

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G397	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250
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W 000 Bldg. 00	<p>This visit was for an annual recertification and state licensure survey. This visit included the investigation of complaints #IN00165097 and #IN00165161.</p> <p>Complaint #IN00165097: Substantiated, federal and state deficiencies related to the allegations are cited at: W102, W104, W122, W149, W153, W154 and W157.</p> <p>Complaint #IN00165161: Substantiated, federal and state deficiencies related to the allegations are cited at: W102, W104, W122, W149, W153, W154 and W157, W318, W336, W356 and W368.</p> <p>Dates of Survey: 2/9/15, 2/10/15, 2/11/15, 2/12/15, 2/13/15, 2/16/15 and 2/19/15.</p> <p>Facility Number: 000911 Provider Number: 15G397 AIMS Number: 100244420</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/25/15 by</p>	W 000		

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

TITLE

(X6) DATE

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

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W 102 Bldg. 00	<p>Ruth Shackelford, QIDP.</p> <p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 3 of 3 sampled clients (A, B and C) plus 4 additional clients (D, E, F and G). The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent emotional and psychological abuse/intimidation of client A, to prevent neglect of clients A, B, C, D, E, F and G by failing to ensure adequate food supply in the group home, to report 4 separate incidents of physical altercations between clients A and F and 3 allegations of mistreatment, exploitation, theft and dental neglect for</p>	W 102	<p>CORRECTION:</p> <p><i>The facility must ensure that specific governing body and management requirements are met. Specifically, the governing body has facilitated the following: The Team Lead, identified in the 2567 as HM#1 no longer works for the company. Facility staff, including Direct Support Professional staff #1, will be retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect</i></p>	03/21/2015
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	<p>client G to BDDS (Bureau of Developmental Disabilities Services) within 24 hours, to complete thorough investigations regarding an allegation of medical neglect following client A's head injury, 4 allegations of intimidation and theft and personal property destruction by clients E and F towards client A, to thoroughly investigate allegations of theft, exploitation and dental neglect regarding client G and to develop and implement corrective measures to prevent recurrence of intimidation and emotional abuse regarding client A, three incidents of client to client aggression between clients A and F and two allegations of theft and personal property destruction by clients E and F towards client A. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the health status of clients A, B and C was reviewed on a quarterly basis, ensure client G received dental treatment services and ensure client G received medication as ordered by the dentist.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent emotional and</p>		<p>other clients. The program Manager has completed an investigation into three allegations of theft and medical neglect regarding Client G. Moving forward, the Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Through ongoing assessment, the interdisciplinary team consensually agreed that Client A would be more comfortable in a Medicaid Waiver setting with housemates that more closely shared his developmental, social and behavioral needs. Therefore the team assisted him in transitioning to a new residential setting. The Clinical Supervisor will review all facility grocery receipts to assure an adequate supply of food is being purchased for the home.</p>	

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	<p>psychological abuse/intimidation of client A, to prevent neglect of clients A, B, C, D, E, F and G by failing to ensure adequate food supply in the group home, to report 4 separate incidents of physical altercations between clients A and F and 3 allegations of mistreatment, exploitation, theft and dental neglect for client G to BDDS (Bureau of Developmental Disabilities Services) within 24 hours, to complete thorough investigations regarding an allegation of medical neglect following client A's head injury, 4 allegations of intimidation and theft and personal property destruction by clients E and F towards client A, to thoroughly investigate allegations of theft, exploitation and dental neglect regarding client G and to develop and implement corrective measures to prevent recurrence of intimidation and emotional abuse regarding client A, three incidents of client to client aggression between clients A and F and two allegations of theft and personal property destruction by clients E and F towards client A. Please see W104.</p> <p>2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections for 3 of 3 sampled clients (A, B and C) plus 4</p>		<p>Checks of the facility food supply will be incorporated into routine Operations Team visits to the facility. The facility's current nurse has been trained on expectations for quarterly nursing physicals and nursing physicals which have been completed for the current quarter for Clients A, B and C. A record review indicated the deficient practice also affected Clients D, E, F and G, and nursing physicals have been completed for the current quarter for these individuals. Although Client G has moved out of the facility, the governing body has met with Client G's family to determine appropriate compensation for any current dental needs not covered by Medicaid. An audit conducted by the Operations Team determined that dental follow-along and required follow-up had not occurred for two additional clients, C and D and dental appointments have been scheduled for these individuals. During an investigation into allegations of neglect of Client G's dental care needs, the Operations Team discovered that the Listermint Fluoride Rinse prescribed by Client G's dentist had been discontinued by the manufacturer and that the dentist changed the prescription to Prevident 5000, to take the place of the Listermint. The pharmacy sent one tube of Prevident 5000 on 10/11/13 and a tube of SF</p>	

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	<p>additional clients (D, E, F and G). The governing body failed to implement its policy and procedures to prevent emotional and psychological abuse/intimidation of client A, to prevent neglect of clients A, B, C, D, E, F and G by failing to ensure adequate food supply in the group home, to report 4 separate incidents of physical altercations between clients A and F and 3 allegations of mistreatment, exploitation, theft and dental neglect for client G to BDDS (Bureau of Developmental Disabilities Services) within 24 hours, to complete thorough investigations regarding an allegation of medical neglect following client A's head injury, 4 allegations of intimidation and theft and personal property destruction by clients E and F towards client A, to thoroughly investigate allegations of theft, exploitation and dental neglect regarding client G and to develop and implement corrective measures to prevent recurrence of intimidation and emotional abuse regarding client A, three incidents of client to client aggression between clients A and F and two allegations of theft and personal property destruction by clients E and F towards client A. Please see W122.</p> <p>3. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the</p>		<p>5000 (generic equivalent for Preventid 5000) on 2/4/14 and 6/15/14. The facility's Team Lead and Medical Coach will work directly with the facility nurse to assure prescriptions are filled in a timely manner to facilitate administration of medication in compliance with physician's orders. PREVENTION: Supervisory staff will review all facility documentation to assure incidents are reported as required. Specifically, Team Leads will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment. 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</p>	

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	<p>facility met the Condition of Participation: Health Care Services. The facility's health care services failed to ensure the health status of clients A, B and C was reviewed on a quarterly basis, ensure client G received dental treatment services and ensure client G received medication as ordered by the dentist. Please see W318.</p> <p>This federal tag relates to complaint #IN00165097 and complaint #IN00165161.</p> <p>9-3-1(a)</p>		<p>Team. The Clinical Supervisor (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. Residential Managers 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 Clinical Supervisor 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 Clinical Supervisors will provide weekly updates to the Program 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. The Residential Manager will develop and maintain a staffing</p>		

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			matrix that assures adequate direct support staff who possess the training, skills and capabilities to provide appropriate active treatment and prevent and intervene with challenging behaviors as they occur. The staffing matrix will be reviewed and approved by the Clinical Supervisor and spot checked by the Program Manager. Copies of quarterly nursing physical examinations will be placed in the each individual's medical chart upon completion. The Nurse Manager will maintain a tracking system to assure quarterly nursing physical examinations are completed as required. Specifically when physicals have not been completed by the beginning of the last month of each quarter the Nurse Manager will allot additional nursing resources to the facility to assist with timely completion of required assessments. The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine dental appointments and follow-ups to assure they occur as recommended. The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer medication as	

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			<p>prescribed and that all prescribed medications are available. A new Team Lead is in place at the facility. This Team Lead will be present, supervising active treatment during no less than 4 evening active treatment sessions and one morning active treatment session per week to monitor medication administration and the ordering of newly prescribed medications and treatments. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: 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</p>	

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			include staff from both the day and overnight shifts. 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. 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. 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 and the Director of Operations/Regional Manager no less than monthly for the next 90 days. Administrative support at the home will focus on: 1. Mentorship and training of supervisory staff, monitoring and coaching of direct support staff 2. Evaluation of the effectiveness of current support plans 3. Assuring staff demonstrate necessary competencies. 4. Administrative documentation reviews will focus	

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W 104 Bldg. 00	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 3 of 3 sampled clients (A, B	W 104	on identifying potentially reportable incidents and providing opportunities for training and on site coaching of direct support staff to assure all incidents are reported in a timely manner. 5. Adequate food is present at the facility. Specifically administrators will check to assure food is present in the home corresponding with the menu for the current week and snack food will be present and available to clients based on personal preference within the framework of their prescribed diets. 6. Assuring continuous active treatment occurs. 7. Assuring records of quarterly nursing evaluations are completed and filed appropriately. Copies of audits of medical charts will be provided to the facility nurse and nurse manager to facilitate appropriate follow-up. 8. Assuring required necessary medical follow-along occurs as recommended. 9. Assuring all prescribed medications are available and administered as ordered. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Operations Team CORRECTION: <i>The facility must ensure that specific</i>	03/21/2015	

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	<p>and C) plus 4 additional clients (D, E, F and G), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent emotional and psychological abuse/intimidation of client A, to prevent neglect of clients A, B, C, D, E, F and G by failing to ensure adequate food supply in the group home, to report 4 separate incidents of physical altercations between clients A and F and 3 allegations of mistreatment, exploitation, theft and dental neglect for client G to BDDS (Bureau of Developmental Disabilities Services) within 24 hours, to complete thorough investigations regarding an allegation of medical neglect following client A's head injury, 4 allegations of intimidation and theft and personal property destruction by clients E and F towards client A, to thoroughly investigate allegations of theft, exploitation and dental neglect regarding client G and to develop and implement corrective measures to prevent recurrence of intimidation and emotional abuse regarding client A, three incidents of client to client aggression between clients A and F and two allegations of theft and personal property destruction by clients E and F towards client A.</p> <p>Findings include:</p>		<p><i>governing body and management requirements are met.</i></p> <p>Specifically, the governing body has facilitated the following: The Team Lead, identified in the 2567 as HM#1 no longer works for the company. Facility staff, including Direct Support Professional staff #1, will be retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients.</p> <p>The program Manager has completed an investigation into three allegations of theft and medical neglect regarding Client G. Moving forward, the Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The Governing Body will assume complete responsibility for</p>	

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	<p>1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent emotional and psychological abuse/intimidation of client A, to prevent neglect of clients A, B, C, D, E, F and G by failing to ensure adequate food supply in the group home, to report 4 separate incidents of physical altercations between clients A and F and 3 allegations of mistreatment, exploitation, theft and dental neglect for client G to BDDS within 24 hours, to complete thorough investigations regarding an allegation of medical neglect following client A's head injury, 4 allegations of intimidation and theft and personal property destruction by clients E and F towards client A, to thoroughly investigate allegations of theft, exploitation and dental neglect regarding client G and to develop and implement corrective measures to prevent recurrence of intimidation and emotional abuse regarding client A, three incidents of client to client aggression between clients A and F and two allegations of theft and personal property destruction by clients E and F towards client A. Please see W149.</p> <p>2. The governing body failed to exercise general policy, budget and operating</p>		<p>investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process.</p> <p>Through ongoing assessment, the interdisciplinary team consensually agreed that Client A would be more comfortable in a Medicaid Waiver setting with housemates that more closely shared his developmental, social and behavioral needs. Therefore the team assisted him in transitioning to a new residential setting.</p> <p>The Clinical Supervisor will review all facility grocery receipts to assure an adequate supply of food is being purchased for the home. Checks of the facility food supply will be incorporated into routine Operations Team visits to the facility.</p> <p>The facility's current nurse has been trained on expectations for quarterly nursing physicals and nursing physicals which have been completed for the current quarter for Clients A, B and C. A record review indicated the deficient practice also affected Clients D, E, F and G, and nursing physicals have been completed</p>	

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	<p>direction over the facility to ensure the facility implemented its policy and procedures to report 4 separate incidents of physical altercations between clients A and F and 3 allegations of mistreatment, exploitation, theft and dental neglect for client G to BDDS (Bureau of Developmental Disabilities Services) within 24 hours. Please see W153.</p> <p>3. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to complete thorough investigations regarding an allegation of medical neglect following client A's head injury, 4 allegations of intimidation and theft and personal property destruction by clients E and F towards client A, to thoroughly investigate allegations of theft, exploitation and dental neglect regarding client G. Please see W154.</p> <p>4. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent recurrence of intimidation and emotional abuse regarding client A, three incidents of client to client aggression between clients A and F and two allegations of theft and personal property destruction by clients E</p>		<p>for the current quarter for these individuals.</p> <p>Although Client G has moved out of the facility, the governing body has met with Client G's family to determine appropriate compensation for any current dental needs not covered by Medicaid. An audit conducted by the Operations Team determined that dental follow-along and required follow-up had not occurred for two additional clients, C and D and dental appointments have been scheduled for these individuals.</p> <p>During an investigation into allegations of neglect of Client G's dental care needs, the Operations Team discovered that the Listermint Fluoride Rinse prescribed by Client G's dentist had been discontinued by the manufacturer and that the dentist changed the prescription to Prevident 5000, to take the place of the Listermint. The pharmacy sent one tube of Prevident 5000 on 10/11/13 and a tube of SF 5000 (generic equivalent for Prevident 5000) on 2/4/14 and 6/15/14. The facility's Team Lead and Medical Coach will work directly with the facility nurse to assure prescriptions are filled in a timely manner to facilitate administration of medication in compliance with physician's</p>	

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	<p>and F towards client A. Please see W157.</p> <p>This federal tag relates to complaint #IN00165097 and complaint #IN00165161.</p> <p>9-3-1(a)</p>		<p>orders.</p> <p>PREVENTION: Supervisory staff will review all facility documentation to assure incidents are reported as required. Specifically, Team Leads will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment.</p> <p>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. The Clinical Supervisor (Administrative level</p>	

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			<p>management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers 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 Clinical Supervisor 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 Clinical Supervisors will provide weekly updates to the Program 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.</p> <p>The Residential Manager will</p>	

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			<p>develop and maintain a staffing matrix that assures adequate direct support staff who possess the training, skills and capabilities to provide appropriate active treatment and prevent and intervene with challenging behaviors as they occur. The staffing matrix will be reviewed and approved by the Clinical Supervisor and spot checked by the Program Manager.</p> <p>Copies of quarterly nursing physical examinations will be placed in the each individual's medical chart upon completion. The Nurse Manager will maintain a tracking system to assure quarterly nursing physical examinations are completed as required. Specifically when physicals have not been completed by the beginning of the last month of each quarter the Nurse Manager will allot additional nursing resources to the facility to assist with timely completion of required assessments.</p> <p>The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine dental appointments and follow-ups to assure they occur as recommended.</p> <p>The Residential Manager will be expected to observe no less than</p>	

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			<p>one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer medication as prescribed and that all prescribed medications are available. A new Team Lead is in place at the facility. This Team Lead will be present, supervising active treatment during no less than 4 evening active treatment sessions and one morning active treatment session per week to monitor medication administration and the ordering of newly prescribed medications and treatments.</p> <p>Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active</p>	

