing to follow rules, disregarding others personal space, making sexually inappropriate comments or gestures [(pulls down pants and exposes self)], making threats to kill or harm someone [(usually his mother)] and describing how. [Client #1] does not share attention with peers and will have an escalation in behaviors if he feels he is not receiving the attention from whom he wants to receive it. [Client #1] will also manipulate those around him by antagonizing and intimidating peers by insinuating himself into their activities or events [(sit on floor to block door, pound on doors or windows when staff are paying attention to peers and not him)]. [Client #1] lacks impulse control and does not appear to understand cause and effect and the consequence of his actions. He does not have a sense of limits and will attempt to use the entire bottle or container of anything he has in his hand. This includes food. He has a tendency to hoard items and limit others access to his room. He is at risk to harm himself and others in the kitchen and around appliances [(the stove, microwave, oven)], all sharps, chemicals, flammable devices or materials [(matches, lighters,			

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	<p>gasoline)] and tools and is at risk of exploitation and victimization in the community. He does not demonstrate safe pedestrian skills and may run to the road or traffic. [Client #1] will attempt to exit through a window or door and will follow staff exiting if not redirected. [Client #1] wants immediate gratification and will respond negatively to hearing the word 'no.' He will pick up items that are not his and put them in his pocket or may pull items from the trash to drink if it is a soda bottle. He is influenced by crime shows and will threaten to shoot others and make gun/shooting gestures with his hand. He requires consistent oversight, repetition and redirection in a structured, supportive and encouraging environment."</p> <p>__ "[Client #1] will have enhanced supervision - 1:1 (one staff to one client)/escort staffing [(defined as [client #1] in the same room as designated staff, in that staff's line of sight and within arm's length of that staff) during all waking hours. The purpose of the 1:1 staff is to provide uninterrupted observation of and intervention toward [client #1] to prevent him from running out of his house/building and into the street and protect him from harming himself or others. [Client #1] is that escort staff's only focus. When [client #1] moves, his escort staff must move with</p>			

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	<p>him, wherever he goes and be prepared to intervene as needed.</p> <p>If [client #1] attempts to go to a room with any mode of secondary egress (doors, windows) by himself, escort staff will go with him.</p> <p>If [client #1] attempts to block escort staff from coming with him, staff will utilize YSIS physical redirection to escort [client #1] away from the entry to staff may enter the room and can remain in arm's length of [client #1]</p> <p>The escort staff will walk slightly behind [client #1] and to the side closest to the nearest exit door or window and be close enough to physically intervene to prevent him from running out of the house/building and into the street, harming himself or others.</p> <p>The escort staff will position themselves between [client #1] and peers when walking or sitting at home in the community or in a vehicle and will be close enough to physically intervene to prevent him from hitting/being hit by others.</p> <p>Escort staff will physically block any attempts made by [client #1] to disable door/window alarms and will report attempts to the</p>			

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	<p>supervisor. During waking hours when [client #1] requires 1:1/escort staff, every staff scheduled on each shift will rotate through and provide direct oversight of [client #1] in 30 minute intervals. Staff will change out every 30 minutes and will sign in/out on a 1:1 staffing sheet."</p> <p>Client #2's record was reviewed on 7/13/16 at 3 PM. Client #2's revised 3/4/16 BSP indicated client #2 was a young male admitted to the facility on 12/4/15 with diagnoses of, but not all inclusive, Autism, Oppositional Defiance Disorder, Bipolar Disorder and Borderline Intellectual Functioning. The BSP indicated client #2 had targeted behaviors of suicide attempts, sexual inappropriateness, hyper-sexuality, physical and verbal aggression, property disruption/destruction, emotional manipulation and socially offensive behaviors and indicated client #2 "requires a structured environment with clear and consistent positive direction, visual and verbal prompts, constant repetition and minimal distractions where he can establish a routine."</p> <p>Client #3's record was reviewed on 7/13/16 at 4 PM. Client #3's record</p>				

