

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2015
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NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362
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W 000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 2/9, 2/10, 2/11, 2/12, 2/13, 2/16, 2/17, 2/18, and 2/19/2015.</p> <p>Provider Number: 15G735 Facility Number: 005553 AIM Number: 200854080</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/26/15 by Ruth Shackelford, QIDP.</p>	W 000		
W 104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the governing body failed to exercise operating direction over the facility to</p>	W 104	<p>W104 Governing Body and Management The governing body must exercise general policy, budget and operating direction over the facility. 1. What corrective action will be accomplished? · Area Director arranged carpet replacement. ·</p>	03/21/2015

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

TITLE

(X6) DATE

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

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	<p>complete maintenance and repairs for client #1, #2, #3, #4, #5, #6, and #7's group home.</p> <p>Findings include:</p> <p>On 2/9/15 from 3:35pm until 6:00pm, and on 2/10/15 from 5:57am until 8:05am, observation and interview were conducted at the group home. During both observation periods clients #1, #2, #3, #4, #5, #6, and #7 walked and/or accessed each room throughout the group home independently. During both observation periods clients #1, #2, #3, #4, #5, #6, and #7's living room carpet was stained and worn. On 2/9/15 at 4:10pm, the Residential Manager (RM) stated the living room carpeted area was "13' by 15' (thirteen feet by fifteen feet), was stained and worn with black marks, had a one foot tear, and discolorations throughout" the carpeted area. The RM stated 1 of 3 living room walls had black marks on the wall and "a two foot by two foot (2' by 2') area on the wall damaged by client #7's rocking motion when he sat on the floor against the wall. The RM indicated the carpet was cleaned "about 2 weeks ago" and had black marks and "was worn."</p> <p>On 2/12/15 at 11:30am, an interview was conducted with the QIDP (Qualified</p>		<p>Regional Director has arranged for work to be completed on the bathroom and walls with private contractor and company maintenance personnel. · Home Manager will report they the repairs are complete. · Home Manager will monitor home for obvious repairs needed and report them to maintenance personnel and Program Director. · Program Director will ensure repairs are completed. 2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the same deficient practice. · Area Director arranged carpet replacement. · Regional Director has arranged for work to be completed on the bathroom and walls with private contractor and company maintenance personnel. · Home Manager will report they the repairs are complete. · Home Manager will monitor home for obvious repairs needed and report them to maintenance personnel and Program Director. · Program Director will ensure repairs are completed. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · Home Manager will monitor home for obvious repairs needed and report them to</p>	

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W 149 Bldg. 00	<p>Intellectual Disabilities Professional). The QIDP indicated no further information was available for review.</p> <p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 6 of 29 BDDS (Bureau of Developmental Disabilities Services) reports for two incidents of client #5's AWOL (Absent Without Leave) behaviors and for 4 of 4 allegations of neglect (for clients #1, #2, #3, #4, #5, #6, and #7), the facility neglected to implement their Abuse/Neglect/Mistreatment policy to complete thorough investigations, implement sufficient corrective actions, and ensure staff supervision based on identified client needs.</p> <p>Findings include:</p>	W 149	<p>maintenance personnel and Program Director. · Program Director will ensure repairs are completed. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? · Home Manager will monitor home for obvious repairs needed and report them to maintenance personnel and Program Director. · Program Director will ensure repairs are completed. 5. What is the date by which the systemic changes will be completed? 3/21/15</p> <p>W149 Staff Treatment of Clients The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · All Direct Service Professionals, Home Manager and Program Director, in the home, will be retrained on Suspected Abuse, Neglect and Exploitation Reporting Policy. · All suspected incidents of ANE will be reported to Home Manager and Program Director, immediately upon knowledge. · Program Director will report 	03/21/2015	

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	<p>1. On 2/9/15 at 1:20pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports, non reportable incident reports, and investigations were reviewed and included the following for client #5:</p> <p>-A 1/6/15 BDDS report for an incident on 1/6/15 at 6:30am, indicated client #5 "went AWOL (Absent Without Leave). [GHS (Group Home Staff) #6] said that [client #5] was saying that she wants to go to [name of workshop] then while [GHS #6] was assisting another consumer, [client #5] walked out of the house." The report indicated the staff called the Residential Manager (RM), who drove to the group home, and located client #5 "very close to the house and brought her home. [Client #5] was AWOL for 10 minutes." The report indicated "staff was able to watch [client #5] and keep their eye on her until the [RM] arrived to bring [client #5] home." The 1/6/15 "Incident Management Quality Assurance Review" indicated the same information. The 1/6/15 "Investigative Summary" indicated the same information as the BDDS report, indicated paraphrased witness statements by one staff person, client #5, and the RM. The investigation did not include the number of staff on duty in the group home at the time of the AWOL, did not</p>		<p>suspected incidents of ANE to BDDS and APS, per state law and investigate per Mentor policy.</p> <ul style="list-style-type: none"> Area Director will monitor compliance with reporting and investigation policy. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the same deficient practice. All Direct Service Professionals, Home Manager and Program Director, in the home, will be retrained on Suspected Abuse, Neglect and Exploitation Reporting Policy. All suspected incidents of ANE will be reported to Home Manager and Program Director, immediately upon knowledge. Program Director will report suspected incidents of ANE to BDDS and APS, per state law and investigate per Mentor policy Area Director will monitor compliance with reporting and investigation policy. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> Program Director will report suspected incidents of ANE to BDDS 	

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	<p>include questions asked during the investigation, and did not include specific guidelines to prevent client #5's AWOL. GHS #6's "Interview" indicated he "stated that he was told by another consumer that [client #5] started walking." The investigation indicated client #5's statement "she missed her friends and wanted to work at [name of contracted workshop]." The "Investigative Summary" indicated the staff working with client #5 were notified of the AWOL incident, the procedure of AWOL, and "reminded of [client #5's] risk plan. Staff are to keep a watch on [client #5] and redirect her when AWOL may be occurring." The investigation summary did not include other interviews were attempted with other clients living in the group home and did not include other staff members who were present in the group home.</p> <p>-A 12/5/14 BDDS report for an incident on 12/5/14 at 12:00pm at the contracted workshop and reported by the contracted workshop indicated client #5 "became upset...When [client #5's] work trainer (supervisor) did not see her in the lunch room, she came to the front office area to look for her. [Client #5] was not in the front office area." The report indicated the work coordinator went "outside" to locate client #5. The report indicated</p>		<p>and APS, per state law and investigate per Mentor policy</p> <ul style="list-style-type: none"> · Area Director will monitor compliance with reporting and investigation policy. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Program Director will report suspected incidents of ANE to BDDS and APS, per state law and investigate per Mentor policy · Area Director will monitor compliance with reporting and investigation policy. <p>5. What is the date by which the systemic changes will be completed?</p> <p>3/21/15</p>				

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	<p>"other clients reported" that client #5 left through the back door of the workshop. The workshop coordinator located client #5 walking alone "in the rain along side the road." The report indicated client #5 and the workshop coordinator took shelter out of the rain under a canopy of a business down the street from the workshop building until returning to the workshop. The report indicated client #5 "was only out of sight a few minutes until she was located." The agency 12/5/14 "Incident Report" indicated "see BDDS report" and "Follow BSP." No "Investigative Summary," no witness statements, no review of client #5's plans, and no interviews were available for review.</p> <p>On 2/12/15 at 10:45am, client #5's record was reviewed. Client #5's 2/25/14 ISP (Individual Support Plan), 11/15/14 BSP (Behavior Support Plan), and 2/24/14 "Individual Plan of Protective Oversight" indicated client #5's targeted behavior included AWOL (Absent Without Leave). Client #5's "Individual Plan of Protective Oversight" indicated "Behavior Needs: Yes...Targeted behaviors addressed: Impulse Control Disorder, Physical Aggression, Verbal Aggression, Tantrums, Disrupting Activities of others, Property Destruction, Resist Supervision, AWOL, Suicidal</p>			