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			<p>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> <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</p>	

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			<p>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 and the Director of Operations/Regional Manager no less than monthly for the next 90 days.</p> <p>Administrative support at the home will focus on:</p> <ol style="list-style-type: none"> 1. Mentorship and training of supervisory staff, monitoring and coaching of direct support staff 2. Evaluation of the effectiveness of current support plans 3. Assuring staff demonstrate necessary competencies. 4. Administrative documentation reviews will focus on identifying potentially reportable incidents and providing opportunities for training and on site coaching of direct support staff to assure all incidents are reported in a timely manner. 5. Adequate food is present at the facility. Specifically administrators will check to assure food is present in the home corresponding with the menu for the current week and snack food will be present and available to clients based on 	

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W 122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 3 of 3 sampled clients (A, B and C) plus 4 additional clients (D, E, F and G). The facility failed to implement its policy and procedures to prevent emotional and psychological abuse/intimidation of client A, to prevent neglect of clients A, B, C, D, E, F and G	W 122	personal preference within the framework of their prescribed diets. 6. Assuring continuous active treatment occurs. 7. Assuring records of quarterly nursing evaluations are completed and filed appropriately. Copies of audits of medical charts will be provided to the facility nurse and nurse manager to facilitate appropriate follow-up. 8. Assuring required necessary medical follow-along occurs as recommended. 9. Assuring all prescribed medications are available and administered as ordered. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team CORRECTION: <i>The facility must ensure that specific governing body and management requirements are met. Specifically, the governing body has facilitated the following: The Team Lead, identified in the 2567 as HM#1 no longer works for the company. Facility staff, including Direct Support Professional staff #1, will be retrained regarding procedures</i>	03/21/2015

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	<p>by failing to ensure adequate food supply in the group home, to report 4 separate incidents of physical altercations between clients A and F and 3 allegations of mistreatment, exploitation, theft and dental neglect for client G to BDDS (Bureau of Developmental Disabilities Services) within 24 hours, to complete thorough investigations regarding an allegation of medical neglect following client A's head injury, 4 allegations of intimidation and theft and personal property destruction by clients E and F towards client A, to thoroughly investigate allegations of theft, exploitation and dental neglect regarding client G and to develop and implement corrective measures to prevent recurrence of intimidation and emotional abuse regarding client A, three incidents of client to client aggression between clients A and F and two allegations of theft and personal property destruction by clients E and F towards client A.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to prevent emotional and psychological abuse/intimidation of client A, to prevent neglect of clients A, B, C, D, E, F and G by failing to ensure adequate food supply in the group home, to report 4 separate</p>		<p>for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients.</p> <p>The program Manager has completed an investigation into three allegations of theft and medical neglect regarding Client G. Moving forward, the Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process.</p>	

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	<p>incidents of physical altercations between clients A and F and 3 allegations of mistreatment, exploitation, theft and dental neglect for client G to BDDS (Bureau of Developmental Disabilities Services) within 24 hours, to complete thorough investigations regarding an allegation of medical neglect following client A's head injury, 4 allegations of intimidation and theft and personal property destruction by clients E and F towards client A, to thoroughly investigate allegations of theft, exploitation and dental neglect regarding client G and to develop and implement corrective measures to prevent recurrence of intimidation and emotional abuse regarding client A, three incidents of client to client aggression between clients A and F and two allegations of theft and personal property destruction by clients E and F towards client A. Please see W149.</p> <p>2. The facility failed to implement its policy and procedures to report 4 separate incidents of physical altercations between clients A and F and 3 allegations of mistreatment, exploitation, theft and dental neglect for client G to BDDS (Bureau of Developmental Disabilities Services) within 24 hours. Please see W153.</p> <p>3. The facility failed to implement its</p>		<p>Through ongoing assessment, the interdisciplinary team consensually agreed that Client A would be more comfortable in a Medicaid Waiver setting with housemates that more closely shared his developmental, social and behavioral needs. Therefore the team assisted him in transitioning to a new residential setting.</p> <p>The Clinical Supervisor will review all facility grocery receipts to assure an adequate supply of food is being purchased for the home. Checks of the facility food supply will be incorporated into routine Operations Team visits to the facility.</p> <p>The facility's current nurse has been trained on expectations for quarterly nursing physicals and nursing physicals which have been completed for the current quarter for Clients A, B and C. A record review indicated the deficient practice also affected Clients D, E, F and G, and nursing physicals have been completed for the current quarter for these individuals.</p>	

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	<p>policy and procedures to complete thorough investigations regarding an allegation of medical neglect following client A's head injury, 4 allegations of intimidation and theft and personal property destruction by clients E and F towards client A, to thoroughly investigate allegations of theft, exploitation and dental neglect regarding client G. Please see W154.</p> <p>4. The facility failed to implement its policy and procedures to develop and implement corrective measures to prevent recurrence of intimidation and emotional abuse regarding client A, three incidents of client to client aggression between clients A and F and two allegations of theft and personal property destruction by clients E and F towards client A. Please see W157.</p> <p>This federal tag relates to complaint #IN00165097 and complaint #IN00165161.</p> <p>9-3-2(a)</p>		<p>Although Client G has moved out of the facility, the governing body has met with Client G's family to determine appropriate compensation for any current dental needs not covered by Medicaid. An audit conducted by the Operations Team determined that dental follow-along and required follow-up had not occurred for two additional clients, C and D and dental appointments have been scheduled for these individuals.</p> <p>During an investigation into allegations of neglect of Client G's dental care needs, the Operations Team discovered that the Listermint Fluoride Rinse prescribed by Client G's dentist had been discontinued by the manufacturer and that the dentist changed the prescription to Prevident 5000, to take the place of the Listermint. The pharmacy sent one tube of Prevident 5000 on 10/11/13 and a tube of SF 5000 (generic equivalent for Prevident 5000) on 2/4/14 and 6/15/14. The facility's Team Lead and Medical Coach will work directly with the facility nurse to assure prescriptions are filled in a timely manner to facilitate</p>	

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			<p>administration of medication in compliance with physician's orders.</p> <p>PREVENTION:</p> <p>Supervisory staff will review all facility documentation to assure incidents are reported as required. Specifically, Team Leads will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment.</p>	

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			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. The Clinical Supervisor (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. Residential Managers 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 Clinical Supervisor 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 Clinical Supervisors will provide weekly updates to the Program	

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			<p>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.</p> <p>The Residential Manager will develop and maintain a staffing matrix that assures adequate direct support staff who possess the training, skills and capabilities to provide appropriate active treatment and prevent and intervene with challenging behaviors as they occur. The staffing matrix will be reviewed and approved by the Clinical Supervisor and spot checked by the Program Manager.</p> <p>Copies of quarterly nursing physical examinations will be placed in the each individual's medical chart upon completion. The Nurse Manager will maintain a tracking system to assure quarterly nursing physical examinations are completed as required. Specifically when physicals have not been completed by the beginning of the last month of each quarter the Nurse Manager will allot additional nursing resources to</p>	

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			<p>the facility to assist with timely completion of required assessments.</p> <p>The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine dental appointments and follow-ups to assure they occur as recommended.</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer medication as prescribed and that all prescribed medications are available. A new Team Lead is in place at the facility. This Team Lead will be present, supervising active treatment during no less than 4 evening active treatment sessions and one morning active treatment session per week to monitor medication administration and the ordering of newly prescribed medications and treatments.</p>	

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			<p>Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team 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</p>	

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			<p>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 recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility and the Director of Operations/Regional Manager no less than monthly for the next 90 days.</p>	

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			<p>Administrative support at the home will focus on:</p> <ol style="list-style-type: none"> 1. Mentorship and training of supervisory staff, monitoring and coaching of direct support staff 2. Evaluation of the effectiveness of current support plans 3. Assuring staff demonstrate necessary competencies. 4. Administrative documentation reviews will focus on identifying potentially reportable incidents and providing opportunities for training and on site coaching of direct support staff to assure all incidents are reported in a timely manner. 5. Adequate food is present at the facility. Specifically administrators will check to assure food is present in the home corresponding with the menu for the current week and snack food will be present and available to clients based on personal preference within the framework of their prescribed diets. 6. Assuring continuous active 	

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W 149 Bldg. 00	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 3 of 3 sampled clients (A, B, C) plus 4 additional clients (D, E, F and G), the facility failed to implement its policy and procedures to prevent emotional and psychological abuse/intimidation of client A, to prevent neglect of clients A, B, C, D, E, F and G	W 149	<p>treatment occurs.</p> <p>7. Assuring records of quarterly nursing evaluations are completed and filed appropriately. Copies of audits of medical charts will be provided to the facility nurse and nurse manager to facilitate appropriate follow-up.</p> <p>8. Assuring required necessary medical follow-along occurs as recommended.</p> <p>9. Assuring all prescribed medications are available and administered as ordered.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION: <i>The facility must ensure that specific governing body and management requirements are met. Specifically, the governing body has facilitated the following:</i></p>	03/21/2015

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	<p>by failing to ensure adequate food supply in the group home, to report 4 separate incidents of physical altercations between clients A and F and 3 allegations of mistreatment, exploitation, theft and dental neglect for client G to BDDS (Bureau of Developmental Disabilities Services) within 24 hours, to complete thorough investigations regarding an allegation of medical neglect following client A's head injury, 4 allegations of intimidation and theft and personal property destruction by clients E and F towards client A, to thoroughly investigate allegations of theft, exploitation and dental neglect regarding client G and to develop and implement corrective measures to prevent recurrence of intimidation and emotional abuse regarding client A, three incidents of client to client aggression between clients A and F and two allegations of theft and personal property destruction by clients E and F towards client A.</p> <p>Findings include:</p> <p>1. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/9/15 at 3:00 PM. The review indicated the following:</p> <p>-BDDS report dated 7/19/14 indicated,</p>		<p>Facility staff, including staff #1, will be retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients.</p> <p>The program Manager has completed an investigation into three allegations of theft and medical neglect regarding Client G. Moving forward, the Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is</p>	

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	<p>"[Client A] was looking for his inventory scanner from work in the facility van with assistance from staff. [FC H] came out to the van and became angry when [client A] would not answer his questions regarding what [client A] was doing in the van. [FC H] re-entered the house and returned with a souvenir miniature baseball bat and hit [client A] in the arm, stomach and head in quick succession. Staff intervened immediately and separated them. [Client A] sustained a 2 inch laceration on his forehead. Staff called 911, provided first aid and [client A] was transported to the [hospital] emergency department via ambulance."</p> <p>-Investigative summary form dated 7/23/14 regarding client A's 7/19/14 incident indicated the "Scope of Investigation: Did [staff #2] fail to intervene in a timely manner in order to prevent [client A] from getting injured by [FC H]?" The 7/23/14 Investigative Summary form indicated, "Conclusions: The evidence does not substantiate that [staff #2] failed to intervene in a timely manner in order to prevent [client A] from being injured by [FC H]." The 7/23/14 Investigative form did not indicate documentation of a finding of fact or determination if client A was abused by FC H. The 7/23/14 Investigative form did not substantiate</p>		<p>uncovered or alleged the Operations Team will take control of all aspects of the investigation process.</p> <p>Through ongoing assessment, the interdisciplinary team consensually agreed that Client A would be more comfortable in a Medicaid Waiver setting with housemates that more closely shared his developmental, social and behavioral needs. Therefore the team assisted him in transitioning to a new residential setting.</p> <p>The Clinical Supervisor will review all facility grocery receipts to assure an adequate supply of food is being purchased for the home. Checks of the facility food supply will be incorporated into routine Operations Team visits to the facility.</p> <p>The facility's current nurse has been trained on expectations for quarterly nursing physicals and nursing physicals which have been completed for the current quarter for Clients A, B and C. A record review indicated the deficient practice also affected</p>	

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	<p>client to client abuse regarding FC H's hitting client A with a baseball bat.</p> <p>-BDDS report dated 7/23/14 indicated, "On 7/22/14 [client A] was taken to the ER (Emergency Room) with complaint of headaches, dizziness and not feeling well. While in the ER [client A] had his blood drawn, a urine test and a cat scan. All tests came back normal, the second cat scan showed no signs of bleeding or anything strange. [Client A's] diagnosis is Post Contusion syndrome and all the symptoms he was having are a result of the incident that took place on Friday 7/19/14. He also stated that nothing else can be done at this time and to keep [client A] on an every 30 minute observation. The doctor also stated that this could last for a few days up to six weeks. The doctor took him off work for 2 days so he can rest and see if this helps with his headaches."</p> <p>-BDDS follow up report dated 7/25/14 indicated, "[BDDS Generalist] received call from [client A's] mother, regarding recent incident where [client A] was struck by housemate, went to ER and had another subsequent visit to the ER since the incident. [Client A's] mother is not happy with care consumer has received by group home staff. For example, [client A] was put on bed rest but group home</p>		<p>Clients D, E, F and G, and nursing physicals have been completed for the current quarter for these individuals.</p> <p>Although Client G has moved out of the facility, the governing body has met with Client G's family to determine appropriate compensation for any current dental needs not covered by Medicaid. An audit conducted by the Operations Team determined that dental follow-along and required follow-up had not occurred for two additional clients, C and D and dental appointments have been scheduled for these individuals.</p> <p>During an investigation into allegations of neglect of Client G's dental care needs, the Operations Team discovered that the Listermint Fluoride Rinse prescribed by Client G's dentist had been discontinued by the manufacturer and that the dentist changed the prescription to Prevident 5000, to take the place of the Listermint. The pharmacy sent one tube of Prevident 5000 on 10/11/13 and a tube of SF 5000 (generic equivalent for Prevident 5000) on 2/4/14 and 6/15/14. The facility's Team Lead</p>	

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	<p>staff took [client A] out of the house for transport."</p> <p>The review did not indicate documentation of an investigation regarding client A's mother's concerns/allegations regarding the quality of care provided by group home staff for client A.</p> <p>-BDDS report dated 9/18/14 indicated, "Incident involving [client F] and [client A]. [Client A] became upset about the way that [client F] was cursing at the staff. [Client F] then began to taunt [client A] by saying that he will beat him up. After going to his room to get his phone [client F] began to intimidate [client A] by not allowing [client A] to exit his bedroom."</p> <p>The review did not indicate documentation of an investigation regarding client F's intimidation/emotional abuse of client A. The review did not indicate documentation of corrective measures to prevent recurrence of client F's intimidation/emotional abuse of client A.</p> <p>-BDDS report dated 11/11/14 indicated, "[Client A] informed staff that someone came into his room and broke his TV remote and at least 4 xbox video games."</p>		<p>and Medical Coach will work directly with the facility nurse to assure prescriptions are filled in a timely manner to facilitate administration of medication in compliance with physician's orders.</p> <p>PREVENTION:</p> <p>Supervisory staff will review all facility documentation to assure incidents are reported as required. Specifically, Team Leads will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment.</p>	