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	<p>indicated client #3 had targeted behaviors of physical and verbal aggression, property disruption/destruction, leaving his assigned area (elopement), inappropriate touch and non-compliance with program tasks. The BSP indicated "Staff must keep [client #3] in line of sight when in common areas during all waking hours."</p> <p>Client #4's record was reviewed on 7/13/16 at 4 PM. Client #4's record indicated targeted behaviors of making paranoid statements, physical aggression, verbal aggression and non-compliance with health and safety issues.</p> <p>During interview with staff #4 on 7/13/16 at 6:30 AM, staff #4: __ Indicated clients #1 and #4 required one staff to be with them at all times due to behaviors of elopement. __ Stated, "We mostly have three staff and sometimes four but not very often." __ Stated "A few times we've only had two staff." __ Indicated the facility was in need of additional staff to monitor and supervise clients #1, #2, #3 and #4.</p> <p>During interview with staff #5 on 7/13/16 at 6:40 AM, staff #5: __ Indicated clients #1 and #3 had behaviors of elopement.</p>			

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	<p>__ Indicated one staff was assigned to client #1 and one staff had to keep an eye on client #3.</p> <p>__ Indicated since client #5 was discharged and client #2 was admitted in December of 2015 the facility had decreased the staffing levels and stated, "But it's not working. We need at least four to keep an eye on these guys especially [client #1]."</p> <p>__ Indicated the facility was to have four staff in the home when all four clients were home and awake and stated, "But that hasn't been the case the last few months. We've been working with three (staff) and a few times only two."</p> <p>__ Indicated the group home intersected on a busy highway and that was the direction client #1 "usually took" when he eloped.</p> <p>__ Stated client #1 knew the police department was at the end of the road and would often say he wanted to see the "Po Po" and would run in that direction.</p> <p>__ Indicated there was insufficient staff in the home to be able to adequately block client #1 from getting out of one of the four egress doors. Stated, "When we block him from getting out of one door, he takes off for another door."</p> <p>During interview with client #2 on 7/13/16 at 7 AM, client #2 stated, "Just a couple of days ago there were only two</p>			

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	<p>staff. I wanted to get a pop and I was told I couldn't because there wasn't enough staff. I was stunned. That's not safe because of the way [client #1] acts and somebody has to be with him all the time."</p> <p>During interview with the Residential Manager (RM) on 7/13/16 at 3 PM, the RM:</p> <p>__ Indicated a staff was to be within arm's length of client #1 during all waking hours due to frequent elopements.</p> <p>__ Indicated the staff were to position themselves between client #1 and the nearest egress door and the other staff should be assisting and/or ready to block client #1 also if needed.</p> <p>__ Indicated there were to be four staff in the home at all times and stated, "But we have been working pretty much with three."</p> <p>__ Indicated there had been a few times the facility worked with only two staff in the home.</p> <p>__ Indicated she was not on the staffing schedule but was expected to be in the home every day.</p> <p>__ Indicated she was often pulled out of the home to fulfill other obligations of her position.</p> <p>__ Indicated client #1 was too fast for most of her staff to keep up with.</p> <p>__ Indicated the facility had considered</p>			

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W 0249 Bldg. 00	<p>putting up a fence in the front yard to "Slow him (client #1) down some."</p> <p>During interview with the Program Manager (PM) on 7/14/16 at 2 PM, the PM indicated there were to be four staff in the home when the clients were home and awake.</p> <p>9-3-3(a)</p> <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 on observation, record review and interview for 1 of 2 sampled clients (client #1), the facility failed to ensure the staff followed and implemented client #1's Behavior Support Plan (BSP) in regard to preventing client #1 from leaving the home unsupervised.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/12/16 between 3:15 PM</p>	W 0249	<p>CORRECTION:</p> <p><i>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Specifically, all staff have</i></p>	08/24/2016