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	<p>Ideation, Once tried to jump out of a moving vehicle...last updated: 9/3/14 Residential Information...[Client #5] has a long history of going AWOL. [Client #5] needs close supervision. She has no pedestrian safety skills."</p> <p>On 2/12/15 at 11:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #5 should be supervised by the staff during waking hours. The QIDP indicated staff should know where client #5 was and indicated staff did not know where client #5 was when she continued to leave AWOL. The QIDP indicated the completed investigations were attached to the BDDS reports for client #5. The QIDP indicated there were no questions asked, narrative witness statements, results of the investigations, interviews attempted with the other six clients living in the group home, and recommendations available for review. The QIDP indicated client #5's AWOL incident information reviewed regarding staff ratios, client #5's plans, and effective corrective action were not available for review.</p> <p>2. On 2/9/15 at 1:20pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports, non reportable incident reports, and</p>			

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	<p>investigations were reviewed and included the following for clients #1, #2, #3, #4, #5, #6, and #7:</p> <p>-An 8/18/14 BDDS report for an incident on 8/17/14 at 2:20pm indicated "A staff reported" to the RM that "another staff was asleep while on shift." The report indicated an investigation had begun and the staff was suspended. No investigation, witness statements, staff ratios, or corrective action were available for review. No documentation was available for review on why staff waited to report the allegation until 2:20pm on 8/17/14.</p> <p>-A 7/20/14 BDDS report for an incident on 7/19/14 at 4:15am indicated a staff called the RM to report that "another staff on shift with her had fallen asleep. The [RM] went to the home and it appeared the staff was sleeping. The staff that was said to be sleeping was immediately suspended." The report indicated an investigation "was underway" into the allegation. No investigation, witness statements, staff ratios, or corrective action were available for review.</p> <p>-A 5/14/14 BDDS report for an incident on 5/13/14 indicated "A staff alleged that another staff was sleeping while on shift." The report indicated an</p>			

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	<p>investigation had begun. No investigation, witness statements, staff ratios, or corrective action were available for review.</p> <p>-A 5/19/14 Follow Up BDDS report for an incident on 5/13/14 at 7:00am indicated "A staff alleged that another staff was sleeping while on shift. The investigation was able to substantiate that the staff that was alleged to be sleeping was not sleeping. There was a miscommunication between the home manager and a staff that had called regarding another situation. The home manager will be retrained on what to do if she is not understanding fully something that is reported to her and all staff will be retrained on reporting an incident to the home manager." No investigation, witness statements, staff ratios, or corrective action were available for review. No staff training or retraining was available for review.</p> <p>-A 4/17/14 BDDS report for an incident on 4/17/14 at 3:30am indicated "It was reported by the second midnight staff on 4/17/14 that the other staff fell asleep while working his shift. There was another staff at the home with the residents." No investigation, witness statements, staff ratios, or corrective action were available for review.</p>			

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	<p>-A 4/28/14 BDDS follow up report indicated "There were two staff on shift at [name] group home. One staff reported that the other staff had fallen asleep while on shift. The staff was suspended as indicated on the initial BDDS report. The investigation was unable to substantiate that staff was asleep during his shift on 4/17/14. Staff will undergo training on the supervision level of all clients and be re trained on the responsibilities of [a staff] and go over the policy where they are not to sleep on shift."</p> <p>On 2/9/15 at 1:20pm, on 2/9/15 at 3:35pm, on 2/10/15 at 8:40am, on 2/10/15 at 11:30am, on 2/11/15 at 8:05am, and on 2/12/15 at 11:30am, the facility's investigations were requested from the Residential Manager, the QIDP, and the Area Director (AD). No investigations for the 8/17/14, 7/19/14, 5/13/14, and 4/17/14 allegations of staff sleeping while on duty were provided for review.</p> <p>On 2/10/15 at 10:45am, an interview was conducted with the QIDP and the Area Director (AD). The QIDP and AD both indicated the facility followed the BDDS reporting and investigating policy and procedure. The QIDP indicated no</p>			

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	<p>investigations were available for review for client #1, #2, #3, #4, #5, #6, and #7's allegations of neglect when staff alleged that the other staff on duty was sleeping on 8/17/14, 7/19/14, 5/13/14, and 4/17/14. The QIDP and the AD both indicated clients #1, #2, #3, #4, #5, #6, and #7 required staff supervision at the group home. The QIDP indicated two (2) staff were scheduled at the group home for the overnight hours based on identified client needs. The QIDP indicated no investigations, no witness statements, no administrative oversight monitoring of the facility staff during working hours, and no documented corrective actions were available for review. The QIDP indicated no further information was available for review.</p> <p>On 2/19/15 at 11:15am, an interview was conducted with the AD and QIDP. Both provided "Investigative Summary(s)" for the 8/17/14, 7/19/14, and 4/18/14 allegations of staff sleeping on duty. The investigative summaries did not include individual witness statements, completed client interviews, questions asked during the investigations, administrative oversight monitoring, and recommendations for corrective actions available for review.</p> <p>On 2/9/15 at 2:00pm, a record review</p>			

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W 154 Bldg. 00	<p>was conducted of the 6/11/2002 BDDS "Incident Reporting" policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...."</p> <p>On 2/9/15 at 3:00pm, a record review was conducted of the facility's 4/2011 policy and procedure "Suspected Abuse, Neglect, & Exploitation Reporting." The policy and procedure indicated the agency prohibited abuse, neglect, and/or mistreatment and all employees are responsible to immediately report incidents of abuse, neglect, and/or mistreatment. The policy and procedure indicated "Neglect: the failure to provide the proper care for a resident/consumer, in a timely manner, causing the resident/consumer undue physical or emotional stress or injury; unreasonable delays in providing appropriate services...."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, for 6 of 29 BDDS (Bureau of</p>	W 154	<p>W154 Staff Treatment of Clients The facility must ensure that all alleged violations are thoroughly</p>	03/21/2015

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	<p>Developmental Disabilities Services) reports for two incidents of client #5's AWOL (Absent Without Leave) behaviors and for 4 of 4 allegations of neglect (for clients #1, #2, #3, #4, #5, #6, and #7), the facility failed to complete thorough investigations of allegations of neglect.</p> <p>Findings include:</p> <p>1. On 2/9/15 at 1:20pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports, non reportable incident reports, and investigations were reviewed and included the following for client #5:</p> <p>-A 1/6/15 BDDS report for an incident on 1/6/15 at 6:30am, indicated client #5 "went AWOL (Absent Without Leave). [GHS (Group Home Staff) #6] said that [client #5] was saying that she wants to go to [name of workshop] then while [GHS #6] was assisting another consumer, [client #5] walked out of the house." The report indicated the staff called the Residential Manager (RM), who drove to the group home, and located client #5 "very close to the house and brought her home. [Client #5] was AWOL for 10 minutes." The report indicated "staff was able to watch [client #5] and keep their eye on her until the</p>		<p>investigated.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · All staff will be retrained on protocol for reporting client abuse, neglect or injuries of unknown origin. · Staff will notify Home Manager of any incidents. · Home Manager will notify Program Director of any incidents. · Program Director will report all incidents to BDDS and APS, per state law. · Program Director will investigate and report findings, per policy and state law. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · All staff will be retrained on protocol for reporting client abuse, neglect or injuries of unknown origin. · Staff will notify Home Manager of any incidents. · Home Manager will notify Program Director of any incidents. · Program Director will report all incidents to BDDS and APS, per state law. 	