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	<p>The 11/11/14 BDDS report indicated, "The team did recover a broken remote and at least 4 broken xbox games. It has not been made clear who could have done this. The team will continue to investigate this incident."</p> <p>The review did not indicate documentation of an investigation regarding client A's 11/11/14 incident of his personal property being damaged. The review did not indicate documentation of corrective measures to prevent recurrence of client A's personal property being damaged.</p> <p>-BDDS report dated 11/25/14 indicated, "After returning from church, [client A] found that his bedroom door was kicked open and many of his personal items were broken and destroyed. After communicating with each individual within the home, it was discovered that [client E] did except (sic) responsibility for destroying [client A's] items." The 11/25/14 BDDS report indicated, "The team will meet to discuss possible solutions to prevent this type of behavior in the future."</p> <p>The review did not indicate documentation of corrective measures to prevent recurrence of client A's personal property being damaged.</p>		<p>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. The Clinical Supervisor (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. Residential Managers 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 Clinical Supervisor 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 Clinical Supervisors will provide weekly updates to the Program</p>		

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	<p>-BDDS report dated 2/3/15 indicated, "[Client F] became agitated and excessively pushed open the medication (sic) which caused it to come off of hinges."</p> <p>The 2/3/15 BDDS report did not indicate documentation of client A being chased by client F into the medication room or describe the circumstances of client A holding the medication room door shut to prevent client F from attacking him.</p> <p>The review did not indicate documentation of an investigation regarding the 2/3/15 incident of alleged client to client abuse/intimidation or recommendations to prevent recurrence.</p> <p>Client A was interviewed on 2/10/15 at 10:30 AM. Client A indicated he had been moved from the group home residence to a local hotel on 2/2/15. When asked how things were going at the group home, client A stated, "I'm so glad to be out of that house. I was always [expletive] stressed out. Worried if any of the [expletive], if I was going to have problems with [client E] or [client F]. I was always worried if I was going to get my [expletive] kicked." Client A stated, "We, [client A and client F], fight all the time. I just can't trust that the staff are</p>		<p>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.</p> <p>The Residential Manager will develop and maintain a staffing matrix that assures adequate direct support staff who possess the training, skills and capabilities to provide appropriate active treatment and prevent and intervene with challenging behaviors as they occur. The staffing matrix will be reviewed and approved by the Clinical Supervisor and spot checked by the Program Manager.</p> <p>Copies of quarterly nursing physical examinations will be placed in the each individual's medical chart upon completion. The Nurse Manager will maintain a tracking system to assure quarterly nursing physical examinations are completed as required. Specifically when physicals have not been completed by the beginning of the last month of each quarter the Nurse Manager will allot additional nursing resources to</p>	

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	<p>going to [expletive] do anything. They just stand there and watch. That's how the railing in the kitchen got destroyed. [Client F] was attacking me, he had my whole body up over the railing. My legs kicked the table that sits in the dining area when I was going over the railing. I was like, I don't know if staff are coming to help me or not? I had to fight back." Client A stated, "When I got back to the house from my meeting about leaving the group home for independent living, they told me not to talk to the other guys about my leaving. When I came in the house [client F] was starting to walk toward me. I told [staff #1], 'Hey, can you keep him away from me. I just don't, I don't want him to come near me.' That was in the hallway, [staff #1] just stood there and didn't say a [expletive] thing while [client F] started coming at me. I went downstairs to the medication room, shut the door and sat against it to keep him from attacking me. He busted the door off the hinges and they didn't do anything to help." Client A stated, "It was just constantly something at the house. Every time I would come home my room would be destroyed. I'd come home from church or being home with my mom and find my room tore up. My games, DVD's and television. They tore up my trophies from Special Olympics. [Client E] kicked in my locked bedroom door to get in to tear</p>		<p>the facility to assist with timely completion of required assessments.</p> <p>The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine dental appointments and follow-ups to assure they occur as recommended.</p> <p>The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer medication as prescribed and that all prescribed medications are available. The team Lead will be present during no less than 5 active treatment sessions per week to monitor medication administration and the ordering of newly prescribed medications and treatments.</p> <p>Members of the Operations Team and the QIDP will conduct active treatment observations and documentation reviews no less</p>	

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	<p>up my stuff. The staff were just like, 'Oh, really. We didn't see anything and don't know anything about [client E] tearing up your stuff.'" Client A stated, "Like when [former client H] attacked me last summer. I was in the van looking for my scanner for work. I was worried I was going to lose my job because I couldn't find the scanner. I thought maybe I left it in the van and was looking for it. [FC (Former Client) H] came outside cursing at me, I was [expletive] freaked out. The staff that was outside with me didn't say a thing or do anything so I threw a trash can between me and [FC H], to keep him away. That's when I saw the baseball bat. I started throwing punches while he started hitting me with the bat. I ended up in the hospital. The staff just stood there. He didn't even help me." Client A stated, "It was so stressful being there. When I got to the hotel it took me like three days to just be able to relax and sleep at night. I couldn't sleep the first few nights because I was still so stressed and felt like I had to worry about getting attacked or my stuff destroyed."</p> <p>HM (Home Manager) #1 was interviewed on 2/11/15 at 1:00 PM. HM #1 indicated clients A and F had a physical altercation which resulted in the decorative railing being broken in the group home's kitchen area. HM #1 did not recall the details of</p>		<p>than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Administrative support at the home will focus on:</p> <ol style="list-style-type: none"> 1. Mentorship and training of supervisory staff, monitoring and coaching of direct support staff 2. Evaluation of the effectiveness of current support plans 3. Assuring staff demonstrate necessary competencies. 4. Administrative documentation reviews will focus on identifying potentially reportable incidents and providing opportunities for training and on site coaching of direct support staff to assure all incidents are reported in a timely manner. 5. Adequate food is present at the facility. 	

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	<p>the altercation but stated that he "Thought that [client A] had pushed [client F]".</p> <p>The review did not indicate documentation of clients A and F's physical altercation which resulted in breaking the decorative railing in the group home's kitchen area had been reported to BDDS, investigated or corrective measures being developed and implemented to prevent recurrence.</p> <p>Client F's record was reviewed on 2/11/15 at 8:30 AM. Client F's Progress Notes indicated the following:</p> <p>-"9/25/14, [Client F] was doing good took (sic) his dinner and went to dancing (sic) at the office came back (sic) took his medication and went to downstairs (sic) watching TV. I just heard a noise and I run down see (sic) the other staff try (sic) to stop [client F] and [client A] but they refuse and the other staff run and call [Home Manager (HM) #1] on phone and she come (sic) and try to stop them but [client F] and [client A] was try to jump on them (sic). [Client F] push [client A] and he fell down and later [HM #1] talk to them they stop it (sic)."</p> <p>The review of BDDS reports did not indicate documentation of clients A and</p>		<p>6. Assuring continuous active treatment occurs.</p> <p>7. Assuring records of quarterly nursing evaluations are completed and filed appropriately. Copies of audits of medical charts will be provided to the facility nurse and nurse manager to facilitate appropriate follow-up.</p> <p>8. Assuring required necessary medical follow-along occurs as recommended.</p> <p>9. Assuring all prescribed medications are available and administered as ordered.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>F's 9/25/14 incident of client to client aggression.</p> <p>- "1/2/15, [Client F] took fight with [client A]."</p> <p>The review of BDDS reports did not indicate documentation of clients A and F's 1/2/15 physical altercation being reported to BDDS, investigated or corrective measures being developed and implemented to prevent recurrence.</p> <p>- "2/2/15, [Client F] was good take (sic) his dinner and later fight with [client A]. [Client A] inside the medication room for his medication [client F] try to open but (sic) but [client A] refuse to open (sic). [Client F] push the door down broke it and [client A] left (sic)."</p> <p>The review of BDDS reports did not indicate documentation of clients A and F's 2/2/15 physical altercation being reported to BDDS, investigated or corrective measures being developed and implemented to prevent recurrence.</p> <p>Client A's mother/advocate was interviewed on 2/16/15 at 9:10 AM. Client A's mother/advocate stated, "He, [client A], was so stressed being in the house. Staff would just not help him in those moments when he was getting</p>			

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	<p>upset. Like when they destroyed his bedroom, nobody helped him. No staff talked him through his feelings about the incident or worked with him while he cleaned up his room." Client A's mother/advocate stated, "[Client A] had left a box of his movies and games in the group home van when he was moving some stuff from the group home to his new independent living house. After [client A] dropped off the items at the house he came home for a visit. When they picked him up from our house to take him back to the group home, he found his box on the van. The box was empty. [Clients E and F] had gone through his box and had staff take them to [electronics store] to sell them for cash. How do the staff not know anything about his games? The staff that took [clients E and F] didn't have a clue about what they sold. They just don't care and won't help." Client A's mother/advocate stated, "The care that [client A] received after his concussion was horrible. They had him up and out of the house while he was supposed to be resting." Client A's mother/advocate stated, "The targeting got progressively worse. I can work with ResCare through things like his room being destroyed but when the physical stuff got worse, I was like, I can't work through something physically happening to him. That's when we demanded that</p>			
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	<p>[client A] not return to the group home. [Client A's] been in the hotel since 2/2/15. At one point, [clients E and F] had started trying to get [client C], who is lower functioning, to hit [client A] with a piece of a metal rod." Client A's mother/advocate stated, "We were scared for his safety. [Client A] couldn't deal with the emotional stress and anxiety of being in that house any more. [Client A] was afraid of them and intimidated because the staff would just stand there and not help."</p> <p>AS (Administrative Staff) #1 was interviewed on 2/9/15 at 3:30 PM. AS #1 indicated client F had incidents of aggression towards client A. AS #1 indicated there had been incidents of clients E and F destroying some of client A's personal property. AS #1 stated, "[Client A's] case manager wanted [client A] out of the house." AS #1 indicated client A was moved temporarily to a hotel until his independent living arrangements were finalized. When asked if client A was intimidated or fearful of clients E or F, AS #1 stated, "The parents were probably scared for him. I don't recall hearing him say he was."</p> <p>2. Client G's mother/advocate was interviewed on 2/16/15 at 11:10 AM. Client G's mother/advocate provided the</p>			

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	<p>following electronic correspondences between herself, her husband and AS (Administrative Staff) #1, AS #2 and CS (Clinical Supervisor) #1:</p> <p>-Electronic Correspondence dated 1/22/15 indicated, "[CS #1] is aware of the missing shoes. There was a trash bag filled with all of [client G's] shoes that was stored in the garage and now missing from the house. About 20 pairs or so. They were in the metal storage rack between the door from the house and the garage door closest to the steps to the back porch. That bag was there on December 30th when [client G] went back to [group home] for a couple of days. [HM (Home Manager) #1] is aware that they were stored in the garage as well." The electronic correspondence dated 1/22/15 indicated, "We do not have the Wii." The electronic correspondence dated 1/22/15 indicated, "Additionally, [client G's] computer broke this past summer 2014 and a ResCare employee at [group home] offered to fix it for him. That computer has not been returned and the employee is apparently no longer in your employ. Not the first time [client G's] belongings, cash, wallet, etc have vanished with a former employee. [CS #1] is aware of all these occurrences."</p> <p>-Electronic Correspondence dated</p>			

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	<p>1/25/15 indicated, "On Friday (1/23/15) we determined the fact that many of [client G's] shoes were thrown away as instructed during a garage clean-out. We were in that garage on Tuesday and Friday and it does not look like any of the other residents property had been touched. In that bag were several pairs of sneakers; including two pairs of [designer shoes] (\$150.00/each), 2 pairs of [designer shoes] (\$90.00/each), a pair of [designer shoes] (\$80.00/each), 5 or 6 pairs of random [designer shoes] and [sports shoes] (\$75.00/each), two pairs of dress leather shoes (\$80.00/each), a pair of suede leather shoes (\$70.00), two pairs of lined slipper (\$35.00/each), sandals (\$35.00), (sic) at least two pairs of top quality walking shoes bought for [retail store] job (\$80.00/each). All of these were in excellent, very lightly worn condition. And of course a few old shoes for yard work that have no real value. Some were gifts, some he purchased himself but the origin of where they came from and who purchased them is not relevant.</p> <p>Is it even slightly legal to dispose of property that does not belong to ResCare? This was personal property of a client in your care who had every expectation that his personal property would be 'safe' in his place of residence. One of the guys at the house shared with</p>			

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	<p>us that this was [CS #1's] instruction and that [CS #1] stated if [client G] had wanted them he should have taken them with him. That some logic could have applied to his clothes, bedding, bed, etc because he didn't bring those home with him either."</p> <p>-Electronic Correspondence dated 2/6/15 indicated, "[AS #1], your apologies for recent barriers and vow to make things right are appreciated. I'm curious to know what can restore [client G's] dental health, so as to make this right? [Client G's] dental records indicate that in 2013 it was determined he had 4 cavities. [Client G] was prescribed both fluoride toothpaste and mouthwash. These prescriptions were never filled, nor were the cavities. [Client G's] next dental visit was in 2015, at which time the dentist you lined up for him said there were now 8 cavities. I have since taken [client G] to my dentist. These are not cavities but rather areas of total decay, at a minimum 12 entire areas. [Dentist] has already begun the process of doing what can be done for him, one quadrant of the mouth at a time. Stainless steel caps rather than simple fillings. It will require weeks of additional very painful work to accomplish anything. How can this be made right? Missing items like his shoes or golf clubs can fairly easily be replaced.</p>			

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	<p>You made some indication that there was a willingness to replace his missing game system with one of comparable age and condition. Can you somehow restore his teeth to the comparable age and condition they were in 2013? There seems no way of knowing what impact an immediate follow up visit to address the cavities and having filled the prescriptions which were ignored might have had, were it to have been done in a timely manner."</p> <p>-Electronic Correspondence dated 2/14/15 indicated, "... have gone over the financial statement you provided at our meeting on Friday February 6th. After reviewing each separate entry and the corresponding check copies/receipts that were provided, we have several items in question. During the meeting you agreed... that if there was no signature verification that, yes, those payments should be in question and that [client G] is entitled to have those funds returned to him, including the dances he did not attend." The 2/14/15 Electronic Correspondence indicated, "Additionally, there are few (discrepancies) I will specifically cite:</p> <p>(1.) 11/30/12- A check identified for a game system in the amount of \$430.17 has no signature verification or receipts attached, and no entry found that this was redeposited back into [client G's]</p>			