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	<p>and 5:45 PM.</p> <p>__The group home was a single level brick home with four alarmed egress doors and alarms on all the windows in both living rooms, the dining room and in client #1's bedroom.</p> <p>__The alarms on both windows in the main living room and the alarm on the window near the back egress door in the smaller living room were turned off.</p> <p>__Client #1 was a young male who was loud, in constant motion, fast on his feet and invasive of his peers' and the staffs' personal space.</p> <p>__Client #1 ran past staff several times while his 1:1 staff (one staff to one client supervision) walked slowly behind him.</p> <p>__A staff did not remain within arm's reach of client #1 at all times during this observation period.</p> <p>__The staff did not position themselves between client #1 and the egress doors each time client #1 was having behaviors and/or running through the home.</p> <p>The facility's reportable records were reviewed on 7/12/16 at 1 PM. The records indicated client #1 had evaded the staff and left the home without permission on 2/23/16, 3/23/16, 4/20/16, 5/6/16, 5/26/16, 6/18/16, 6/26/16, 6/28/16 and 7/12/16.</p> <p>Client #1's record was reviewed on</p>		<p>been retrained towards proper implementation of Client #1's Behavior Support Plan including but not limited to prevention of elopement and the facility has hired and completed initial training for three additional direct support staff and the staffing matrix has been modified to assure no less than four direct support staff will be on duty during waking hours and no less than two staff will be on duty during the overnight shift.</p> <p>PREVENTION:</p> <p>The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to proper implementation of behavior supports. Members of the Operations Team, comprised of the Program Managers, Nurse Manager and Executive Director, Quality Assurance Manager, Training Coordinator and Quality Assurance Coordinator, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than twice weekly for the next 30 days, and no less than weekly until all staff demonstrate</p>				

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	<p>7/13/16 at 1 PM.</p> <p>Client #1's revised 5/4/16 Behavior Support Plan (BSP) indicated client #1 had a targeted behavior of leaving his assigned area (elopement).</p> <p>The BSP indicated "[Client #1] has a difficult time focusing for even short amounts of time and difficulty remaining still. He is almost always in motion in some way. [Client #1] has a history of self-injurious behaviors, physical aggression, verbal aggression, property disruption/destruction, threats to harm others, elopement, false allegations and socially offensive behavior which he will demonstrate at home or in the community. As a result of these behavioral issues, [client #1] has been relatively isolated from others and has not learned positive socialization and relationship skills. These behaviors include: yelling, crying, cursing, throwing objects [(rocks, hammers, etc.)], hitting, kicking, hitting his head or hand on objects [(walls, floors, doors, windows)], intentional incontinence, refusing to follow rules, disregarding others personal space, making sexually inappropriate comments or gestures [(pulls down pants and exposes self)], making threats to kill or harm someone [(usually his mother)] and describing how. [Client #1] does not</p>		<p>competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p>		

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	<p>share attention with peers and will have an escalation in behaviors if he feels he is not receiving the attention from whom he wants to receive it. [Client #1] will also manipulate those around him by antagonizing and intimidating peers by insinuating himself into their activities or events [(sit on floor to block door, pound on doors or windows when staff are paying attention to peers and not him)]. [Client #1] lacks impulse control and does not appear to understand cause and effect and the consequence of his actions. He does not have a sense of limits and will attempt to use the entire bottle or container of anything he has in his hand. This includes food. He has a tendency to hoard items and limit others access to his room. He is at risk to harm himself and others in the kitchen and around appliances [(the stove, microwave, oven)], all sharps, chemicals, flammable devices or materials [(matches, lighters, gasoline)] and tools and is at risk of exploitation and victimization in the community. He does not demonstrate safe pedestrian skills and may run to the road or traffic. [Client #1] will attempt to exit through a window or door and will follow staff exiting if not redirected. [Client #1] wants immediate gratification and will respond negatively to hearing the word 'no.' He will pick up items that are not his and put them in his pocket or</p>		<p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to proper implementation of behavior supports.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team</p>	

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	<p>may pull items from the trash to drink if it is a soda bottle. He is influenced by crime shows and will threaten to shoot others and make gun/shooting gestures with his hand. He requires consistent oversight, repetition and redirection in a structured, supportive and encouraging environment."</p> <p>__ "[Client #1] will have enhanced supervision - 1:1 (one staff to one client)/escort staffing [(defined as [client #1] in the same room as designated staff, in that staff's line of sight and within arm's length of that staff) during all waking hours. The purpose of the 1:1 staff is to provide uninterrupted observation of and intervention toward [client #1] to prevent him from running out of his house/building and into the street and protect him from harming himself or others. [Client #1] is that escort staff's only focus. When [client #1] moves, his escort staff must move with him, wherever he goes and be prepared to intervene as needed.</p> <p>If [client #1] attempts to go to a room with any mode of secondary egress (doors, windows) by himself, escort staff will go with him.</p> <p>If [client #1] attempts to block escort staff from coming with him, staff will utilize YSIS physical redirection to escort [client #1]</p>			