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NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362		
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	<p>[RM] arrived to bring [client #5] home." The 1/6/15 "Incident Management Quality Assurance Review" indicated the same information. The 1/6/15 "Investigative Summary" indicated the same information as the BDDS report, indicated paraphrased witness statements by one staff person, client #5, and the RM. The investigation did not include the number of staff on duty in the group home at the time of the AWOL, did not include questions asked during the investigation, and did not include specific guidelines to prevent client #5's AWOL. GHS #6's "Interview" indicated he "stated that he was told by another consumer that [client #5] started walking." The investigation did not indicate interviews with the other six (6) clients living in the group home. The investigation indicated client #5's statement "she missed her friends and wanted to work at [name of contracted workshop]." The "Investigative Summary" indicated the staff working with client #5 were notified of the AWOL incident, the procedure of AWOL, and "reminded of [client #5's] risk plan. Staff are to keep a watch on [client #5] and redirect her when AWOL may be occurring."</p> <p>-A 12/5/14 BDDS report for an incident on 12/5/14 at 12:00pm at the contracted workshop and reported by the contracted</p>		<ul style="list-style-type: none"> · Program Director will investigate and report findings, per policy and state law. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · All staff will be retrained on protocol for reporting client abuse, neglect or injuries of unknown origin. · Staff will notify Home Manager of any incidents. · Home Manager will notify Program Director of any incidents. · Program Director will report all incidents to BDDS and APS, per state law. · Program Director will investigate and report findings, per policy and state law. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Staff will notify Home Manager of any incidents. · Home Manager will notify Program Director of any incidents. · Program Director will report all incidents to BDDS and APS, per state law. · Program Director will investigate and report findings, per policy and state law. <p>5. What is the date by which the systemic changes will be</p>		

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	<p>workshop indicated client #5 "became upset...When [client #5's] work trainer (supervisor) did not see her in the lunch room, she came to the front office area to look for her. [Client #5] was not in the front office area." The report indicated the work coordinator went "outside" to locate client #5. The report indicated "other clients reported" that client #5 left through the back door of the workshop. The workshop coordinator located client #5 walking alone "in the rain along side the road." The report indicated client #5 and the workshop coordinator took shelter out of the rain under a canopy of a business down the street from the workshop building until returning to the workshop. The report indicated client #5 "was only out of sight a few minutes until she was located." The agency 12/5/14 "Incident Report" indicated "see BDDS report" and "Follow BSP." No "Investigative Summary," no witness statements, no review of client #5's plans, and no interviews were available for review.</p> <p>On 2/12/15 at 10:45am, client #5's record was reviewed. Client #5's 2/25/14 ISP (Individual Support Plan), 11/15/14 BSP (Behavior Support Plan), and 2/24/14 "Individual Plan of Protective Oversight" indicated client #5's targeted behavior included AWOL (Absent Without Leave)</p>		<p>completed? 3/21/15</p>	

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	<p>behaviors. Client #5's "Individual Plan of Protective Oversight" indicated "Behavior Needs: Yes...Targeted behaviors addressed: Impulse Control Disorder, Physical Aggression, Verbal Aggression, Tantrums, Disrupting Activities of others, Property Destruction, Resist Supervision, AWOL, Suicidal Ideation, Once tried to jump out of a moving vehicle...last updated: 9/3/14 Residential Information...[Client #5] has a long history of going AWOL. [Client #5] needs close supervision. She has no pedestrian safety skills."</p> <p>On 2/12/15 at 11:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the completed investigations were attached to the BDDS reports for client #5. The QIDP indicated there were no questions asked, narrative witness statements, results of the investigations, and recommendations available for review. The QIDP indicated client #5's AWOL incident information reviewed regarding staff ratios, and client #5's plans were not available for review.</p> <p>2. On 2/9/15 at 1:20pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports, non reportable incident reports, and investigations were reviewed and</p>			

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	<p>included the following for clients #1, #2, #3, #4, #5, #6, and #7:</p> <p>-An 8/18/14 BDDS report for an incident on 8/17/14 at 2:20pm indicated "A staff reported" to the RM that "another staff was asleep while on shift." The report indicated an investigation had begun and the staff was suspended. No investigation, witness statements, and staff ratios were available for review. No documentation was available for review for why staff waited to report the allegation until 2:20pm on 8/17/14.</p> <p>-A 7/20/14 BDDS report for an incident on 7/19/14 at 4:15am indicated a staff called the RM to report that "another staff on shift with her had fallen asleep. The [RM] went to the home and it appeared the staff was sleeping. The staff that was said to be sleeping was immediately suspended." The report indicated an investigation "was underway" into the allegation. No investigation, witness statements, or staff ratios were available for review.</p> <p>-A 5/14/14 BDDS report for an incident on 5/13/14 indicated "A staff alleged that another staff was sleeping while on shift." The report indicated an investigation had begun. No investigation, witness statements, or staff</p>			

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	<p>ratios were available for review.</p> <p>-A 5/19/14 Follow Up BDDS report for an incident on 5/13/14 at 7:00am indicated "A staff alleged that another staff was sleeping while on shift. The investigation was able to substantiate that the staff that was alleged to be sleeping was not sleeping. There was a miscommunication between the home manager and a staff that had called regarding another situation. The home manager will be retrained on what to do if she is not understanding fully something that is reported to her and all staff will be retrained on reporting an incident to the home manager." No investigation, witness statements, or staff ratios were available for review.</p> <p>-A 4/17/14 BDDS report for an incident on 4/17/14 at 3:30am indicated "It was reported by the second midnight staff on 4/17/14 that the other staff fell asleep while working his shift. there was another staff at the home with the residents." No investigation, witness statements, or staff ratios were available for review.</p> <p>-A 4/28/14 BDDS follow up report indicated "There were two staff on shift at [name] group home. One staff reported that the other staff had fallen</p>			

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	<p>asleep while on shift. The staff was suspended as indicated on the initial BDDS report. The investigation was unable to substantiate that staff sleep during his shift on 4/17/14. Staff will undergo training on the supervision level of all clients and be re trained on the responsibilities of [a staff] and go over the policy where they are not to sleep on shift."</p> <p>On 2/9/15 at 1:20pm, on 2/9/15 at 3:35pm, on 2/10/15 at 8:40am, on 2/10/15 at 11:30am, on 2/11/15 at 8:05am, and on 2/12/15 at 11:30am, the facility's investigations were requested from the Residential Manager, the QIDP, and the Area Director (AD). No investigations for the 8/17/14, 7/19/14, 5/13/14, and 4/17/14 allegations of staff sleeping while on duty were provided for review.</p> <p>On 2/10/15 at 10:45am, an interview was conducted with the QIDP and the Area Director (AD). The QIDP and AD both indicated the facility followed the BDDS reporting and investigating policy and procedure. The QIDP indicated no investigations were available for review for client #1, #2, #3, #4, #5, #6, and #7's allegations of neglect when staff alleged that the other staff on duty was sleeping on 8/17/14, 7/19/14, 5/13/14, and</p>			

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W 157 Bldg. 00	<p>4/17/14. The QIDP and the AD both indicated clients #1, #2, #3, #4, #5, #6, and #7 required staff supervision at the group home. The QIDP indicated two (2) staff were scheduled at the group home for the overnight hours based on client identified needs. The QIDP indicated no investigations, no witness statements, no administrative oversight monitoring of the facility staff during working hours were available for review.</p> <p>On 2/19/15 at 11:15am, an interview was conducted with the AD and QIDP. Both provided "Investigative Summary(s)" for the 8/17/14, 7/19/14, and 4/18/14 allegations of staff sleeping on duty. The investigative summaries did not include individual witness statements, completed client interviews, questions asked during the investigations, administrative oversight monitoring, and recommendations for corrective actions available for review.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, for 6 of 29 BDDS (Bureau of Developmental Disabilities Services)</p>	W 157	<p>W157 Staff Treatment of Clients If the alleged violation is verified, appropriate corrective action must be taken.</p>	03/21/2015			