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	<p>account; (2.) 12/28/12- a check identified as simply cash for \$317.00 has no receipts or signature documentation attached to validate it and no entry that this was redeposited back into his account; (3.) 12/18/14- a check identified for cigarettes in the amount of \$100.00 has no signature validation or receipts attached and again, no entry that this was redeposited back into his account. None of this takes into account [client G's] statement that frequently he was forced to sign over his checks in exchange for partial funds and a check cashing fee charged by the staff member who processed the transaction for him. Taking all these facts into account we have determined that [client G] is owed reimbursement on this topic in the amount of \$1,771.17.</p> <p>Then there is the matter of the shoes which were detailed in the email that I sent you on 1/25/15 titled [client G]-discarded personal property. The reimbursement to replace the shoes is a very fair estimate- as you agreed to in our meeting on 2/6/15. Please review the email below. [Client G] is entitled to a reimbursement for his discarded shoes in the amount of \$1430.00. The Wii Fitness that was stolen and never replaced needs to be reimbursed as well- replacement value of \$100.00. [AS #1] indicated that</p>			

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	<p>[former manager] indicated that this had been returned to me. If that is the case, please provide a document I signed for receipt of the return of this property.</p> <p>Total for loss of personal property and funds that cannot be validated as being received by [client G] total \$3,729.16. [Client G] should also be reimbursed for various personal items that were stolen/taken from him- such as his missing wallet and identification, taken by a former ResCare employee, that had to be replaced, keys/lanyards taken by staff 'in the event they needed to access his locker' and never returned. The replacement cost of several new locks due to the lost keys, etc. The value of these items is insignificant in comparison with the above issues, but has been an ongoing topic since the day [client G's] care was entrusted to the supervision of ResCare.</p> <p>On the matter of [client G's] dental care this must remain an open issue until all the dental work is completed and it is determined what Medicaid will cover. [Client G] has had two appointments to date resulting in 3 silver caps. It will be at least two more visits to finish the repair/restoration work. [Client G's] mouth is in too much pain to do a third appointment this week, so it is scheduled for the following week."</p>			

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	<p>The facility's BDDS reports and investigations were reviewed on 2/9/15 at 3:00 PM. The review did not indicate documentation of client G's mother/advocate's 1/22/15, 1/25/15 or 2/6/15 allegations of mistreatment, exploitation, theft and dental neglect had been reported to BDDS. The review did not indicate documentation of an investigation being completed regarding the 1/22/15 and 1/25/15 allegations. The review did not indicate documentation of an investigation being initiated regarding the 2/6/15 allegations.</p> <p>AS #1 was interviewed on 2/9/15 at 3:30 PM. AS #1 stated, "[Client G's] mom had concerns so we set up a meeting on 2/6/15 to try to sit down and talk. There were emails from her but it seemed like it would be better to sit down and talk in person to get clarification. Mom told us that [client G] had been to the dentist on 1/13/15 and had found something like 8 cavities. Then mom took [client G] to their family dentist and they said it wasn't cavities but areas of decay." AS #1 stated, "When I started looking into it, I was not able to find documentation of [client G] going to the dentist in 2014."</p> <p>Client G's record was reviewed on 2/11/15 at 8:48 AM. Client G's Dental</p>			

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	<p>Summary Progress Report dated 9/18/13 indicated, "Exam/, fluoride varnish. Oral hygiene extremely poor. New decay/cavities. Brushing stressed. Recommendations: Listermint with fluoride. Next visit restoration with follow up visit 3/2014." Client G's Physician's Orders form dated 12/19/14 did not indicate documentation of an order for Listermint with fluoride. Client G's record of visit form dated 1/13/15 indicated client G had 8 cavities. Client G's record did not indicate documentation of dental care from 9/18/13 through 1/13/15.</p> <p>DON (Director of Nursing) was interviewed on 2/11/15 at 12:02 PM. DON #1 indicated client G had a dental prescription for Listermint with fluoride dated 9/18/13. DON #1 indicated there was not documentation of client G's 9/18/13 prescription for Listermint with fluoride had been filled or implemented.</p> <p>AS #1 was interviewed on 2/10/15 at 2:20 PM. AS #1 indicated client G's mother/advocate had voiced concerns through a series of emails. AS #1 indicated the concerns/allegations included missing electronic items, shoes, money and dental treatment. AS #1 indicated client G's mother/advocate's allegations had not been reported to</p>			

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	<p>BDDS and had not been formally investigated.</p> <p>3. The facility's BDDS reports and investigations were reviewed on 2/9/15 at 3:00 PM. The review indicated the following:</p> <p>-BDDS report dated 2/3/15 indicated, "[BDDS Generalist] made unannounced visit to the consumer's group home. One staff person was at the home, when [BDDS Generalist] asked what consumers were in the home, staff provided 2 names. Upon looking throughout the home, [BDDS Generalist] found [client B] in hallway (staff did not realize he was in the home, staff did not know where remaining consumers and other staff were). Since this consumer, [client B], had just experienced a recent incident report regarding his diabetes, [BDDS Generalist] asked a few questions as to how he is currently feeling. [Client B] stated regarding the incident he is fine, but also stated he hasn't been to work at (the) sheltered workshop for a while due to a problem with his back. [BDDS Generalist] has not been made aware of any ongoing issues regarding [client B's] back. [Client B] also stated, he has been taken to look at a potential [independent living] home, by ResCare staff, and he believes he is already paying rent towards</p>			

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	<p>the home to reserve his spot in the home. [BDDS Generalist] explained to consumer that he does not currently have a [independent living] waiver yet, and shouldn't be taken to look at potential homes until then. [Client B] seemed confused and mildly upset. [BDDS Generalist] then witnessed consumer serving himself dinner, which consisted of 3 hot dogs and a handful of french fries, staff was not present in the room when [client B] served himself. [BDDS Generalist] asked staff, why the consumer was eating alone. Staff reported that all other consumers had eaten earlier, [client B] reported he was never told dinner was ready. [BDDS Generalist] then asked if [client B's] dinner was appropriate according to any kind of dietary plans for diabetes, staff stated she knew nothing of any kind of restrictions. [BDDS Generalist] then asked to see (the) menu planner, staff did not know where it was, when one book was located by (an) alternate staff, the book had no menus in it for February 2015. [BDDS Generalist] looked in refrigerator, only a half gallon of milk for 8 male consumers, no fresh fruit or vegetables were in (the) refrigerator; very little frozen items either. Upon further questioning of all of the consumers in the home, none could state what they had eaten for lunch or breakfast that day, nor</p>			
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	<p>was there any kind of documentation of what the day's menu consisted of. [Client B] also stated he hadn't eaten all day, and it was obvious to [BDDS Generalist] that [client B] had not bathed/washed hair for at least a few days. [Client B] showed [BDDS Generalist] his room, which was extremely dirty and messy, [client B] stated he is never really encouraged to clean, but knows himself it should be cleaner. Out of all the concerns [BDDS Generalist] has from visit, meals for [client B] are the most concerning, especially since staff was not paying attention to what he was eating and consumer was not being encouraged to eat fresh fruit/vegetables, very concerning because of his diabetes."</p> <p>-Investigative Summary form dated 2/9/15 indicated, "On 2/4/15, [CS #2] received notification that a reportable was submitted to the state by [BDDS Generalist], outlining some concerns she observed while visiting the [group home] on 2/3/15. The incident type was listed as alleged neglect." The Investigative Summary form dated 2/9/15 did not indicate documentation of BDDS Generalist being interviewed or HM #1 who was responsible for purchasing the home's food. The 2/9/15 Investigative Summary form indicated, "(4.) The evidence does substantiate that the staff</p>			

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	<p>and consumers at the [group home] do not participate in family style dining on a regular basis. Interviews by staff and consumers indicate that until recently the consumers would not eat together or at designated times; (5.) The evidence does substantiate that the staff do not prepare meals for the consumers according to the menu. Interviews with staff and consumers indicate that staff were not following a menu in the home when preparing meals; (6.) The evidence does substantiate that staff do not document on the substitution menu when consumers eat meal items not on the menu. Interviews with staff and consumers indicate that staff were not documenting on a substitute menu; (7.) The evidence does substantiate that not all of the staff at [group home] are trained on [client B's] diabetes."</p> <p>Observations were conducted at the group home of clients B, C, D, E, F and G on 2/9/15 from 1:15 PM through 3:15 PM. The group home's kitchen refrigerator contained a package of 2 dozen eggs, a gallon size plastic baggie of bacon, a package of ground beef, three packages of chicken meat, no milk, no fruit and no vegetables. The group home's kitchen refrigerator freezer compartment contained 2 containers of frozen juice concentrate and 5 packages</p>			

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	<p>of chicken meat and no fruit or vegetables. The group home's freezer in the laundry room area contained 1 bag of corn on the cob, 1 bag of green beans, 1 bag broccoli and 5 packages of chicken meat. The group home's storage cabinet in the kitchen contained 10 packages of pre-mixed dried rice and seasonings with no cans of vegetables, fruits or other dry goods. The group home's refrigerator located in the basement contained a package of bottled waters and 2 two liter bottles of diet soda.</p> <p>BDDS Generalist #1 was interviewed on 2/9/15 at 1:15 PM. BDDS Generalist #1 stated, "There's really not enough food in the house. No fruit, no vegetables, no milk. There's no menu to look at to see what they should be eating."</p> <p>Client B was interviewed on 2/9/15 at 5:20 PM. Client B stated, "There's not always food in the house. Except, chicken. I mean we get chicken for like every meal. Chicken and rice. Sometimes we leave for work without breakfast and without lunches packed. We will leave and the staff will be like, 'don't worry about it we'll bring you lunch at the workshop later'. Today, we knew state was in the house, we knew something was up when staff showed up at work at around 3:00 PM with our lunches. I was</p>			
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	<p>like, lunch was at 12:00 PM and we leave at 3:30 PM why are you bringing us lunch now? I had to get some apple juice from the nurse's station at work so my blood sugar wouldn't drop."</p> <p>Client A was interviewed on 2/10/15 at 10:30 AM. Client A stated, "There was never enough food in the house. You know, it was like, we got chicken. [Expletive] chicken for every meal. I was like, can we have anything besides [exp letive] chicken? We would ask for more food or things to eat and the staff would tell us they didn't have money on the account to buy anything. Lunches [expletive], would be like a sandwich and bottle of water. I mean, hello, this is not [expletive] enough."</p> <p>Client A's mother/advocate was interviewed on 2/16/15 at 9:10 AM. Client A's mother/advocate stated, "The house was often low on food supply. Staff would say that they had a budget of \$1,200.00 for food but the fridge was almost empty at times. Clients were routinely given small portions. I asked to see staff's documentation of [client A's] chart for his weight, I knew he had lost weight. The chart had blank spaces and notes that [client A] had refused to be weighed. They weigh the clients on Sundays. [Client A] goes to church on</p>			

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	<p>Sundays so there's no way he was refusing since he wasn't even in the house. There was not accurate documentation of his weight but I could see that he clearly had been losing weight. [Client A] would call me all the time and say 'Mom, we are hungry. There's not any food in the house.' [Client A] took pictures of his meals with his cell phone and sent them to us. The size of some of the meals was minimal."</p> <p>Client G's mother/advocate was interviewed on 2/16/15 at 11:10 AM. Client G's mother/advocate stated, " The diets are not being followed in the house. The staff will skip meals. Then they had staff in the home that weren't familiar with how to make sandwiches. They would send sandwiches to work with peanut butter, jelly and lunch meat."</p> <p>CS #1 was interviewed on 2/11/15 at 1:00 PM. CS #1 indicated the facility's abuse and neglect policy should be implemented. CS #1 indicated all allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be reported to BDDS within 24 hours of knowledge of the allegation. CS #1 indicated all allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be thoroughly</p>			

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	<p>investigated and the results of the investigation reported to the facility administrator within 5 business days. CS #1 indicated the corrective actions to prevent abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be developed and implemented to prevent reoccurrence.</p> <p>The facility's policies and procedures were reviewed on 2/18/15 at 11:49 AM. The facility's policy entitled, "Abuse, Neglect, Exploitation, Mistreatment" dated 2/26/11 indicated the following:</p> <p>- "Adept staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, or mistreatment 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 and state and federal guidelines."</p> <p>- "Physical abuse: the act or failure to act that results or could result in physical injury to an individual. Non-accidental injury inflicted by another person or persons."</p> <p>- "Intimidation/emotional abuse: the act or failure to act that results or could result in</p>			

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	<p>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>- "Exploitation: an act that deprives an individual of real or personal property property by fraudulent or illegal means. Utilization of another person for selfish purposes."</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, drink, shelter, clothing and to provide a safe environment."</p> <p>- "Medical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide necessary medical attention, proper nutritional support or administering medications as prescribed."</p> <p>The facility's policy entitled,</p>			

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	<p>'Investigations' dated 9/14/07 indicated the following:</p> <p>- "The primary purpose of an investigation is to describe and explain factors contributing to an incident and to prevent (sic) recurrence."</p> <p>- "Witnesses: Anyone who directly observed an incident or was affected by the incident, or who was directly or indirectly involved in the process i.e. injured parties, eyewitnesses, or other participants."</p> <p>- "A thorough investigation final report will be written at the completion of the investigation. The report shall include, but is not limited to, the following:... Finding of fact and determination as to whether or not the allegations are substantiated, unsubstantiated or inconclusive; Concerns and recommendations...; Methods to prevent future incidents."</p> <p>This federal tag relates to complaint #IN00165097 and complaint #IN00165161.</p> <p>9-3-2(a)</p>			

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W 153 Bldg. 00	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 7 of 17 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to report 4 separate incidents of physical altercations between clients A and F and 3 allegations of mistreatment, exploitation, theft and dental neglect for client G to BDDS (Bureau of Developmental Disabilities Services) within 24 hours in accordance with state law.</p> <p>Findings include:</p> <p>1. The facility's BDDS reports and investigations were reviewed on 2/9/15 at 3:00 PM. The review indicated the following:</p> <p>-BDDS report dated 2/3/15 indicated, "[Client F] became agitated and excessively pushed open the medication (sic) which caused it to come off of hinges."</p> <p>The 2/3/15 BDDS report did not indicate</p>	W 153	<p>CORRECTION: The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Specifically, The Team Lead, identified in the 2567 as HM#1 no longer works for the company. Facility staff, including Direct Support Professional staff #1, will be retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients. PREVENTION: Supervisory staff will review all facility documentation to assure incidents are reported as required. Specifically, Team Leads will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations</p>	03/21/2015