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	<p>away from the entry to staff may enter the room and can remain in arm's length of [client #1]</p> <p>The escort staff will walk slightly behind [client #1] and to the side closest to the nearest exit door or window and be close enough to physically intervene to prevent him from running out of the house/building and into the street, harming himself or others.</p> <p>The escort staff will position themselves between [client #1] and peers when walking or sitting at home in the community or in a vehicle and will be close enough to physically intervene to prevent him from hitting/being hit by others.</p> <p>Escort staff will physically block any attempts made by [client #1] to disable door/window alarms and will report attempts to the supervisor.</p> <p>During waking hours when [client #1] requires 1:1/escort staff, every staff scheduled on each shift will rotate through and provide direct oversight of [client #1] in 30 minute intervals. Staff will change out every 30 minutes and will sign in/out on a 1:1 staffing sheet."</p>			

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	<p>During interview with staff #3 on 7/12/16 at 3:15 PM, staff #3:</p> <p>__ Indicated he was not aware the window alarms had been turned off.</p> <p>__ Indicated client #1 was quick and difficult to keep up with.</p> <p>__ Indicated client #1 would sometimes turn the alarms off and/or disable the alarms.</p> <p>__ Indicated he was not sure how or why the alarms were off because the staff assigned to client #1 should have seen client #1 turning the alarms off and corrected it as soon as they saw it.</p> <p>__ Indicated he was not able to keep up with and/or out run client #1.</p> <p>During interview with staff #4 on 7/13/16 at 6:30 AM, staff #4:</p> <p>__ Indicated one staff was to be within arm's reach of client #1 at all times due to behaviors of elopement.</p> <p>__ Stated, "He's (client #1) really fast. It's hard to keep up with him."</p> <p>__ Indicated the staff are to block client #1 when headed for an egress door.</p> <p>__ Indicated client #1 had pushed through staff blocking and gotten outside anyway.</p> <p>During interview with staff #5 on 7/13/16 at 6:40 AM, staff #5:</p> <p>__ Stated the staff could not take their eyes off of client #1 because he would dart out of the home in the "bat of an</p>			

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	<p>eye." ___ Indicated client #1 was fast and it was difficult for him to keep up with client #1. ___ Stated client #1 knew the police department was at the end of the road and would often say he wanted to see the "Po Po" and would run in that direction. ___ Indicated the group home intersected on a busy highway and that was the direction client #1 "usually took" when he eloped. ___ Indicated clients #1 and #3 had behaviors of elopement. ___ Indicated one staff was assigned to client #1 and one staff had to keep an eye on client #3.</p> <p>During interview with the Residential Manager (RM) on 7/13/16 at 3 PM, the RM: ___ Indicated a staff was to be within arm's length of client #1 during all waking hours due to frequent elopements. ___ Indicated if client #1 was in a room with an egress door, the staff were to position themselves between the door and client #1 to prevent client #1 from getting to and/or out of the door. ___ Indicated client #1 would often turn off and/or disable the alarms. ___ Indicated because client #1 had a 1:1 staff at all times while awake, the staff should always know if the alarms were</p>			

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W 0331 Bldg. 00	<p>on or off and ensure the alarms were always working.</p> <p>__ When asked how client #1 could turn the alarms off without the staff knowing, the RM stated, "That's a good question."</p> <p>__ Indicated client #1 was quick and could get past many of the staff in the home without much difficulty.</p> <p>__ Indicated some of the staff in the home were larger individuals and it was difficult for them to chase after client #1.</p> <p>__ Indicated client #1 was too fast for most of her staff and stated, "Except for a few of the younger staff."</p> <p>__ Stated the facility had considered putting up a fence in the front yard to "Slow him (client #1) down some."</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 additional client (#3), the facility's nursing services failed to ensure the facility staff followed the Core A and B Medication Administration Manual.</p> <p>Findings include:</p> <p>Observations were conducted at the</p>	W 0331	<p>CORRECTION:</p> <p><i>The facility must provide clients with nursing services in accordance with their needs. Specifically: the facility nurse will retrain all staff regarding the fact that the employee who prepares medication for administration must be the person who actually</i></p>	08/24/2016