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	<p>reports for two incidents of client #5's AWOL (Absent Without Leave) behaviors and for 4 of 4 allegations of neglect (for clients #1, #2, #3, #4, #5, #6, and #7), the facility failed to implement sufficient corrective actions and ensure staff supervision based on identified client needs for clients #1, #2, #3, #4, #5, #6, and #7.</p> <p>Findings include:</p> <p>1. On 2/9/15 at 1:20pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports, non reportable incident reports, and investigations were reviewed and included the following for client #5:</p> <p>-A 1/6/15 BDDS report for an incident on 1/6/15 at 6:30am, indicated client #5 "went AWOL (Absent Without Leave). [GHS (Group Home Staff) #6] said that [client #5] was saying that she wants to go to [name of workshop] then while [GHS #6] was assisting another consumer, [client #5] walked out of the house." The report indicated the staff called the Residential Manager (RM), who drove to the group home, and located client #5 "very close to the house and brought her home. [Client #5] was AWOL for 10 minutes." The report indicated "staff was able to watch [client</p>		<p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · All staff will be retrained on protocol for reporting client abuse, neglect or injuries of unknown origin. · Staff will notify Home Manager of any incidents. · Home Manager will notify Program Director of any incidents. · Program Director will report all incidents to BDDS and APS, per state law. · Program Director will investigate and report findings, per policy and state law. · All corrective actions recommended from the completed investigation will be executed and documented by the Program Director. · Area Director will monitor the actions are consistently implemented per policy. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · All staff will be retrained on protocol for reporting client abuse, neglect or injuries of unknown origin. 	

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	<p>#5] and keep their eye on her until the [RM] arrived to bring [client #5] home." GHS #6's "Interview" indicated he "stated that he was told by another consumer that [client #5] started walking." The investigation indicated client #5's statement "she missed her friends and wanted to work at [name of contracted workshop]." The "Investigative Summary" indicated the staff working with client #5 were notified of the AWOL incident, the procedure of AWOL, and "reminded of [client #5's] risk plan. Staff are to keep a watch on [client #5] and redirect her when AWOL may be occurring." No evidence was available for review of completed corrective action.</p> <p>-A 12/5/14 BDDS report for an incident on 12/5/14 at 12:00pm at the contracted workshop and reported by the contracted workshop indicated client #5 "became upset...When [client #5's] work trainer (supervisor) did not see her in the lunch room, she came to the front office area to look for her. [Client #5] was not in the front office area." The report indicated the work coordinator went "outside" to locate client #5. The report indicated "other clients reported" that client #5 left through the back door of the workshop. The workshop coordinator located client #5 walking alone "in the rain along side</p>		<ul style="list-style-type: none"> · Staff will notify Home Manager of any incidents. · Home Manager will notify Program Director of any incidents. · Program Director will report all incidents to BDDS and APS, per state law. · Program Director will investigate and report findings, per policy and state law. · All corrective actions recommended from the completed investigation will be executed and documented by the Program Director. · Area Director will monitor the actions are consistently implemented per policy. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · All staff will be retrained on protocol for reporting client abuse, neglect or injuries of unknown origin. · Staff will notify Home Manager of any incidents. · Home Manager will notify Program Director of any incidents. · Program Director will report all incidents to BDDS and APS, per state law. · Program Director will investigate and report findings, per policy and state law. · All corrective actions recommended from the completed 		

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	<p>the road." The report indicated client #5 and the workshop coordinator took shelter out of the rain under a canopy of a business down the street from the workshop building until returning to the workshop. The report indicated client #5 "was only out of sight a few minutes until she was located." The agency 12/5/14 "Incident Report" indicated "see BDDS report" and "Follow BSP." No evidence was available for review of completed corrective action.</p> <p>On 2/12/15 at 10:45am, client #5's record was reviewed. Client #5's 2/25/14 ISP (Individual Support Plan), 11/15/14 BSP (Behavior Support Plan), and 2/24/14 "Individual Plan of Protective Oversight" indicated client #5's targeted behavior included AWOL (Absent Without Leave) behaviors. Client #5's "Individual Plan of Protective Oversight" indicated "Behavior Needs: Yes...Targeted behaviors addressed: Impulse Control Disorder, Physical Aggression, Verbal Aggression, Tantrums, Disrupting Activities of others, Property Destruction, Resist Supervision, AWOL, Suicidal Ideation, Once tried to jump out of a moving vehicle...last updated: 9/3/14 Residential Information...[Client #5] has a long history of going AWOL. [Client #5] needs close supervision. She has no pedestrian safety skills."</p>		<p>investigation will be executed and documented by the Program Director.</p> <ul style="list-style-type: none"> · Area Director will monitor the actions are consistently implemented, per policy. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Staff will notify Home Manager of any incidents. · Home Manager will notify Program Director of any incidents. · Program Director will report all incidents to BDDS and APS, per state law. · Program Director will investigate and report findings, per policy and state law. · All corrective actions recommended from the completed investigation will be executed and documented by the Program Director. · Area Director will monitor the actions are consistently implemented per policy. <p>5. What is the date by which the systemic changes will be completed? 3/21/15</p>		

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	<p>On 2/12/15 at 11:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #5 should be supervised by the staff during waking hours. The QIDP indicated staff should know where client #5 was and did not when she continued to leave AWOL. The QIDP indicated client #5's AWOL incidents had no information reviewed regarding effective corrective action available for review.</p> <p>2. On 2/9/15 at 1:20pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports, non reportable incident reports, and investigations were reviewed and included the following for clients #1, #2, #3, #4, #5, #6, and #7:</p> <p>-An 8/18/14 BDDS report for an incident on 8/17/14 at 2:20pm indicated "A staff reported" to the RM that "another staff was asleep while on shift." The report indicated an investigation had begun and the staff was suspended. No corrective action was available for review.</p> <p>-A 7/20/14 BDDS report for an incident on 7/19/14 at 4:15am indicated a staff called the RM to report that "another staff on shift with her had fallen asleep. The</p>			

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	<p>[RM] went to the home and it appeared the staff was sleeping. The staff that was said to be sleeping was immediately suspended." The report indicated an investigation "was underway" into the allegation. No corrective action was available for review.</p> <p>-A 5/14/14 BDDS report for an incident on 5/13/14 indicated "A staff alleged that another staff was sleeping while on shift." The report indicated an investigation had begun. No corrective action was available for review.</p> <p>-A 5/19/14 Follow Up BDDS report for an incident on 5/13/14 at 7:00am indicated "A staff alleged that another staff was sleeping while on shift. The investigation was able to substantiate that the staff that was alleged to be sleeping was not sleeping. There was a miscommunication between the home manager a a staff that had called regarding another situation. The home manager will be retrained on what to do if she is not understanding fully something that is reported to her and all staff will be retrained on reporting an incident to the home manager." No corrective action was available for review. No staff training or retraining were available for review.</p>			

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	<p>-A 4/17/14 BDDS report for an incident on 4/17/14 at 3:30am indicated "It was reported by the second midnight staff on 4/17/14 that the other staff fell asleep while working his shift. There was another staff at the home with the residents." No corrective action was available for review.</p> <p>-A 4/28/14 BDDS follow up report indicated "There were two staff on shift at [name] group home. One staff reported that the other staff had fallen asleep while on shift. The staff was suspended as indicated on the initial BDDS report. The investigation was unable to substantiate that staff sleep during his shift on 4/17/14. Staff will undergo training on the supervision level of all clients and be re trained on the responsibilities of [a staff] and go over the policy where they are not to sleep on shift."</p> <p>On 2/9/15 at 1:20pm, on 2/9/15 at 3:35pm, on 2/10/15 at 8:40am, on 2/10/15 at 11:30am, on 2/11/15 at 8:05am, and on 2/12/15 at 11:30am, the facility's corrective actions taken after the allegations were reported were requested from the Residential Manager, the QIDP, and the Area Director (AD). No completed corrective actions after the 8/17/14, 7/19/14, 5/13/14, and 4/17/14</p>			