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	<p>documentation of client A being chased by client F into the medication room or describe the circumstances of client A holding the medication room door shut to prevent client F from attacking him.</p> <p>Client A was interviewed on 2/10/15 at 10:30 AM. Client A stated, "We, [client A and client F], fight all the time. I just can't trust that the staff are going to [expletive] do anything. They just stand there and watch. That's how the railing in the kitchen got destroyed. [Client F] was attacking me, he had my whole body up over the railing. My legs kicked the table that sits in the dining area when I was going over the railing. I was like, I don't know if staff are coming to help me or not? I had to fight back." Client A stated, "When I got back to the house from my meeting about leaving the group home for independent living, they told me not to talk to the other guys about my leaving. When I came in the house [client F] was starting to walk toward me. I told [staff #1], 'Hey, can you keep him away from me. I just don't, I don't want him to come near me.' That was in the hallway, [staff #1] just stood there and didn't say a [expletive] thing while [client F] started coming at me. I went downstairs to the medication room, shut the door and sat against it to keep him from attacking me. He busted the door off the hinges and</p>		<p>Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment. Members of the Operations Team and the QIDP will conduct documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. These administrative documentation reviews will focus on identifying potentially reportable incidents, providing opportunities for training and on site coaching of direct support staff to assure all incidents are reported in a timely manner. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>they didn't do anything to help."</p> <p>HM (Home Manager) #1 was interviewed on 2/11/15 at 1:00 PM. HM #1 indicated clients A and F had a physical altercation which resulted in the decorative railing being broken in the group home's kitchen area. HM #1 did not recall the details of the altercation but stated that he "Thought that [client A] had pushed [client F]".</p> <p>The review did not indicate documentation of clients A and F's physical altercation which resulted in breaking the decorative railing in the group home's kitchen area had been reported to BDDS.</p> <p>Client F's record was reviewed on 2/11/15 at 8:30 AM. Client F's Progress Notes indicated the following:</p> <p>- "9/25/14, [Client F] was doing good took (sic) his dinner and went to dancing (sic) at the office came back (sic) took his medication and went to downstairs (sic) watching TV. I just heard a noise and I run down see (sic) the other staff try (sic) to stop [client F] and [client A] but they refuse and the other staff run and call [Home Manager (HM) #1] on phone and she come (sic) and try to stop them but [client F] and [client A] was try to jump</p>			

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	<p>on them (sic). [Client F] push [client A] and he fell down and later [HM #1] talk to them they stop it (sic)."</p> <p>The review of BDDS reports did not indicate documentation of clients A and F's 9/25/14 incident of client to client aggression.</p> <p>- "1/2/15, [Client F] took fight (sic) with [client A]."</p> <p>The review of BDDS reports did not indicate documentation of clients A and F's 1/2/15 physical altercation.</p> <p>- "2/2/15, [Client F] was good take (sic) his dinner and later fight with [client A]. [Client A] inside the medication room for his medication [client F] try to open but (sic) but [client A] refuse to open (sic). [Client F] push the door down broke it and [client A] left (sic)."</p> <p>The review of BDDS reports did not indicate documentation of clients A and F's 2/2/15 physical altercation.</p> <p>2. Client G's mother/advocate was interviewed on 2/16/15 at 11:10 AM. Client G's mother/advocate provided the following electronic correspondences between herself, her husband and AS #1, AS #2 and CS (Clinical Supervisor) #1:</p>			

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	<p>-Electronic Correspondence dated 1/22/15 indicated, "[CS #1] is aware of the missing shoes. There was a trash bag filled with all of [client G's] shoes that was stored in the garage and now missing from the house. About 20 pairs or so. They were in the metal storage rack between the door from the house and the garage door closest to the steps to the back porch. That bag was there on December 30th when [client G] went back to [group home] for a couple of days. [HM (Home Manager) #1] is aware that they were stored in the garage as well." The electronic correspondence dated 1/22/15 indicated, "We do not have the Wii." The electronic correspondence dated 1/22/15 indicated, "Additionally, [client G's] computer broke this past summer 2014 and a ResCare employee at [group home] offered to fix it for him. That computer has not been returned and the employee is apparently no longer in your employ (sic). Not the first time [client G's] belongings, cash, wallet, etc have vanished with a former employee. [CS #1] is aware of all these occurrences."</p> <p>-Electronic Correspondence dated 1/25/15 indicated, "On Friday (1/23/15) we determined the fact that many of [client G's] shoes were thrown away as</p>			

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	<p>instructed during a garage clean-out. We were in that garage on Tuesday and Friday and it does not look like any of the other residents property had been touched. In that bag were several pairs of sneakers; including two pairs of [designer shoes] (\$150.00/each), 2 pairs of [designer shoes] (\$90.00/each), a pair of [designer shoes] (\$80.00/each), 5 or 6 pairs of random [designer shoes] and [sports shoes] (\$75.00/each), two pairs of dress leather shoes (\$80.00/each), a pair of suede leather shoes (\$70.00), two pairs of lined slipper (\$35.00/each), sandals (\$35.00), (sic) at least two pairs of top quality walking shoes bought for [retail store] job (\$80.00/each). All of these were in excellent, very lightly worn condition. And of course a few old shoes for yard work that have no real value. Some were gifts, some he purchased himself but the origin of where they came from and who purchased them is not relevant.</p> <p>Is it even slightly legal to dispose of property that does not belong to ResCare? This was personal property of a client in your care who had every expectation that his personal property would be 'safe' in his place of residence. One of the guys at the house shared with us that this was [CS #1's] instruction and that [CS #1] stated if [client G] had wanted them he should have taken them</p>			

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	<p>with him. That some logic could have applied to his clothes, bedding, bed, etc because he didn't bring those home with him either."</p> <p>-Electronic Correspondence dated 2/6/15 indicated, "[AS #1], your apologies for recent barriers and vow to make things right are appreciated. I'm curious to know what can restore [client G's] dental health, so as to make this right? [Client G's] dental records indicate that in 2013 it was determined he had 4 cavities. [Client G] was prescribed both fluoride toothpaste and mouthwash. These prescriptions were never filled, nor were the cavities. [Client G's] next dental visit was in 2015, at which time the dentist you lined up for him said there were now 8 cavities. I have since taken [client G] to my dentist. These are not cavities but rather areas of total decay, at a minimum 12 entire areas. [Dentist] has already begun the process of doing what can be done for him, one quadrant of the mouth at a time. Stainless steel caps rather than simple fillings. It will require weeks of additional very painful work to accomplish anything. How can this be made right? Missing items like his shoes or golf clubs can fairly easily be replaced. You made some indication that there was a willingness to replace his missing game system with one of comparable age and</p>			

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	<p>condition. Can you somehow restore his teeth to the comparable age and condition they were in 2013? There seems no way of knowing what impact an immediate follow up visit to address the cavities and having filled the prescriptions which were ignored might have had, were it to have been done in a timely manner."</p> <p>-Electronic Correspondence dated 2/14/15 indicated, "... have gone over the financial statement you provided at our meeting on Friday February 6th. After reviewing each separate entry and the corresponding check copies/receipts that were provided, we have several items in question. During the meeting you agreed with... that if there was no signature verification that, yes, those payments should be in question and that [client G] is entitled to have those funds returned to him, including the dances he did not attend." The 2/14/15 Electronic Correspondence indicated, "Additionally, there are few (discrepancies) I will specifically cite: (1.) 11/30/12- A check identified for a game system in the amount of \$430.17 has no signature verification or receipts attached, and no entry found that this was redeposited back into [client G's] account; (2.) 12/28/12- a check identified as simply cash for \$317.00 has no receipts or signature documentation</p>			

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	<p>attached to validate it and no entry that this was redeposited back into his account; (3.) 12/18/14- a check identified for cigarettes in the amount of \$100.00 has no signature validation or receipts attached and again, no entry that this was redeposited back into his account. None of this takes into account [client G's] statement that frequently he was forced to sign over his checks in exchange for partial funds and a check cashing fee charged by the staff member who processed the transaction for him. Taking all these facts into account we have determined that [client G] is owed reimbursement on this topic in the amount of \$1,771.17.</p> <p>Then there is the matter of the shoes which were detailed in the email that I sent you on 1/25/15 titled [client G]-discarded personal property. The reimbursement to replace the shoes is a very fair estimate- as you agreed to in our meeting on 2/6/15. Please review the email below. [Client G] is entitled to a reimbursement for his discarded shoes in the amount of \$1430.00. The Wii Fitness that was stolen and never replaced needs to be reimbursed as well- replacement value of \$100.00. [AS #1] indicated that [former manager] indicated that this had been returned to me. If that is the case, please provide a document I signed for</p>			

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	<p>receipt of the return of this property. Total for loss of personal property and funds that cannot be validated as being received by [client G] total \$3,729.16. [Client G] should also be reimbursed for various personal items that were stolen/taken from him- such as his missing wallet and identification, taken by a former ResCare employee, that had to be replaced, keys/lanyards taken by staff 'in the event they needed to access his locker' and never returned. The replacement cost of several new locks due to the lost keys, etc. The value of these items is insignificant in comparison with the above issues, but has been an ongoing topic since the day [client G's] care was entrusted to the supervision of ResCare.</p> <p>On the matter of [client G's] dental care this must remain an open issue until all the dental work is completed and it is determined what Medicaid will cover. [Client G] has had two appointments to date resulting in 3 silver caps. it will be at least two more visits to finish the repair/restoration work. [Client G's] mouth is in too much pain to do a third appointment this week, so it is scheduled for the following week."</p> <p>The facility's BDDS reports and investigations were reviewed on 2/9/15 at</p>			

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	<p>3:00 PM. The review did not indicate documentation of client G's mother/advocate's 1/22/15, 1/25/15 or 2/6/15 allegations of mistreatment, exploitation, theft and dental neglect had been reported to BDDS.</p> <p>AS #1 was interviewed on 2/10/15 at 2:20 PM. AS #1 indicated client G's mother/advocate had voiced concerns through a series of emails. AS #1 indicated the concerns/allegations included missing electronic items, shoes, money and dental treatment. AS #1 indicated client G's mother/advocates allegations had not been reported to BDDS.</p> <p>CS #1 was interviewed on 2/11/15 at 1:00 PM. CS #1 indicated all allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be reported to BDDS within 24 hours of knowledge of the allegation.</p> <p>This federal tag relates to complaint #IN00165097 and complaint #IN00165161.</p> <p>9-3-2(a)</p>			

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W 154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 10 of 17 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to complete a thorough investigation regarding an incident of client to client aggression regarding clients A and FC (Former Client) H, an allegation of medical neglect following client A's head injury, three incidents of client to client aggression regarding clients A and F, two allegations of intimidation and theft and personal property destruction by clients E and F towards client A, an allegation of abuse and neglect regarding the quality of care and treatment of clients A, B, C, D, E and F and three allegations of theft, exploitation and dental neglect regarding client G.</p> <p>Findings include:</p> <p>1. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/9/15 at 3:00 PM. The review indicated the following:</p>	W 154	<p>CORRECTION:</p> <p><i>The facility must have evidence that all alleged violations are thoroughly investigated.</i> Specifically: the program Manager has completed an investigation into three allegations of theft and medical neglect regarding Client G. Moving forward, the Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process.</p>	03/21/2015

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	<p>-BDDS report dated 7/19/14 indicated, "[Client A] was looking for his inventory scanner from work in the facility van with assistance from staff. [FC H] came out to the van and became angry when [client A] would not answer his questions regarding what [client A] was doing in the van. [FC H] re-entered the house and returned with a souvenir miniature baseball bat and hit [client A] in the arm, stomach and head in quick succession. Staff intervened immediately and separated them. [Client A] sustained a 2 inch laceration on his forehead. Staff called 911, provided first aid and [client A] was transported to the [hospital] emergency department via ambulance."</p> <p>-Investigative summary form dated 7/23/14 regarding client A's 7/19/14 incident indicated the "Scope of Investigation: Did [staff #2] fail to intervene in a timely manner in order to prevent [client A] from getting injured by [FC H]?" The 7/23/14 Investigative Summary form indicated, "Conclusions: The evidence does not substantiate that [staff #2] failed to intervene in a timely manner in order to prevent [client A] from being injured by [FC H]." The 7/23/14 Investigative form did not indicate documentation of a finding of fact or determination if client A was abused by FC H. The 7/23/14</p>		<p>PREVENTION:</p> <p>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. The Clinical Supervisor (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. Residential Managers 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 Clinical Supervisor 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</p>	

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	<p>Investigative form did not substantiate client to client abuse regarding FC H's hitting client A with a baseball bat.</p> <p>-BDDS report dated 7/23/14 indicated, "On 7/22/14 [client A] was taken to the ER (Emergency Room) with complaint of headaches, dizziness and not feeling well. While in the ER [client A] had his blood drawn, a urine test and a cat scan. All tests came back normal, the second cat scan showed no signs of bleeding or anything strange. [Client A's] diagnosis is Post Contusion syndrome and all the symptoms he was having are a result of the incident that took place on Friday 7/19/14. He also stated that nothing else can be done at this time and to keep [client A] on an every 30 minute observation. The doctor also stated that this could last for a few days up to six weeks. The doctor took him off work for 2 days so he can rest and see if this helps with his headaches."</p> <p>-BDDS follow up report dated 7/25/14 indicated, "[BDDS Generalist] received call from [client A's] mother, regarding recent incident where [client A] was struck by housemate, went to ER and had another subsequent visit to the ER since the incident. [Client A's] mother is not happy with care consumer has received by group home staff. For example, [client</p>		<p>result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program 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.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>				

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	<p>A] was put on bed rest but group home staff took [client A] out of the house for transport."</p> <p>The review did not indicate documentation of an investigation regarding client A's mother's concerns/allegations regarding the quality of care provided by group home staff for client A.</p> <p>-BDDS report dated 9/18/14 indicated, "Incident involving [client F] and [client A]. [Client A] became upset about the way that [client F] was cursing at the staff. [Client F] then began to taunt [client A] by saying that he will beat him up. After going to his room to get his phone [client F] began to intimidate [client A] by not allowing [client A] to exit his bedroom."</p> <p>The review did not indicate documentation of an investigation regarding client F's intimidation/emotional abuse of client A.</p> <p>-BDDS report dated 11/11/14 indicated, "[Client A] informed staff that someone came into his room and broke his TV remote and at least 4 xbox video games." The 11/11/14 BDDS report indicated, "The team did recover a broken remote and at least 4 broken xbox games. It has</p>			

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	<p>not been made clear who could have done this. The team will continue to investigate this incident."</p> <p>The review did not indicate documentation of an investigation regarding client A's 11/11/14 incident of his personal property being damaged.</p> <p>Client A was interviewed on 2/10/15 at 10:30 AM. Client A stated, "We, [client A and client F], fight all the time. I just can't trust that the staff are going to [expletive] do anything. They just stand there and watch. That's how the railing in the kitchen got destroyed. [Client F] was attacking me, he had my whole body up over the railing. My legs kicked the table that sits in the dining area when I was going over the railing. I was like, I don't know if staff are coming to help me or not? I had to fight back." Client A stated, "When I got back to the house from my meeting about leaving the group home for independent living, they told me not to talk to the other guys about my leaving. When I came in the house [client F] was starting to walk toward me. I told [staff #1], 'Hey, can you keep him away from me. I just don't, I don't want him to come near me.' That was in the hallway, [staff #1] just stood there and didn't say a [expletive] thing while [client F] started coming at me. I went downstairs to the</p>			