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	<p>group home on 7/12/16 between 3:15 PM and 5:45 PM. At 4:30 PM staff #1 entered the medication room and popped a 500 mg (milligram) tablet of Depakote into a paper soufflé cup that was sitting on the counter in the medication room. Staff #1 then left the medication room to prompt client #3 to come to the medication room to take his medication. Client #3 refused. Staff #1 stated, "He doesn't like taking his medication from me for some reason." After another refusal, staff #1 asked staff #3 if he would give client #3 his PM medication. Staff #1 left the medication room and went to the kitchen. Staff #3 prompted client #3 to come to the medication room and client #3 agreed. Staff #3 and client #3 entered the medication room. Staff #3 picked up the soufflé cup sitting on the counter in the medication room and handed it to client #3. Client #3 took the medication.</p> <p>During interview with staff #3 on 7/12/16 at 4:40 PM, staff #3 stated, "He (client #3) wasn't going to take it from her (staff #1) that's why I gave it." Staff #3 was asked if staff were to give a medication prepared by another staff. Staff #3 stated, "No, I guess I shouldn't have given it."</p> <p>During interview with the Qualified Intellectual Disabilities Professional</p>		<p>administers it.</p> <p>PERVENTION: The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts and the facility nurse will be present at the facility as needed but no less than weekly to assist with and monitor staff actions including but not limited to administration of medication per established procedures. Members of the Operations Team, comprised of the Program Managers, Nurse Manager and Executive Director, Quality Assurance Manager, Training Coordinator and Quality Assurance Coordinator, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than twice weekly for the next 30 days, and no less than weekly until all staff demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p>		

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	<p>(QIDP) on 7/12/16 at 4:45 PM, the QIDP: ___ Indicated the facility followed the Core A and B Medication Administration Manual. ___ Indicated staff were not to give a medication that they did not prepare themselves. ___ Indicated staff #3 should have discarded the medication prepared by staff #1 if staff #1 was not going to be present when the client took the medication.</p> <p>Review of the 2004 "Living in the Community Medication Administration Manual" on 7/12/16 at 7 PM indicated "Principles of administering medications.... Medication must be given by the person who pours it."</p> <p>9-3-6(a)</p>		<p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p>	

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330
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W 0382 Bldg. 00	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 2 of 2 sampled clients (#1 and #2) and 2 additional clients (#3 and #4), the facility failed to ensure the clients' medications/treatments were secured at all times.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/12/16 between 3:15 PM</p>	W 0382	<p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff administer medication per established procedures.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p> <p>CORRECTION:</p> <p><i>The facility must keep all drugs and biologicals locked except when being prepared for administration. Specifically, all staff have been retrained to assure that medication is secured at all times</i></p>	08/24/2016

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	<p>and 5:45 PM. At 4:30 PM staff #1 entered the locked medication room where client #1, #2, #3 and #4's medications were stored. Staff #1 popped a 500 mg (milligram) tablet of Depakote into a paper soufflé cup that was sitting on the counter in the medication room and then left the medication room to prompt client #3 to come to the medication room to take his medications. Staff #1 did not close and/or secure the medication room door upon leaving the medication room.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 7/12/16 at 4:45 PM, the QIDP: ___ Indicated he had witnessed staff #1 leaving the medication room to get client #3 for his PM medication. ___ Indicated staff #1 should not have left the medication room door open and/or unlocked. ___ Indicated the medication room door was to be closed and locked whenever staff were not in the medication room.</p> <p>9-3-6(a)</p>		<p>PREVENTION:</p> <p>The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts and the facility nurse will be present at the facility as needed but no less than weekly to assist with and monitor staff actions including but not limited to assuring medications are secured at all times. Members of the Operations Team, comprised of the Program Managers, Nurse Manager and Executive Director, Quality Assurance Manager, Training Coordinator and Quality Assurance Coordinator, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than twice weekly for the next 30 days, and no less than weekly until all staff demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport</p>		

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			<p>and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional</p>	

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			<p>Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring medications are secured at all times.</p> <p>RESPONSIBLE PARTIES: Health Services Team, Residential Manager, Direct Support Staff, QIDP, Operations Team</p>		