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W 249 Bldg. 00	<p>allegations of staff sleeping while on duty were provided for review.</p> <p>On 2/10/15 at 10:45am, an interview was conducted with the QIDP and the Area Director (AD). The QIDP indicated no completed corrective actions were available for review for client #1, #2, #3, #4, #5, #6, and #7's allegations of neglect when staff alleged that the other staff on duty was sleeping on 8/17/14, 7/19/14, 5/13/14, and 4/17/14. The QIDP and the AD both indicated clients #1, #2, #3, #4, #5, #6, and #7 required staff supervision at the group home. The QIDP indicated two (2) staff were scheduled at the group home for the overnight hours based on identified client needs. The QIDP indicated no administrative oversight monitoring of the facility staff during working hours and no documented corrective actions were available for review. The QIDP indicated no further information was available for review.</p> <p>9-3-2(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient</p>			

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	<p>number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview, and record review, for 2 of 4 sampled clients (clients #3 and #4) and 1 additional client (client #5), the facility failed to use formal and informal opportunities to implement clients #3, #4, and #5's ISPs (Individual Support Plans), BSPs (Behavior Support Plans) and risk plans when opportunities existed.</p> <p>Findings include:</p> <p>1. On 2/9/15 from 3:35pm until 6:00pm, and on 2/10/15 from 5:57am until 8:05am, observation and interview were conducted at the group home. During both the observation periods the hand soap and chemicals were locked. During both observation periods client #1 had twenty-three denture tablets in her bedroom, individually packaged, and the tablets laid unsecured on top of her night stand. During both observation periods clients #3 and #4 walked independently throughout the facility and would stop at the doorway to client #1 and #5's shared bedroom to look inside. Clients #3 and #4 were redirected verbally and guided physically by the Residential Manager (RM) and the group home staff each time to other areas of the facility. During both</p>	W 249	<p>W 249 PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. REVISION:</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · All individual program plans will include continuous active treatment. · Helmets, and all protective equipment ordered in individual plans, will be available at the home, at all times. · Staff will be retrained on implementing active treatment consistently and sufficiently, appropriately securing sharps and hazardous material, use of protective equipment and supervision levels. · Home manager will monitor the daily execution of these trainings and report any concerns to Program Director. · Program Director will deliver and monitor trainings, as needed to ensure compliance. · Program Director will monitor 	03/21/2015			

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	<p>observation periods the chemical cleaners and hand soaps were kept secured by the facility staff.</p> <p>On 2/9/15 at 4:35pm, the RM indicated the facility kept "Sharps and hazardous materials locked" because of client #3 and #4's histories of drinking and misusing sharp items and chemicals. At 4:35pm, the RM opened a locked door, indicated staff had the key to locked sharps and chemicals, and clients could ask staff to use chemicals or sharp items.</p> <p>Client #3's record review was conducted on 2/11/15 at 11:55am. Client #3's 3/14/14 "Individual Plan of Protective Oversight" indicated "Behavioral Needs...Other Significant Information: [Client #3] can handle sharps safely. [Client #3] cannot handle hazardous materials safely. Both the sharps and the hazardous materials are locked in [client #3's] home." Client #3's 3/14/14 "Behavior Support Plan (BSP)" did not indicate locked chemicals or a plan to reduce the restriction for locked chemicals. Client #3's BSP indicated targeted behaviors of Agitation, Physical Aggression, and Self Injurious Behaviors of hitting his face leaving welts, red marks, and bruising.</p> <p>On 2/12/15 at 11:30am, an interview with</p>		<p>program implementation by pulling and reviewing programmatic data collection reports monthly.</p> <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice · All individual program plans will include continuous active treatment. · Helmets, and all protective equipment ordered in individual plans, will be available at the home, at all times. · Staff will be retrained on implementing active treatment consistently and sufficiently, appropriately securing sharps and hazardous material, use of protective equipment and supervision levels. · Home manager will monitor the daily execution of these trainings and report any concerns to Program Director. · Program Director will deliver and monitor trainings, as needed to ensure compliance. · Program Director will monitor program implementation by pulling and reviewing programmatic data collection reports monthly. <p>3. What measures will be put</p>	

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	<p>the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated clients #3 and #4 needed chemicals to be locked in the group home. The QIDP indicated client #1's denture tablets should not have been left unsecured in her bedroom. The QIDP indicated clients #3 and #4's plans were not implemented when client #1's denture tablets were not secured.</p> <p>2. On 2/9/15 from 3:35pm until 6:00pm, client #4 was observed at the group home. Client #4 walked in and out of rooms and then walked to the living room of the facility to sit down on the floor. From 3:55pm until 4:45pm, client #4 chewed on his shoe and hit himself in the face and head with his fist and the palms of his left and right hands three hundred, forty-seven (347) times. During the observation periods staff switched off with different staff, offered client #4 his weighted vest, offered cause/effect items, offered the bathroom, a nap, and offered different activities without client #4 stopping the behavior of punching himself in the head. Client #4's face, nose, neck, forehead, and hairline around his face were bright red in color. At 3:55pm, GHS #3 stated the staff had "forgotten" client #4's helmet at the day services workshop and the group home did not have a second helmet available</p>		<p>into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Home manager will monitor the daily execution of these trainings and report any concerns to Program Director. · Program Director will deliver and monitor trainings, as needed to ensure compliance. · Program Director will monitor program implementation by pulling and reviewing programmatic data collection reports monthly. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Home manager will monitor the daily execution of these trainings and report any concerns to Program Director. · Program Director will deliver and monitor trainings, as needed to ensure compliance. · Program Director will monitor program implementation by pulling and reviewing programmatic data collection reports monthly. <p>5. What is the date by which the systemic changes will be completed? 3/21/15</p>	

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	<p>for client #4. At 4:05pm, GHS #5 stated client #4's helmet was used "almost" daily to prevent client #4 from hurting himself when he hits himself in the head. GHS #5 stated "since [client #4's] day services was changed about 2 weeks ago, he has come home like this just about every day." At 4:25pm, client #4 walked into the kitchen, opened the pantry door, and retrieved the bread and peanut butter from the pantry closet. GHS (Group Home Staff) #4 retrieved a knife and provided hand over hand assistance to client #4 to make a peanut butter sandwich. Client #4 fed himself the sandwich and returned to living room. Client #4 sat back down on the living room carpet and continued to hit himself in the head with his hands and the palms of his hands. The RM and the facility staff continuously sat behind client #4 on the floor and placed their arms around client #4 in a physical hold to prevent him from hitting himself. When client #4 stopped attempting to hit himself, he was released, client #4 would hit himself more, and staff reapplied the hold. At 4:35pm, the RM offered client #4 a shower. Client #4 got up from the floor, walked to the bathroom, and took a shower. At 5:00pm, client #4 walked to the living room, and had slowed the rate and intensity of hitting himself in the head. At 5:40pm, client #4 walked to the</p>			

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	<p>dining room table for supper and fed himself the meal.</p> <p>On 2/10/15 at 5:57am, GHS #5 stated client #4's behaviors of hitting himself in his head were "bad last night." GHS #5 stated client #4 "wears a helmet, but it wasn't here. It (the helmet) was probably at day services." GHS #5 indicated client #4's backpack usually transferred his protective helmet back and forth between the group home and the day services.</p> <p>On 2/11/15 at 11:40am, client #4's record review was conducted. Client #4's 4/30/14 ISP (Individual Support Plan) and 11/15/14 BSP (Behavior Support Plan) indicated client #4 wore a protective helmet when he had SIB (Self Injurious Behaviors) of hitting/punching himself in the head. Client #4's BSP indicated "Self Injurious Behavior head hitting biting arm...severe Self Injurious Behavior hitting himself or biting himself hard enough to break skin and cause bleeding or to leave bruises on self...offer [client #4] his helmet for use...[Client #4] seems to become agitated around transition times, getting ready in the morning, riding the van, going different places, different staff, etc...At these time he is more likely to hit himself or bite himself."</p>			