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	<p>medication room, shut the door and sat against it to keep him from attacking me. He busted the door off the hinges and they didn't do anything to help."</p> <p>HM (Home Manager) #1 was interviewed on 2/11/15 at 1:00 PM. HM #1 indicated clients A and F had a physical altercation which resulted in the decorative railing being broken in the group home's kitchen area. HM #1 did not recall the details of the altercation but stated that he "Thought that [client A] had pushed [client F]".</p> <p>The review did not indicate documentation of clients A and F's physical altercation which resulted in breaking the decorative railing in the group home's kitchen area had been investigated.</p> <p>Client F's record was reviewed on 2/11/15 at 8:30 AM. Client F's Progress Notes indicated the following:</p> <p>- "9/25/14, [Client F] was doing good took (sic) his dinner and went to dancing (sic) at the office came back (sic) took his medication and went to downstairs (sic) watching TV. I just heard a noise and I run down see (sic) the other staff try (sic) to stop [client F] and [client A] but they refuse and the other staff run and call</p>			

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	<p>[Home Manager (HM) #1] on phone and she come (sic) and try to stop them but [client F] and [client A] was try to jump on them (sic). [Client F] push [client A] and he fell down and later [HM #1] talk to them they stop it (sic)."</p> <p>The review did not indicate documentation of an investigation of clients A and F's 9/25/14 incident of client to client aggression.</p> <p>- "1/2/15, [Client F] took fight with [client A]."</p> <p>The review did not indicate documentation of an investigation of clients A and F's 1/2/15 physical altercation.</p> <p>- "2/2/15, [Client F] was good take (sic) his dinner and later fight with [client A]. [Client A] inside the medication room for his medication [client F] try to open but (sic) but [client A] refuse to open (sic). [Client F] push the door down broke it and [client A] left (sic)."</p> <p>The review did not indicate documentation of an investigation regarding the 2/3/15 incident of alleged client to client abuse/intimidation.</p> <p>Client A's mother/advocate was</p>			

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	<p>interviewed on 2/16/15 at 9:10 AM. Client A's mother/advocate stated, "The care that [client A] received after his concussion was horrible. They had him up and out of the house while he was supposed to be resting."</p> <p>2. Client G's mother/advocate was interviewed on 2/16/15 at 11:10 AM. Client G's mother/advocate provided the following electronic correspondences between herself, her husband and AS #1, AS #2 and CS (Clinical Supervisor) #1:</p> <p>-Electronic Correspondence dated 1/22/15 indicated, "[CS #1] is aware of the missing shoes. There was a trash bag filled with all of [client G's] shoes that was stored in the garage and now missing from the house. About 20 pairs or so. They were in the metal storage rack between the door from the house and the garage door closest to the steps to the back porch. That bag was there on December 30th when [client G] went back to [group home] for a couple of days. [HM (Home Manager) #1] is aware that they were stored in the garage as well." The electronic correspondence dated 1/22/15 indicated, "We do not have the Wii." The electronic correspondence dated 1/22/15 indicated, "Additionally, [client G's] computer broke this past summer 2014 and a ResCare employee at</p>			

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	<p>[group home] offered to fix it for him. That computer has not been returned and the employee is apparently no longer in your employ (sic). Not the first time [client G's] belongings, cash, wallet, etc have vanished with a former employee. [CS #1] is aware of all these occurrences."</p> <p>-Electronic Correspondence dated 1/25/15 indicated, "On Friday (1/23/15) we determined the fact that many of [client G's] shoes were thrown away as instructed during a garage clean-out. We were in that garage on Tuesday and Friday and it does not look like any of the other residents property had been touched. In that bag were several pairs of sneakers; including two pairs of [designer shoes] (\$150.00/each), 2 pairs of [designer shoes] (\$90.00/each), a pair of [designer shoes] (\$80.00/each), 5 or 6 pairs of random [designer shoes] and [sports shoes] (\$75.00/each), two pairs of dress leather shoes (\$80.00/each), a pair of suede leather shoes (\$70.00), two pairs of lined slipper (\$35.00/each), sandals (\$35.00), (sic) at least two pairs of top quality walking shoes bought for [retail store] job (\$80.00/each). All of these were in excellent, very lightly worn condition. And of course a few old shoes for yard work that have no real value. Some were gifts, some he purchased</p>			
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	<p>himself but the origin of where they came from and who purchased them is not relevant.</p> <p>Is it even slightly legal to dispose of property that does not belong to ResCare? This was personal property of a client in your care who had every expectation that his personal property would be 'safe' in his place of residence. One of the guys at the house shared with us that this was [CS #1's] instruction and that [CS #1] stated if [client G] had wanted them he should have taken them with him. That some logic could have applied to his clothes, bedding, bed, etc because he didn't bring those home with him either."</p> <p>-Electronic Correspondence dated 2/6/15 indicated, "[AS #1], your apologies for recent barriers and vow to make things right are appreciated. I'm curious to know what can restore [client G's] dental health, so as to make this right? [Client G's] dental records indicate that in 2013 it was determined he had 4 cavities. [Client G] was prescribed both fluoride toothpaste and mouthwash. These prescriptions were never filled, nor were the cavities. [Client G's] next dental visit was in 2015, at which time the dentist you lined up for him said there were now 8 cavities. I have since taken [client G] to my dentist. These are not cavities but</p>			

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	<p>rather areas of total decay, at a minimum 12 entire areas. [Dentist] has already begun the process of doing what can be done for him, one quadrant of the mouth at a time. Stainless steel caps rather than simple fillings. It will require weeks of additional very painful work to accomplish anything. How can this be made right? Missing items like his shoes or golf clubs can fairly easily be replaced. You made some indication that there was a willingness to replace his missing game system with one of comparable age and condition. Can you somehow restore his teeth to the comparable age and condition they were in 2013? There seems no way of knowing what impact an immediate follow up visit to address the cavities and having filled the prescriptions which were ignored might have had, were it to have been done in a timely manner."</p> <p>-Electronic Correspondence dated 2/14/15 indicated, "... have gone over the financial statement you provided at our meeting on Friday February 6th. After reviewing each separate entry and the corresponding check copies/receipts that were provided, we have several items in question. During the meeting you agreed with... that if there was no signature verification that, yes, those payments should be in question and that [client G] is entitled to have those funds returned to</p>			

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	<p>him, including the dances he did not attend." The 2/14/15 Electronic Correspondence indicated, "Additionally, there are few (discrepancies) I will specifically cite:</p> <p>(1.) 11/30/12- A check identified for a game system in the amount of \$430.17 has no signature verification or receipts attached, and no entry found that this was redeposited back into [client G's] account; (2.) 12/28/12- a check identified as simply cash for \$317.00 has no receipts or signature documentation attached to validate it and no entry that this was redeposited back into his account; (3.) 12/18/14- a check identified for cigarettes in the amount of \$100.00 has no signature validation or receipts attached and again, no entry that this was redeposited back into his account. None of this takes into account [client G's] statement that frequently he was forced to sign over his checks in exchange for partial funds and a check cashing fee charged by the staff member who processed the transaction for him. Taking all these facts into account we have determined that [client G] is owed reimbursement on this topic in the amount of \$1,771.17.</p> <p>Then there is the matter of the shoes which were detailed in the email that I sent you on 1/25/15 titled [client G]-</p>						

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	<p>discarded personal property. The reimbursement to replace the shoes is a very fair estimate- as you agreed to in our meeting on 2/6/15. Please review the email below. [Client G] is entitled to a reimbursement for his discarded shoes in the amount of \$1430.00. The Wii Fitness that was stolen and never replaced needs to be reimbursed as well- replacement value of \$100.00. [AS #1] indicated that [former manager] indicated that this had been returned to me. If that is the case, please provide a document I signed for receipt of the return of this property.</p> <p>Total for loss of personal property and funds that cannot be validated as being received by [client G] total \$3,729.16. [Client G] should also be reimbursed for various personal items that were stolen/taken from him- such as his missing wallet and identification, taken by a former ResCare employee, that had to be replaced, keys/lanyards taken by staff 'in the event they needed to access his locker' and never returned. The replacement cost of several new locks due to the lost keys, etc. The value of these items is insignificant in comparison with the above issues, but has been an ongoing topic since the day [client G's] care was entrusted to the supervision of ResCare.</p> <p>On the matter of [client G's] dental care</p>			

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	<p>this must remain an open issue until all the dental work is completed and it is determined what Medicaid will cover. [Client G] has had two appointments to date resulting in 3 silver caps. It will be at least two more visits to finish the repair/restoration work. [Client G's] mouth is in too much pain to do a third appointment this week, so it is scheduled for the following week."</p> <p>The facility's BDDS reports and investigations were reviewed on 2/9/15 at 3:00 PM. The review did not indicate documentation of client G's mother/advocate's 1/22/15, 1/25/15 or 2/6/15 allegations of mistreatment, exploitation, theft and dental neglect had been investigated. The review did not indicate documentation of an investigation being initiated regarding the 2/6/15 allegations.</p> <p>AS #1 was interviewed on 2/10/15 at 2:20 PM. AS #1 indicated client G's mother/advocate had voiced concerns through a series of emails. AS #1 indicated the concerns/allegations included missing electronic items, shoes, money and dental treatment. AS #1 indicated client G's mother/advocate's allegations had not been formally investigated.</p>			

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	<p>3. The facility's BDDS reports and investigations were reviewed on 2/9/15 at 3:00 PM. The review indicated the following:</p> <p>-BDDS report dated 2/3/15 indicated, "[BDDS Generalist] made unannounced visit to the consumer's group home. One staff person was at the home, when [BDDS Generalist] asked what consumers were in the home, staff provided 2 names. Upon looking throughout the home, [BDDS Generalist] found [client B] in hallway (staff did not realize he was in the home, staff did not know where remaining consumers and other staff were). Since this consumer, [client B], had just experienced a recent incident report regarding his diabetes, [BDDS Generalist] asked a few questions as to how he is currently feeling. [Client B] stated regarding the incident he is fine, but also stated he hasn't been to work at (the) sheltered workshop for a while due to a problem with his back. [BDDS Generalist] has not been made aware of any ongoing issues regarding [client B's] back. [Client B] also stated, he has been taken to look at a potential [independent living] home, by ResCare staff, and he believes he is already paying rent towards the home to reserve his spot in the home. [BDDS Generalist] explained to consumer that he does not currently have</p>			

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	a [independent living] waiver yet, and shouldn't be taken to look at potential homes until then. [Client B] seemed confused and mildly upset. [BDDS Generalist] then witnessed consumer serving himself dinner, which consisted of 3 hot dogs and a handful of french fries, staff was not present in the room when [client B] served himself. [BDDS Generalist] asked staff, why the consumer was eating alone. Staff reported that all other consumers had eaten earlier, [client B] reported he was never told dinner was ready. [BDDS Generalist] then asked if [client B's] dinner was appropriate according to any kind of dietary plans for diabetes, staff stated she knew nothing of any kind of restrictions. [BDDS Generalist] then asked to see (the) menu planner, staff did not know where it was, when one book was located by (an) alternate staff, the book had no menus in it for February 2015. [BDDS Generalist] looked in refrigerator, only a half gallon of milk for 8 male consumers, no fresh fruit or vegetables were in (the) refrigerator; very little frozen items either. Upon further questioning of all of the consumers in the home, none could state what they had eaten for lunch or breakfast that day, nor was there any kind of documentation of what the day's menu consisted of. [Client B] also stated he hadn't eaten all day, and			

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	<p>it was obvious to [BDDS Generalist] that [client B] had not bathed/washed hair for at least a few days. [Client B] showed [BDDS Generalist] his room, which was extremely dirty and messy, [client B] stated he is never really encouraged to clean, but knows himself it should be cleaner. Out of all the concerns [BDDS Generalist] has from visit, meals for [client B] are the most concerning, especially since staff was not paying attention to what he was eating and consumer was not being encouraged to eat fresh fruit/vegetables, very concerning because of his diabetes."</p> <p>-Investigative Summary form dated 2/9/15 indicated, "On 2/4/15, [CS #2] received notification that a reportable was submitted to the state by [BDDS Generalist], outlining some concerns she observed while visiting the [group home] on 2/3/15. The incident type was listed as alleged neglect." The Investigative Summary form dated 2/9/15 did not indicate documentation of BDDS Generalist being interviewed or HM #1 who was responsible for purchasing the home's food.</p> <p>CS #1 was interviewed on 2/11/15 at 1:00 PM. CS #1 indicated all allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown</p>			

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W 157 Bldg. 00	<p>origin should be thoroughly investigated.</p> <p>This federal tag relates to complaint #IN00165097 and complaint #IN00165161.</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 10 of 17 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to develop and implement corrective measures to prevent recurrence of intimidation and emotional abuse regarding client A, three incidents of client to client aggression between clients A and F and two allegations of theft and personal property destruction by clients E and F towards client A.</p> <p>Findings include:</p> <p>1. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/9/15 at 3:00 PM. The review indicated the following:</p>	W 157	<p>CORRECTION:</p> <p><i>If the alleged violation is verified, appropriate corrective action must be taken. Specifically, through ongoing assessment, the interdisciplinary team consensually agreed that Client A would be more comfortable in a Medicaid Waiver setting with housemates that more closely shared his developmental, social and behavioral needs. Therefore the team assisted him in transitioning to a new residential setting. Additionally, QIDP will bring the interdisciplinary team together to develop revisions to client F's Behavior support Plan that address intimidation and aggression. Through documentation and incident review the team has determined that Client E has also displayed a</i></p>	03/21/2015

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	<p>-BDDS report dated 9/18/14 indicated, "Incident involving [client F] and [client A]. [Client A] became upset about the way that [client F] was cursing at the staff. [Client F] then began to taunt [client A] by saying that he will beat him up. After going to his room to get his phone [client F] began to intimidate [client A] by not allowing [client A] to exit his bedroom."</p> <p>The review did not indicate documentation of corrective measures to prevent client F's intimidation/emotional abuse of client A.</p> <p>-BDDS report dated 11/11/14 indicated, "[Client A] informed staff that someone came into his room and broke his TV remote and at least 4 xbox video games." The 11/11/14 BDDS report indicated, "The team did recover a broken remote and at least 4 broken xbox games. It has not been made clear who could have done this. The team will continue to investigate this incident."</p> <p>The review did not indicate documentation of corrective measures to prevent client A's personal property from being damaged.</p> <p>Client A was interviewed on 2/10/15 at 10:30 AM. Client A stated, "We, [client</p>		<p>pattern of intimidating and aggressive behavior and his Behavior Support Plan will be revised.</p> <p>PREVENTION:</p> <p>The Residential Manager will develop and maintain a staffing matrix that assures adequate direct support staff who possess the training, skills and capabilities to provide appropriate active treatment and prevent and intervene with challenging behaviors as they occur. The staffing matrix will be reviewed and approved by the Clinical Supervisor and spot checked by the Program Manager. Members of the Operations Team and the QIDP will conduct active treatment observations and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Administrative support at the home will focus on mentorship and training of supervisory staff,</p>	