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	<p>On 2/12/15 at 11:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #4's plans were not implemented without access to his protective helmet. The QIDP indicated client #4's protective helmet should be in the same location with client #4.</p> <p>3. On 2/9/15 at 1:20pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports, non reportable incident reports, and investigations were reviewed and included the following for client #5:</p> <p>-A 1/6/15 BDDS report for an incident on 1/6/15 at 6:30am, indicated client #5 "went AWOL (Absent Without Leave). [GHS (Group Home Staff) #6] said that [client #5] was saying that she wants to go to [the name workshop] then while [GHS #6] was assisting another consumer, [client #5] walked out of the house." The report indicated the staff called the Residential Manager (RM), who drove to the group home, and located client #5 "very close to the house and brought her home. [Client #5] was AWOL for 10 minutes." The report indicated "staff was able to watch [client #5] and keep their eye on her until the [RM] arrived to bring [client #5] home."</p>			

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	<p>-A 12/5/14 BDDS report for an incident on 12/5/14 at 12:00pm at the contracted workshop and reported by the contracted workshop indicated client #5 "became upset...When [client #5's] work trainer (supervisor) did not see her in the lunch room, she came to the front office area to look for her. [Client #5] was not in the front office area." The report indicated the work coordinator went "outside" to locate client #5. The report indicated "other clients reported" that client #5 left through the back door of the workshop. The workshop coordinator located client #5 walking alone "in the rain along side the road." The report indicated client #5 and the workshop coordinator took shelter out of the rain under a canopy of a business down the street from the workshop building until returning to the workshop. The report indicated client #5 "was only out of sight a few minutes until she was located."</p> <p>On 2/12/15 at 10:45am, client #5's record was reviewed. Client #5's 2/25/14 ISP (Individual Support Plan), 11/15/14 BSP (Behavior Support Plan), and 2/24/14 "Individual Plan of Protective Oversight" indicated client #5's targeted behavior included AWOL (Absent Without Leave) behaviors. Client #5's "Individual Plan of Protective Oversight" indicated</p>			

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W 331 Bldg. 00	<p>"Behavior Needs: Yes...Targeted behaviors addressed: Impulse Control Disorder, Physical Aggression, Verbal Aggression, Tantrums, Disrupting Activities of others, Property Destruction, Resist Supervision, AWOL, Suicidal Ideation, Once tried to jump out of a moving vehicle...last updated: 9/3/14 Residential Information...[Client #5] has a long history of going AWOL. [Client #5] needs close supervision. She has no pedestrian safety skills."</p> <p>On 2/12/15 at 11:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #5 should be supervised by the staff during waking hours.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 1 of 1 sampled client (client #1) who had her blood sugar tested at the group home, the facility's nursing services failed to provide oversight of client #1's blood sugar testing to ensure her medical care was accurately completed and monitored.</p>	W 331	<p>W 331 NURSING SERVICES The facility must provide nursing services in accordance with their need. REVISION: 1. What corrective action will be accomplished? · Staff will be retrained on the protocol for taking client #1's blood sugar before meals and what levels</p>	03/21/2015			

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	<p>Findings include:</p> <p>On 2/10/15 from 5:57am until 8:05am, client #1 was observed at the group home. From 5:57am until 7:00am, client #1 independently went outside to smoke, drank coffee, selected her plate with fried eggs and toast fixed by GHS (Group Home Staff) #1, carried her plate of food to the table, drank juice, milk, coffee, and ate her food at the dining room table. At 7:00am, GHS #2 asked client #1 to come to the medication room, tested her blood sugar level, and indicated client #1's blood sugar level was 162. At 7:00am, GHS #2 stated he took client #1's blood sugar level "after breakfast because if I (GHS #2) took it before it would be too high."</p> <p>On 2/10/15 at 10:30am, client #1's 2/2015 MAR (Medication Administration Record) indicated "Blood Sugar Check, every day 7:00am starting from 12/5/2014, monitor blood sugar."</p> <p>On 2/11/15 at 11:20am, client #1's record was reviewed. Client #1's 12/2014 "Physician Orders" included to take client #1's blood sugar daily to monitor. Client #1's record indicated she was a Diabetic and took the prescribed medication Metformin for her diabetes. Client #1's</p>		<p>warrant reporting to the nurse.</p> <ul style="list-style-type: none"> · MAR and risk plan will reflect that client #1's blood sugar will be taken before meals. · Nurse and Program Director will conduct retraining for staff. · Home Manager will observe and supervise Direct Support Staff in the home to ensure protocol is followed. · Home Manager will monitor compliance by checking the MAR documentation daily. · Program Directors will monitor compliance through checking the MAR weekly. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Staff will be retrained on the protocol for taking client #1's blood sugar before meals and what levels warrant reporting to the nurse. · MAR and risk plan will reflect that client #1's blood sugar will be taken before meals. · Nurse and Program Director will conduct retraining for staff. · Home Manager will observe and supervise Direct Support Staff in the home to ensure protocol is followed. · Home Manager will monitor compliance by checking the MAR documentation daily. 		

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	<p>10/2014 "Risk Plan for Diabetes" indicated Monitor blood sugar levels as ordered and report abnormalities...Report blood sugar greater than 300 to house manager who will report to nurse."</p> <p>On 2/12/15 at 9:20am, an interview with the agency nurse was conducted. The agency nurse indicated "staff were trained and should follow Core A/Core B Medication Training" for taking blood sugar testing for client #1. The agency nurse indicated client #1's blood sugar should be taken before client #1 eats food to ensure an accurate reading every morning for client #1's blood sugar level. The agency nurse indicated the MAR indicated "7:00am" and the time was to ensure it was taken before client #1 consumed food. The agency nurse indicated if client #1 got up earlier than Core A/Core B teaches that the blood sugar should be taken earlier. The agency nurse indicated she had not been notified of low or high blood sugar levels for client #1. The agency nurse indicated she had not asked or observed the staff at the group home complete blood sugar level testing for client #1.</p> <p>On 2/10/15 at 9:30am, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy</p>		<ul style="list-style-type: none"> · Program Directors will monitor compliance through checking the MAR weekly. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Staff will be retrained on the protocol for taking client #1's blood sugar before meals and what levels warrant reporting to the nurse. · MAR and risk plan will reflect that client #1's blood sugar will be taken before meals. · Nurse and Program Director will conduct retraining for staff. · Home Manager will observe and supervise Direct Support Staff in the home to ensure protocol is followed. · Home Manager will monitor compliance by checking the MAR documentation daily. · Program Director will monitor compliance through checking the MAR weekly. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Home Manager will observe and supervise Direct Support Staff in the home to ensure protocol is followed. · Home Manager will monitor compliance by checking the MAR documentation daily. · Program Director will 		

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W 369 Bldg. 00	<p>and procedure indicated the facility should follow physician orders. The Core A/Core B policy indicated "Blood tests are also used to monitor sugar levels. Fasting blood sugar (FBS) involves the individual drawing blood in the morning after eight hours without food. Postprandial glucose is blood tested for sugar after two hours without food. Monitoring of blood for sugar levels is the method of choice for managing diabetes." The policy indicated blood should be drawn before the client eats.</p> <p>9-3-6(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview, for 1 of 7 medications administered during the evening medication administration (client #6), the facility failed to ensure medications were given without error.</p> <p>Findings include:</p> <p>On 2/9/15 at 5:25pm, client #6 was observed to sit at the dining room table</p>	W 369	<p>monitor compliance by reviewing MAR weekly.</p> <p>5. What is the date by which the systemic changes will be completed?</p> <p>3/21/15</p> <p>W 369 DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>1. What corrective action will be accomplished?</p>	03/21/2015			

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	<p>consuming his supper meal. At 5:35pm, the Residential Manager (RM) asked client #6 to come to the medication room. The RM unlocked the medication cabinet, retrieved client #6's medication card of "Omeprazole 20mg (milligrams) take 1 capsule orally at least 30 min. (minutes) before meal for reflux," and administered client #6 the medication. Client #6 took the medication with water and left the medication area. At 5:47pm, client #6 continued to consume his supper meal.</p> <p>On 2/9/15 at 5:47pm, Client #6's 2/2015 MAR (Medication Administration Record) indicated "Omeprazole (Prilosec) 20mg, take 1 capsule orally at least 30 min. (minutes) before meal for reflux."</p> <p>On 2/9/15 at 5:47pm, client #6's 12/2014 "Physician's Order" indicated "Omeprazole 20mg take 1 capsule" orally at least 30 min. (minutes) before meal for reflux.</p> <p>On 2/10/15 at 9:30am, a record review was completed of the facility's policy and procedures, 4/2011 "Medication Administration by Staff" indicated "Check the information on the pharmacy medication label by comparing it to the medication administration record and the</p>		<ul style="list-style-type: none"> · All medication will be administered per doctor's orders. · Staff will be retrained on medication administration protocol. · Home manager will monitor medication administration daily. · Program Director will monitor medication administration weekly. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · All medication will be administered per doctor's orders. · Staff will be retrained on medication administration protocol. · Home manager will monitor medication administration daily. · Program Director will monitor medication administration weekly. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · All medication will be administered per doctor's orders. · Staff will be retrained on medication administration protocol. · Home manager will monitor medication administration daily. · Program Director will 	

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	<p>physician's order, for the individual's name, medication ordered, dosage, site of instillation, and the time...Check the medication listed on the medication administration record with the medication label three times...." The policy and procedure indicated staff should administer client medications according to physician's orders and the pharmacy instructions should be followed.</p> <p>On 2/10/15 at 9:30am, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders and the pharmacy instructions.</p> <p>On 2/12/15 at 9:20am, an interview with the agency nurse was conducted. The agency nurse indicated staff should administer medications according to physician's orders. The agency nurse indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders. The agency nurse stated the facility staff should have administered client #6's Omeprazole medication "at least" 30 minutes before the meal. The agency nurse indicated this was an</p>		<p>monitor medication administration weekly.</p> <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur? · Program Directors will monitor medication administration weekly.</p> <p>5. What is the date by which the systemic changes will be completed? 3/21/15</p>	

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W 407 Bldg. 00	<p>medication absorption issue for client #6. The agency nurse indicated client #6's medication would be considered a medication error.</p> <p>9-3-6(a)</p> <p>483.470(a)(1) CLIENT LIVING ENVIRONMENT The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.</p> <p>Based on observation, record review, and interview, for 1 of 4 sample clients (client #1), the facility failed to ensure the housing environment met client #1's functional level, active treatment needs, social skills, and abilities to promote independence and learning.</p> <p>Findings include:</p> <p>On 2/9/15 from 3:35pm until 6:00pm, and on 2/10/15 from 5:57am until 8:05am, observation and interview were conducted at the group home. During both observation periods client #1 independently greeted visitors outside the group home while she was smoking in the parking lot and no staff were present.</p>	W 407	<p>W 407 Client Living Situation</p> <p>The facility must not house clients of grossly different ages, developmental levels and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all of those housed together.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Meet with client #1 and IDT to determine short term and long term goals and plan for client. · Continue to work on programs to increase client #1's 	03/21/2015

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	<p>During both observation periods client #1 made her bed independently, sorted laundry, cooked independently on the stove and oven with verbal prompts from staff, opened packages of food to prepare for cooking independently, assembled supplies for cooking independently, followed a recipe for cooking, sliced foods/meats with a knife, washed her hands independently, loaded/unloaded the dishwasher in the kitchen, completed medication administration with facility staff, cleaned/rinsed her dentures independently, tested her blood sugar with facility staff, watched television, and completed her word find puzzle book with a pen. During both observation periods client #1 interacted with the facility staff and clients #2, #3, #4, #5, #6, and #7 inside the group home independently. During both observation periods client #1 poured drinks for clients #2 and #5. Client #1 helped client #5 fold and put away clean clothing. During both observation periods client #1 walked throughout the group home and outside the group home without interaction with staff and other clients. Client #1 did not interact socially with clients #2, #3, #4, #5, #6, and #7.</p> <p>On 2/9/15 at 4:35pm, the RM (Residential Manager) indicated client #1 was learning skills to take care of herself.</p>		<p>independent living skills in her current living situation.</p> <ul style="list-style-type: none"> · Involve client #1 in decisions to move her into a more appropriate living situation, as it is appropriate. · Program Director will facilitate communication and team meetings, advocating for client's needs. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Meet with client #1 and IDT to determine short term and long term goals and plan for client. · Continue to work on programs to increase client #1's independent living skills in her current living situation. · Involve client #1 in decisions to move her into a more appropriate living situation, as it is appropriate. · Program Director will facilitate communication and team meetings, advocating for client's needs. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Program Director will facilitate communication and team meetings, advocating for client's 				

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	<p>The RM indicated client #1 was not appropriately placed at the group home. The RM indicated client #1 did not socialize on the same level of interaction with other clients living in the group home. The RM indicated client #1 was higher functioning than the other clients who were living in the group home.</p> <p>On 2/10/15 at 7:00am, client #1 indicated she liked living at the group home and helping the other clients. Client #1 indicated she worked at the sheltered workshop every day. Client #1 indicated she was divorced with three (3) sons and one (1) daughter. Client #1 stated she "used to live in a trailer park in [name of city]," went to the hospital with a medical emergency, was sent to a nursing home for 90 days, and then placed at the group home "a year ago in June." Client #1 indicated she could read, write, and manage her own money. Client #1 stated she was independent with her daily living activities of personal hygiene, dressing, caring for her teeth, cooking with "little help," and liked living with other people. Client #1 stated she "thought that living alone in the trailer" before her medical emergency was why she had the problem. Client #1 stated she liked the group home "but I want more independence."</p> <p>Client #1's record was reviewed on</p>		<p>needs.</p> <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> Program Director will facilitate communication and team meetings, advocating for client's needs. <p>5. What is the date by which the systemic changes will be completed?</p> <p>3/21/15</p>	

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	2/11/15 at 11:20am. Client #1's record indicated she did not need a guardian and was emancipated. Client #1's record indicated she was verbal and independently ambulatory. Client #1's 6/2/14 ISP (Individual Support Plan) indicated goals/objectives to independently withdraw funds she needs for the week, will state why she takes Ativan (for behaviors), will decrease episodes of targeted behaviors, will use a key to access hazardous materials, will state her rights, will independently cook main dish, and will independently plan her monthly activities. Client #1's 6/30/14 "Individual Plan of Protective Oversight-Residential Information" indicated client #1 can regulate her own water temperatures, did not "always wash her entire body if staff were not there to remind her" and use soap, was at risk for falls, can safely handle \$5.00, knows the values of coins, needed verbal prompts to wear clothing for weather "and to not wear clothing with stains or holes...wears depends and will change them as needed" independently, and client #1 "was on 15 minute checks for skin picking" behaviors. Client #1's record indicated she was not independent with her medical needs, medications, medical emergencies, financial planning, planning meals, advocating her rights, planning medical appointments, planning activities, and			