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	<p>A and client F], fight all the time. I just can't trust that the staff are going to [expletive] do anything. They just stand there and watch. That's how the railing in the kitchen got destroyed. [Client F] was attacking me, he had my whole body up over the railing. My legs kicked the table that sits in the dining area when I was going over the railing. I was like, I don't know if staff are coming to help me or not? I had to fight back." Client A stated, "When I got back to the house from my meeting about leaving the group home for independent living, they told me not to talk to the other guys about my leaving. When I came in the house [client F] was starting to walk toward me. I told [staff #1], 'Hey, can you keep him away from me. I just don't, I don't want him to come near me.' That was in the hallway, [staff #1] just stood there and didn't say a [expletive] thing while [client F] started coming at me. I went downstairs to the medication room, shut the door and sat against it to keep him from attacking me. He busted the door off the hinges and they didn't do anything to help."</p> <p>HM (Home Manager) #1 was interviewed on 2/11/15 at 1:00 PM. HM #1 indicated clients A and F had a physical altercation which resulted in the decorative railing being broken in the group home's kitchen area. HM #1 did not recall the details of</p>		<p>monitoring and coaching of direct support staff, and evaluation of the effectiveness of current support plans.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team</p>	

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	<p>the altercation but stated that he "Thought that [client A] had pushed [client F]".</p> <p>The review did not indicate documentation of corrective actions to prevent further physical altercations between clients A and F.</p> <p>Client F's record was reviewed on 2/11/15 at 8:30 AM. Client F's Progress Notes indicated the following:</p> <p>- "9/25/14, [Client F] was doing good took (sic) his dinner and went to dancing (sic) at the office came back (sic) took his medication and went to downstairs (sic) watching TV. I just heard a noise and I run down see (sic) the other staff try (sic) to stop [client F] and [client A] but they refuse and the other staff run and call [Home Manager (HM) #1] on phone and she come (sic) and try to stop them but [client F] and [client A] was try to jump on them (sic). [Client F] push [client A] and he fell down and later [HM #1] talk to them they stop it (sic)."</p> <p>The review did not indicate documentation of corrective measure to prevent further incidents of client to client aggression between clients A and F.</p>			

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	<p>- "1/2/15, [Client F] took fight with [client A]."</p> <p>The review did not indicate documentation of corrective measures to prevent further incidents of client to client aggression between clients A and F.</p> <p>- "2/2/15, [Client F] was good take (sic) his dinner and later fight with [client A]. [Client A] inside the medication room for his medication [client F] try to open but (sic) but [client A] refuse to open (sic). [Client F] push the door down broke it and [client A] left (sic)."</p> <p>The review did not indicate documentation of corrective measures to prevent further client to client abuse/intimidation between clients A and F.</p> <p>CS #1 was interviewed on 2/11/15 at 1:00 PM. CS #1 indicated corrective measures should be developed and implemented to prevent recurrence of incidents of abuse, neglect, mistreatment, exploitation and injuries of unknown origin.</p> <p>This federal tag relates to complaint #IN00165097 and complaint #IN00165161.</p>			

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W 159 Bldg. 00	<p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 3 of 3 sampled clients (A, B and C), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor clients B and C's objectives to determine if clients B and C had successfully completed/achieved the objectives, to ensure all staff working with client B were trained on his diabetic care protocols, to ensure staff implement clients B and C's ISPs (Individual Support Plans) training objectives during formal and informal training opportunities and to ensure clients A, B and C's use of psychotropic medication and modification of rights used for behavior management was reviewed and approved by the facility's HRC (Human Rights Committee).</p> <p>Findings include:</p> <p>1. Client B's record was reviewed on</p>	W 159	<p>CORRECTION:</p> <p><i>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Specifically,</i></p> <p>The QIDP will receive additional training regarding expectations for program monitoring and change, with emphasis on timely modification of prioritized learning objectives. A review of documentation by the Operations Team indicated that in addition to Clients A, B and C, this deficient practice also affected Clients D, E and F.</p> <p>The QIDP has facilitated Training of all current facility staff from the facility nurse regarding Client</p>	03/21/2015

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	<p>2/11/15 at 10:15 AM. Client B's ISP dated 9/20/14 indicated client B had formal training objectives to prepare a meal, clean his room, make a purchase in the community, will identify side effects of medication, will complete his self-care routine, will stay on task at work, will engage in a physical activity and will wear his eyeglasses. Client B's record did not indicate documentation of review of client B's goals, there were no monthly goal summaries or quarterly reviews available to review.</p> <p>2. Client C's record was reviewed on 2/11/15 at 11:20 AM. Client C's ISP dated 4/16/14 indicated client C had formal training objectives to stay on task, complete an activity, will brush his teeth, will greet others appropriately, will state a side effect of his medications and will identify the correct amount of money needed to make a purchase. Client C's record did not indicate documentation of review of client C's goals, there were no monthly goal summaries or quarterly reviews available to review.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 2/11/15 at 12:11 PM. CS #1 indicated there was not additional documentation of QIDP goal/objective review. CS #1 indicated clients B and C's goals should be monitored and reviewed</p>		<p>B's diabetic care protocols. Through active treatment observation and a review of training documentation, the team has determined that this deficient practice did not affect other clients.</p> <p>The QIDP will facilitate retraining of all facility direct support staff regarding the need to provide consistent, aggressive and continuous active treatment for all clients including but not limited to meal preparation. Administrative Team observation of active treatment determined that, in addition to clients B and C, this deficient practice affected all clients who reside in the facility.</p> <p>The QIDP has located documentation of approval from the Human Rights Committee for Client A, B and C's use of psychotropic medications. A review of Human Rights Committee documentation indicated that this deficient practice also affected Clients D, E and F. Human Rights Committee approval will also be obtained for restrictive programs for these clients, including the use of psychotropic medications.</p>	

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	<p>quarterly.</p> <p>3. The QIDP failed to integrate, coordinate and monitor client B's active treatment program by failing to ensure all staff working with client B were trained on his diabetic care protocols. Please see W189.</p> <p>4. The QIDP failed to integrate, coordinate and monitor clients B and C's active treatment programs by failing to ensure staff implemented clients B and C's ISPs training objectives during formal and informal training opportunities. Please see W249.</p> <p>5. The QIDP failed to integrate, coordinate and monitor clients A, B and C's active treatment program by failing to ensure clients A, B and C's use of psychotropic medication was reviewed and approved by the facility's HRC. Please see W262.</p> <p>9-3-3(a)</p>		<p>PREVENTION:</p> <p>The Clinical Supervisor (Administrative level management) will incorporate review of learning objective progress and modification into a routine audit process that will occur no less than monthly</p> <p>The QIDP has been retrained regarding the need to bring all elements of the interdisciplinary team, including but not limited to the facility nurse, together to assess and develop training programs that provide staff the competencies necessary to provide appropriate supports for all clients.</p> <p>The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week and the Team Leader will be required to observe and participate in active treatment sessions on varied shifts no less than five times per week. The QIDP will also maintain an ongoing presence at the facility. During Active Treatment</p>	

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			<p>observations, supervisors will assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff implement learning objectives and provide frequent choices of activities.</p> <p>The QIDP will be retrained regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs for all clients. The QIDP, facility nurse and Human Rights Committee liaison will each maintain copies of Human rights Committee approval forms to assure the ability to reproduce copies of HRC records for surveyors upon request. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent.</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and</p>	

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			<p>training including but not limited assuring staff administer medication as prescribed and that all prescribed medications are available. A new Team Lead is in place at the facility. This Team Lead will be present, supervising active treatment during no less than 4 evening active treatment sessions and one morning active treatment session per week to monitor medication administration and the ordering of newly prescribed medications and treatments.</p> <p>Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, will conduct observations during active Treatment sessions and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team 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>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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			<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 and the Director of Operations/Regional Manager no less than monthly for the next 90 days.</p> <p>With regard to the QIDP, administrative support at the home will focus on:</p> <ol style="list-style-type: none"> 1. Review of objective data collection to assure appropriate monitoring and modification of learning objectives occurs. 2. Evaluation of the effectiveness of current support plans 3. Assuring staff demonstrate necessary competencies. 4. Assuring continuous active treatment occurs. 	

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W 189 Bldg. 00	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 1 of 3 sampled clients (B), the facility failed to ensure all staff working with client B were trained on his diabetic care protocols.</p> <p>Findings include:</p> <p>The facility's BDDS reports and investigations were reviewed on 2/9/15 at 3:00 PM. The review indicated the following:</p>	W 189	<p>5. Assuring restrictive programs occur only with prior approval from the Human Rights Committee.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>Corrections completed by: 2/22/15</p> <p>CORRECTION:</p> <p><i>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Specifically, All current facility staff have now received training from the facility nurse regarding Client B's diabetic care protocols. Through active treatment observation and a review of training documentation, the team has</i></p>	03/21/2015

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	<p>-BDDS report dated 2/3/15 indicated, "Upon looking throughout the home, [BDDS Generalist] found [client B] in hallway (staff did not realize he was in the home, staff did not know where remaining consumers and other staff were). Since this consumer, [client B], had just experienced a recent incident report regarding his diabetes, [BDDS Generalist] asked a few questions as to how he is currently feeling. The 2/3/15 BDDS report indicated, "[BDDS Generalist] then witnessed consumer serving himself dinner, which consisted of 3 hot dogs and a handful of french fries, staff was not present in the room when [client B] served himself. [BDDS Generalist] asked staff, why the consumer was eating alone. Staff reported that all other consumers had eaten earlier, [client B] reported he was never told dinner was ready. [BDDS Generalist] then asked if [client B's] dinner was appropriate according to any kind of dietary plans for diabetes, staff stated she knew nothing of any kind of restrictions."</p> <p>-Investigative Summary form dated 2/9/15 indicated, "The evidence does substantiate that not all of the staff at [group home] are trained on [client B's] diabetes."</p>		<p>determined that this deficient practice did not affect other clients.</p> <p>PERVENTION:</p> <p>The QIDP has been retrained regarding the need to bring all elements of the interdisciplinary team, including but not limited to the facility nurse, together to assess and develop training programs that provide staff the competencies necessary to provide appropriate supports for all clients. Members of the Operations Team and the QIDP will conduct active treatment observations and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Administrative support at the home will include assuring staff demonstrate necessary competencies.</p>	

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W 249 Bldg. 00	<p>Client B's record was reviewed on 2/11/15 at 10:15 AM. Client B's CHRHP (Comprehensive High Risk Health Plan) for Diabetes dated 10/13/14 indicated, "Encourage living lite (carbohydrate controlled menu at all times)."</p> <p>AS (AS #2) was interviewed on 2/11/15 at 2:45 PM. AS #2 indicated the 2/9/15 investigation substantiated that not all of the staff working with client B had been trained regarding his diabetic care.</p> <p>9-3-3(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 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 2 of 3 sampled clients (B and C), the facility failed to implement clients B and C's ISPs (Individual Support Plans) training objectives during formal and informal training opportunities.</p>	W 249	<p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION: <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</i></p>	03/21/2015			

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	<p>Findings include:</p> <p>Observations were conducted at the group home on 2/10/15 from 6:05 AM through 8:30 AM. At 6:05 AM, DSP #3 cooked bacon, fried eggs and toast with butter. Clients B and C were not encouraged to participate in preparing the morning meal. At 6:37 AM, DSP #3 placed bacon and eggs on serving plates. DSP #3 then placed the food, plates, utensils and milk on the dining room table. Clients B and C were not encouraged to participate in setting the table.</p> <p>DSP #3 was interviewed on 2/11/15 at 7:30 AM. DSP #3 indicated clients B and C had not assisted with the morning meal preparation. DSP #3 stated, "Sometimes [client B] will help but it's usually hard to get the others to help."</p> <p>1. Client B's record was reviewed on 2/11/15 at 10:15 AM. Client B's ISP dated 9/20/14 indicated, "Implement this objective during any meal time. Given three verbal prompts, [client B] will prepare a meal during meal time 50% of the time for three consecutive months."</p> <p>2. Client C's record was reviewed on 2/11/15 at 9:00 AM. Client C's ISP dated 4/16/14 indicated, "[Client C] would</p>		<p><i>interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</i> Specifically, all direct support staff will be retrained regarding the need to provide consistent, aggressive and continuous active treatment for all clients including but not limited to meal preparation. Administrative Team observation of active treatment determined that, in addition to clients B and C, this deficient practice affected all clients who reside in the facility.</p> <p>PREVENTION:</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer medication as prescribed and that all prescribed medications are available. A new Team Lead is in place at the facility. This Team Lead will be present, supervising active treatment during no less than 4 evening active treatment sessions and one morning active treatment session per week to</p>		

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	<p>generally comply whenever he has been asked to participate in activities but would generally require numerous prompts to stay on task. Given skills training and three verbal prompts, [client C] will stay on talks for 10 minutes, 55% of the time for three consecutive months." Client C's 4/16/14 ISP indicated client C should be encouraged to participate in domestic activities such as meal preparation.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 2/11/15 at 12:11 PM. CS #1 indicated active treatment should occur at each available opportunity.</p> <p>9-3-4(a)</p>		<p>monitor medication administration and the ordering of newly prescribed medications and treatments.</p> <p>Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team 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</p>	

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			<p>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 recommendations as appropriate. As stated above, the Executive Director will participate directly in</p>	

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W 262 Bldg. 00	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview for 3 of 3 sampled clients with restrictive programs (A, B and C), the facility failed to ensure clients A, B and C's use of psychotropic medication was reviewed and approved by the facility's HRC (Human Rights Committee).</p> <p>Findings include:</p>	W 262	<p>administrative monitoring of the facility and the Director of Operations/Regional Manager no less than monthly for the next 90 days.</p> <p>Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION: <i>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Specifically, the QIDP has located documentation of approval from</i></p>	03/21/2015

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	<p>1. Client A's record was reviewed on 2/11/15 at 10:15 AM. Client A's physician's order form dated 12/19/14 indicated client A received Risperidone tablet 0.5 milligrams (anxiety). Client A's record did not indicate documentation of HRC review or approval regarding client A's use of Risperidone for behavior management.</p> <p>2. Client B's record was reviewed on 2/11/15 at 10:15 AM. Client B's BSP (Behavior Support Plan) dated 9/20/14 indicated client B received Escitalopram 20 milligrams (depression) and Seroquel extended release 150 milligrams (mood). Client B's record did not indicate documentation of HRC review or approval regarding client B's use of Escitalopram or Seroquel for behavior management.</p> <p>3. Client C's record was reviewed on 2/11/15 at 11:20 AM. Client C's BSP dated 4/7/14 indicated client C received Risperidone 1.5 milligrams (attention deficit hyper activity disorder). Client C's record did not indicate documentation of HRC review or approval regarding client C's use of Risperidone for behavior management.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 2/11/15 at 12:11 PM. CS</p>		<p>the Human Rights Committee for Client A, B and C's use of psychotropic medications. A review of Human Rights Committee documentation indicated that this deficient practice also affected Clients D, E and F. Human Rights Committee approval will also be obtained for restrictive programs for these clients, including the use of psychotropic medications.</p> <p>PREVENTION:</p> <p>The QIDP will be retrained regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs for all clients. The QIDP, facility nurse and Human Rights Committee liaison will each maintain copies of Human rights Committee approval forms to assure the ability to reproduce copies of HRC records for surveyors upon request. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Members of the Operations Team and the QIDP will conduct documentation reviews no less than five times weekly for the next 21 days, no</p>	