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	<p>client #1 continued to be at risk from her behaviors of skin picking which impacted her medical needs for her Diabetes Mellitus.</p> <p>On 2/12/15 at 11:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and AD (Area Director) was conducted. The QIDP stated client #1 "was not appropriately placed at the group home" and "needed an environment" which allowed her more flexibility. The QIDP indicated client #1 had current goals and objectives to teach her to advocate more for herself and to teach client #1 skills. The QIDP indicated client #1 had behaviors when admitted of skin picking, crying, verbal aggression, and suicidal Ideation. The QIDP stated client #1 could be "manipulated by others." The QIDP indicated client #1 was not appropriate for the group home. The QIDP indicated client #1 independently smoked outside the group home and carried her own smoking materials safety. The AD and QIDP both indicated client #1 was more independent with her daily care needs currently than when client #1 was admitted in 6/2014. The QIDP indicated after client #1 became medically stable with her medical care, behaviors, and diabetes then client #1 began acquiring skills for independence at the group</p>			

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W 436 Bldg. 00	<p>home.</p> <p>9-3-7(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 1 sampled client (client #4) with adaptive/protective head equipment, the facility failed to ensure client #4's protective helmet was used when needed and available at the group home.</p> <p>Findings include:</p> <p>On 2/9/15 from 3:35pm until 6:00pm, client #4 was observed at the group home. Client #4 walked in and out of rooms and then walked to the living room of the facility to sit down on the floor. From 3:55pm until 4:45pm, client #4 chewed on his shoe and punched himself in the face and head with his fist and the palms of his left and right hands three</p>	W 436	<p>W 436 Space and Equipment</p> <p>The facility must not furnish, maintain in good repair and teach clients to use and make informed choices about the use of dentures, eye glasses, hearing and other communication devices identified by the IDT, as needed by the client..</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Helmets, and all protective equipment ordered in individual plans, will be available at the home, at all times. · Staff will be retrained on implementing use of protective 	03/21/2015

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	<p>hundred, forty-seven (347) times. During the observation period staff switched off with a different staff member, offered client #4 his weighted vest, offered cause/effect items, offered the bathroom, offered a nap, and offered different activities without client #4 stopping the behavior of punching himself in the face/head. Client #4's face, nose, neck, forehead, and hairline around his face were bright red in color. At 3:55pm, GHS #3 stated the staff had "forgotten" client #4's helmet at the day services workshop and the group home did not have a second helmet available for client #4 to wear. At 4:05pm, GHS #5 stated client #4's helmet was used "almost" daily to prevent client #4 from hurting himself when he hits himself in the head. GHS #5 stated "since [client #4's] day services was changed about 2 weeks ago, he has come home like this just about every day." At 4:25pm, client #4 walked into the kitchen, opened the pantry door, and retrieved the bread and peanut butter from the pantry closet. GHS (Group Home Staff) #4 retrieved a knife and provided hand over hand assistance to client #4 to make a peanut butter sandwich. Client #4 fed himself the sandwich and returned to living room. Client #4 sat back down on the living room carpet and continued to hit himself in the head with his fists and the palms of</p>		<p>equipment and supervision levels.</p> <ul style="list-style-type: none"> · Home manager will monitor the daily execution of these trainings and report any concerns to Program Director. · Program Director will deliver and monitor trainings, as needed to ensure compliance. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Helmets, and all protective equipment ordered in individual plans, will be available at the home, at all times. · Staff will be retrained on implementing and use of protective equipment and supervision levels. · Home manager will monitor the daily execution of these trainings and report any concerns to Program Director. · Program Director will deliver and monitor trainings, as needed to ensure compliance. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Home manager will monitor the daily execution of these trainings and report any concerns to Program Director. · Program Director will deliver 	

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	<p>his hands. The RM and the facility staff continuously sat behind client #4 on the floor and placed their arms around client #4 in a physical hold to prevent him from hitting himself. When client #4 stopped attempting to hit himself, he was released, client #4 would hit himself more, and staff reapplied the hold continuously. At 4:35pm, the RM offered client #4 a shower. Client #4 got up from the floor, walked to the bathroom, and took a shower. At 5:00pm, client #4 walked to the living room, and had slowed the rate and intensity of him hitting himself in the head. At 5:40pm, client #4 walked to the dining room table for supper and fed himself the meal.</p> <p>On 2/10/15 at 5:57am, GHS #5 stated client #4's behaviors of hitting himself in his head were "bad last night." GHS #5 stated client #4 "wears a helmet, but it wasn't here. It (the helmet) was probably at day services." GHS #5 indicated client #4's backpack usually transferred his protective helmet back and forth between the group home and the day services.</p> <p>On 2/11/15 at 11:40am, client #4's record review was conducted. Client #4's 4/30/14 ISP (Individual Support Plan) and 11/15/14 BSP (Behavior Support Plan) indicated client #4 wore a</p>		<p>and monitor trainings, as needed to ensure compliance.</p> <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Home manager will monitor the daily execution of these trainings and report any concerns to Program Director. · Program Director will deliver and monitor trainings, as needed to ensure compliance. · <p>5. What is the date by which the systemic changes will be completed?</p> <p>3/21/15</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 999 Bldg. 00	<p>protective helmet when he had SIB (Self Injurious Behaviors) of hitting/punching himself in the head. Client #4's BSP indicated "Self Injurious Behavior head hitting biting arm...severe Self Injurious Behavior hitting himself or biting himself hard enough to break skin and cause bleeding or to leave bruises on self...offer [client #4] his helmet for use...[Client #4] seems to become agitated around transition times, getting ready in the morning, riding the van, going different places, different staff, etc...At these time he is more likely to hit himself or bite himself."</p> <p>On 2/12/15 at 11:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #4's plans were not implemented without access to his protective helmet. The QIDP indicated client #4's protective helmet should be in the same location with client #4.</p> <p>9-3-7(a)</p> <p>STATE FINDINGS:</p>	W 999	<p>W9999 Final Observation Prior to assuming residential job</p>	03/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2015
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	<p>The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met.</p> <p>(2) 460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin (TB) test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview for 1 of 5 newly hired personnel records reviewed (Group Home Staff (GHS) #9), the facility failed to obtain yearly PPD and/or a chest x-ray for employed staff #9.</p>		<p>duties and annually thereafter, each staff shall submit written evidence that a Mantoux test or chest xray was completed.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · All staff will comply with providing written evidence of Mantoux test or chest xrays, upon hire and annually, per policy. · Human Resource Coordinator will track and notify Program Director of any staff member not in compliance with this policy. · Program Director will communicate with staff and monitor compliance. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · All staff will comply with providing written evidence of Mantoux test or chest xrays, upon hire and annually, per policy. · Human Resource Coordinator will track and notify Program Director of any staff member not in compliance with this policy. · Program Director will communicate with staff and monitor compliance. <p>3. What measures will be put</p>	

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	<p>Findings include:</p> <p>On 2/11/15 at 9:10am, the facility staff personnel records were reviewed for GHS #9 and indicated the following:</p> <p>-GHS #9 was hired on 10/20/14. GHS #9's record did not indicate a current chest x-ray and/or Mantoux test to ensure the staff person was free of communicable disease.</p> <p>On 2/11/15 at 9:10am, the Human Resource Director (HRD) indicated GHS #9 should have had a chest X-ray to ensure he was free of communicable disease and no further information was available for review.</p> <p>9-3-3(e)</p>		<p>into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Human Resource Coordinator will track and notify Program Director of any staff member not in compliance with this policy. · Program Director will communicate with staff and monitor compliance. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Human Resource Coordinator will track and notify Program Director of any staff member not in compliance with this policy. · Program Director will communicate with staff and monitor compliance. <p>5. What is the date by which the systemic changes will be completed? 3/21/15</p>		