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W 318 Bldg. 00	<p>#1 indicated there was not additional documentation of HRC review or approval regarding clients A, B or C's use of psychotropic medications for behavior management.</p> <p>9-3-4(a)</p> <p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Health Care Services. The facility's health care services failed to ensure the health status of clients A, B and C was reviewed on a quarterly basis, ensure client G received dental treatment services and ensure client G received medication as ordered by the dentist.</p> <p>Findings include:</p>	W 318	<p>less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include review of Human Rights Committee records to assure appropriate approvals have been obtained.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p><i>The facility must ensure that specific health care services requirements are met.</i> Specifically:</p> <p>The facility's current nurse has been trained on expectations for quarterly nursing physicals and nursing physicals which have</p>	03/21/2015

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	<p>1. The facility's health care services failed to ensure the health status of clients A, B and C was reviewed on a quarterly basis. Please see W336.</p> <p>2. The facility's health care services failed to ensure client G received dental treatment services. Please see W356.</p> <p>3. The facility's health care services failed to ensure client G received medication as ordered by the dentist. Please see W368.</p> <p>This federal tag relates to complaint #IN00165161.</p> <p>9-3-6(a)</p>		<p>been completed for the current quarter for Clients A, B and C. A record review indicated the deficient practice also affected Clients D, E, F and G, and nursing physicals have been completed for the current quarter for these individuals.</p> <p>Although Client G has moved out of the facility, the governing body has met with Client G's family to determine appropriate compensation for any current dental needs not covered by Medicaid. An audit conducted by the Operations Team determined that dental follow-along and required follow-up had not occurred for two additional clients, C and D and dental appointments have been scheduled for these individuals.</p> <p>During an investigation into allegations of neglect of Client G's dental care needs, the Operations Team discovered that the Listermint Fluoride Rinse prescribed by Client G's dentist had been discontinued by the manufacturer and that the dentist changed the prescription to Prevident 5000, to take the place of the Listermint. The pharmacy sent one tube of Prevident 5000</p>		

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			<p>on 10/11/13 and a tube of SF 5000 (generic equivalent for Preivent 5000) on 2/4/14 and 6/15/14. The facility's Team Lead and Medical Coach will work directly with the facility nurse to assure prescriptions are filled in a timely manner to facilitate administration of medication in compliance with physician's orders.</p> <p>PREVENTION:</p> <p>Copies of quarterly nursing physical examinations will be placed in the each individual's medical chart upon completion. The Nurse Manager will maintain a tracking system to assure quarterly nursing physical examinations are completed as required. Specifically when physicals have not been completed by the beginning of the last month of each quarter the Nurse Manager will allot additional nursing resources to the facility to assist with timely completion of required assessments. Additionally, Operations Team members will review nursing documentation while conducting routine audits in the home, no less than monthly, to assure records of quarterly nursing evaluations are completed and filed</p>	

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			<p>appropriately. Copies of audits of medical charts will be provided to the facility nurse and nurse manager to facilitate appropriate follow-up.</p> <p>The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine dental appointments and follow-ups to assure they occur as recommended.</p> <p>Members of the Operations Team and the QIDP will conduct documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. This administrative support will include:</p> <ol style="list-style-type: none"> 1. Assuring records of quarterly nursing evaluations are completed and filed appropriately. Copies of audits of medical charts will be provided to the facility nurse and nurse 	

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W 336 Bldg. 00	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>Based on record review and interview for 3 of 3 sampled clients (A, B and C), the facility failed to ensure the health status of clients A, B and C was reviewed on a quarterly basis.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 2/11/15 at 9:00 AM. Client A's Physicians Orders Form (POF) dated 12/9/14 indicated client A's diagnoses</p>	W 336	<p>manager to facilitate appropriate follow-up.</p> <p>2. Review of medical documentation to arrange for appropriate follow-up as needed.</p> <p>3. Assuring all prescribed medications are available and administered as ordered.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Lead, Direct Support Staff, Health Services Team, Operations Team</p> <p>CORRECTION:</p> <p><i>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Specifically, the facility's current nurse has been trained on expectations for quarterly nursing physicals and nursing physicals which have</i></p>	03/21/2015	

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	<p>included but were not limited to Intellectual Disability, Cerebral Palsy, Pacemaker and reading disorder. Client A's QNA (Quarterly Nursing Assessment) indicated documentation of nursing review of client A's health status with physical examination on 2/10/14 and 10/28/14. The review did not indicate additional documentation of nursing review with physical examination.</p> <p>2. Client B's record was reviewed on 2/11/15 at 10:15 AM. Client B's POF dated 12/9/14 indicated client B's diagnoses included but were not limited to Mild Intellectual Disability, Anxiety, Diabetes and Depression. Client B's QNA indicated documentation of nursing review of client B's health status with physical examination on 2/10/14 and 10/28/14. The review did not indicate additional documentation of nursing review with physical examination.</p> <p>3. Client C's record was reviewed on 2/11/15 at 11:20 AM. Client C's POF dated 12/9/14 indicated client C's diagnoses included but were not limited to Mild Intellectual Disability, Attention Deficit Hyperactivity Disorder, Asthma and Tourettes. Client C's QNA indicated documentation of nursing review of client C's health status with physical examination on 2/10/14 and 10/28/14.</p>		<p>been completed for the current quarter for Clients A, B and C. A record review indicated the deficient practice also affected Clients D, E, F and G, and nursing physicals have been completed for the current quarter for these individuals.</p> <p>PREVENTION:</p> <p>Copies of quarterly nursing physical examinations will be placed in the each individual's medical chart upon completion. The Nurse Manager will maintain a tracking system to assure quarterly nursing physical examinations are completed as required. Specifically when physicals have not been completed by the beginning of the last month of each quarter the Nurse Manager will allot additional nursing resources to the facility to assist with timely completion of required assessments. Additionally, Operations Team members will review nursing documentation while conducting routine audits in the home, no less than monthly, to assure records of quarterly nursing evaluations are completed and filed appropriately. Copies of audits of medical charts will be provided to the facility nurse and nurse</p>		

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W 356 Bldg. 00	<p>The review did not indicate additional documentation of nursing review with physical examination.</p> <p>DON (Director of Nursing) #1 was interviewed on 2/11/15 at 12:02 PM. DON #1 indicated there was not additional documentation available for review regarding clients A, B and C's nursing reviews with physical examinations.</p> <p>9-3-6(a)</p> <p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>Based on record review and interview for 1 additional client (G), the facility failed to ensure client G received dental treatment services.</p> <p>Findings include:</p> <p>Client G's mother/advocate was interviewed on 2/16/15 at 11:10 AM. Client G's mother/advocate provided the following electronic correspondences between herself, her husband and AS</p>	W 356	<p>manager to facilitate appropriate follow-up.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Lead, Direct Support Staff, Health Services Team, Operations Team</p> <p>CORRECTION:</p> <p><i>The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Specifically, although Client G has moved out of the facility, the governing body has agreed to compensate client G's family for Client G's current</i></p>	03/21/2015

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	<p>(Administrative Staff) #1, AS #2 and CS (Clinical Supervisor) #1:</p> <p>-Electronic Correspondence dated 2/6/15 indicated, "[AS #1], your apologies for recent barriers and vow to make things right are appreciated. I'm curious to know what can restore [client G's] dental health, so as to make this right? [Client G's] dental records indicate that in 2013 it was determined he had 4 cavities. [Client G] was prescribed both fluoride toothpaste and mouthwash. These prescriptions were never filled, nor were the cavities. [Client G's] next dental visit was in 2015, at which time the dentist you lined up for him said there were now 8 cavities. I have since taken [client G] to my dentist. These are not cavities but rather areas of total decay, at a minimum 12 entire areas. [Dentist] has already begun the process of doing what can be done for him, one quadrant of the mouth at a time. Stainless steel caps rather than simple fillings. It will require weeks of additional very painful work to accomplish anything. How can this be made right? Missing items like his shoes or golf clubs can fairly easily be replaced. You made some indication that there was a willingness to replace his missing game system with one of comparable age and condition. Can you somehow restore his teeth to the comparable age and condition</p>		<p>dental needs. An audit conducted by the Operations Team determined that dental follow-along and required follow-up had not occurred for two additional clients, C and D and dental appointments have been scheduled for these individuals.</p> <p>PREVENTION:</p> <p>The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine dental appointments and follow-ups to assure they occur as recommended. Members of the Operations Team and the QIDP will conduct documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. This administrative support will include review of medical documentation to arrange for appropriate follow-up as needed.</p>	

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	<p>they were in 2013? There seems no way of knowing what impact an immediate follow up visit to address the cavities and having filled the prescriptions which were ignored might have had, were it to have been done in a timely manner."</p> <p>-Electronic Correspondence dated 2/14/15 indicated, "On the matter of [client G's] dental care this must remain an open issue until all the dental work is completed and it is determined what Medicaid will cover. [Client G] has had two appointments to date resulting in 3 silver caps. It will be at least two more visits to finish the repair/restoration work. [Client G's] mouth is in too much pain to do a third appointment this week, so it is scheduled for the following week."</p> <p>AS #1 was interviewed on 2/9/15 at 3:30 PM. AS #1 stated, "[Client G's] mom had concerns so we set up a meeting on 2/6/15 to try to sit down and talk. There were emails from her but it seemed like it would be better to sit down and talk in person to get clarification. Mom told us that [client G] had been to the dentist on 1/13/15 and had found something like 8 cavities. Then mom took [client G] to their family dentist and they said it wasn't cavities but areas of decay." AS #1 stated, "When I started looking into it, I was not</p>		<p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Lead, Direct Support Staff, Health Services Team, Operations Team</p>	

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W 368 Bldg. 00	<p>able to find documentation of [client G] going to the dentist in 2014."</p> <p>Client G's record was reviewed on 2/11/15 at 8:48 AM. Client G's Dental Summary Progress Report dated 9/18/13 indicated, "Exam/, fluoride varnish. Oral hygiene extremely poor. New decay/cavities. Brushing stressed. Recommendations: Listermint with fluoride. Next visit restoration with follow up visit 3/2014." Client G's record of visit form dated 1/13/15 indicated client G had 8 cavities. Client G's record did not indicate documentation of dental care from 9/18/13 through 1/13/15.</p> <p>DON (Director of Nursing) was interviewed on 2/11/15 at 12:02 PM. DON #1 indicated there was not additional documentation available for review regarding client G's dental treatment.</p> <p>This federal tag relates to complaint #IN00165161.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in</p>						

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	<p>compliance with the physician's orders. Based on record review and interview for 1 additional client (G), the facility failed to ensure client G received medication as ordered by the dentist.</p> <p>Findings include:</p> <p>Client G's mother/advocate was interviewed on 2/16/15 at 11:10 AM. Client G's mother/advocate provided the following electronic correspondences between herself, her husband and AS (Administrative Staff) #1, AS #2 and CS (Clinical Supervisor) #1:</p> <p>-Electronic Correspondence dated 2/6/15 indicated, "[AS #1], your apologies for recent barriers and vow to make things right are appreciated. I'm curious to know what can restore [client G's] dental health, so as to make this right? [Client G's] dental records indicate that in 2013 it was determined he had 4 cavities. [Client G] was prescribed both fluoride toothpaste and mouthwash. These prescriptions were never filled, nor were the cavities. [Client G's] next dental visit was in 2015, at which time the dentist you lined up for him said there were now 8 cavities. I have since taken [client G] to my dentist. These are not cavities but rather areas of total decay, at a minimum 12 entire areas. [Dentist] has already</p>	W 368	<p>CORRECTION:</p> <p><i>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Specifically, during an investigation into allegations of neglect of Client G's dental care needs, the Operations Team discovered that the Listermint Fluoride Rinse prescribed by Client G's dentist had been discontinued by the manufacturer and that the dentist changed the prescription to Prevident 5000, to take the place of the Listermint. The pharmacy sent one tube of Prevident 5000 on 10/11/13 and a tube of SF 5000 (generic equivalent for Prevident 5000) on 2/4/14 and 6/15/14. The facility's Team Lead and Medical Coach will work directly with the facility nurse to assure prescriptions are filled in a timely manner to facilitate administration of medication in compliance with physician's orders.</i></p> <p>PREVENTION:</p> <p>The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per</p>	03/21/2015

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	<p>begun the process of doing what can be done for him, one quadrant of the mouth at a time. Stainless steel caps rather than simple fillings. It will require weeks of additional very painful work to accomplish anything. How can this be made right? Missing items like his shoes or golf clubs can fairly easily be replaced. You made some indication that there was a willingness to replace his missing game system with one of comparable age and condition. Can you somehow restore his teeth to the comparable age and condition they were in 2013? There seems no way of knowing what impact an immediate follow up visit to address the cavities and having filled the prescriptions which were ignored might have had, were it to have been done in a timely manner."</p> <p>Client G's record was reviewed on 2/11/15 at 8:48 AM. Client G's Dental Summary Progress Report dated 9/18/13 indicated, "Exam/, fluoride varnish. Oral hygiene extremely poor. New decay/cavities. Brushing stressed. Recommendations: Listermint with fluoride. Next visit restoration with follow up visit 3/2014." Client G's Physician's Orders form dated 12/19/14 did not indicate documentation of an order for Listermint with fluoride.</p> <p>DON (Director of Nursing) was</p>		<p>week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer medication as prescribed and that all prescribed medications are available. The team Lead will be present during no less than 5 active treatment sessions per week to monitor medication administration and the ordering of newly prescribed medications and treatments. Members of the Operations Team and the QIDP will conduct active treatment observations and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Administrative support at the home will include assuring all prescribed medications are available and administered as ordered.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Lead, Direct Support Staff,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G397		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/19/2015	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250			
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	<p>interviewed on 2/11/15 at 12:02 PM. DON #1 indicated client G had a dental prescription for Listermint with fluoride dated 9/18/13. DON #1 indicated there was not documentation of client G's 9/18/13 prescription for Listermint with fluoride had been filled or implemented.</p> <p>This federal tag relates to complaint #IN00165161.</p> <p>9-3-6(a)</p>				<p>Health Services Team, Operations Team</p>		